STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185122	A. Building B. Wing	07/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Louisville Rehabilitation and Nursing	1155 Eastern Parkway Louisville, KY 40217

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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. 34116 Based on observation, interview, record review, and review of the facility's policy it was determined the facility failed to ensure dignity during dining for residents on two (2) of six (6) floors (2nd and 5th floors). The facility provided disposable cutlery and dishware for residents dining on the second and fifth floors. The findings include: Review of the facility's policy, Resident Rights, undated, revealed the facility would treat residents with dignity and respect in full recognition of their individuality. The facility did not provide a policy for Dignity and Dining. Observation of dining on the fifth floor, on 05/05/2021 at 8:24 AM, revealed the facility provided plastic utensils on breakfast trays. Interview with Resident #36, on 05/05/2021 at 9:00 AM, revealed the facility provided plastic utensils and their meals were served in Styrofoam boxes most of the time. Continued interview revealed the resident had no strength in his/her right hand and he/she had a hard time cutting food with the disposable utensils. Resident #36 stated he/she hated the plastic utensils. According to the resident, the facility did not have enough plates and silverware. Observation, on 05/05/2021 at 9:22 AM, revealed the facility provided Resident #15 with disposable utensils with breakfast. Interview during the observation revealed the resident preferred regular silverware. Resident #15 stated he/she sometimes had trouble gripping and could not pick up as much food with the disposable utensils. According to the resident, there were times when the facility served his/her coffee in a disposable cup. Interview with Certified Nursing Assistant (CNA) #43, on 05/17/2021 at 3:35 PM, revealed the facility had used disposable cups for meals for a long time. CNA #43 stated the kitchen sometimes provided disposable utensils when the dishwasher was broken or they were short staffed. The CNA stated disposable utensils were not homelike. (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 - Few	Interview with CNA #13, on 05/13/2021 at 11:07 AM, revealed the facility used disposable cups and utensils off and on at times. CNA #13 stated the kitchen usually ran out of cups. The CNA stated she noticed the facility did not provide knives and it was hard to cut up meat with a disposable fork and spoon. Interview with CNA #48, 05/17/2021 at 3:07 PM, revealed the facility had used disposable cups and utensils since she worked there. She stated dietary sent juice with the meal cart; however, they did not send cups. She stated staff used the disposable cups that were stocked on the unit. CNA #48 stated residents should be provided with non-disposable dishes and utensils to ensure a homelike environment. Interview with Licensed Practical Nurse (LPN) #26, on 05/17/2021 at 2:15 PM, revealed the facility had been using disposable utensils and cups for months. The LPN stated she was not aware of any concerns regarding the disposable utensils; however, it was a little hard to cut meat with a plastic spoon and fork. According to the LPN, the disposable dishware made it seem more like a restaurant instead of homelike. 2. Observation of the fifth (5th) floor dining, on 05/04/2021 at 12:49 through 1:10 PM, revealed the facility provided plastic utensils on lunch trays, and the plates, drinks and eating utensils remained on the tray. Observation of Residents #14, #21, #59 and #115 during the lunch meal service, on 05/04/2021 at 12:49 PM through 1:10 PM revealed the residents' drinks were served in plastic cups and the eating utensils provided were plastic. Attempted interview with Resident #14, on 05/04/2021 at 1:05 PM, without success. Interview with Licensed Practical Nurse (LPN) #20, on 05/04/2021 at 1:00 PM revealed the residents frequently ate with the plastic spoons, forks and knives. She stated she suspected the kitchen ran out of silver wear while preparing lunch trays; therefore, substituted with the plastic ware. Interview with Nurse Aide (NA) #2, on 05/08/2021 at 8:47 AM revealed the kitchen provided the plastic spoons and forks to the residents to eat their meals. She stated the plastic spoons and forks were sent on the meals trays for the past six (6) months since she had been employed there. NA #2 stated most people used metal spoons and forks in their home. Continued interview revealed the kitchen sent the plastic for the residents to use. She stated this was not much like home when using the plastic items, but this was the type of spoons and forks available. NA #2 stated the food plates and drinks stayed on the trays when their meals were served in the dining room. She stated the residents should have silverware like they used in their home, and plates should be served on the tables. Interview with the Dietary Director, on 05/14/2021 at 9:15 AM, revealed the facility constantly lost dishware and had to use disposable plastic. He stated he conducted a daily walk through to recover missing dishes in residents' rooms. The Dietary Director stated he communicated with UM's and management regarding the shortage of dishware and they ordered supplies as needed. He stated the disposable dishware could potentially make it difficult for a resident to eat and could result in weight loss. According to the Dietary Director, the use of disposable dishware was not a regular occurrence. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing (DON), on 05/28/2021 at 11:44 AM, revealed she was not aware of an issue with disposable cups and utensils. She stated meals should be served on regular/washable dishes for dignity and respect of the residents. Interview with the Administrator, on 05/27/2021 at 2:21 PM revealed there were a lot of residents that hoarded dishes/silverware. She stated some residents would not allow staff to touch their room. The Administrator stated administrative staff were assigned, Guardian Angel rounds weekly to check on residents and they returned any hoarded items as needed.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 43328 Based on interview, review of grievance forms and logs, review of Resident Council minutes, and review of the facility's policy it was determined the facility failed to ensure the resident council concerns were addressed and followed-up. The resident council concerns were not addressed and followed up for eight (8) of eight (8) sampled residents attending the Resident Council, out of a total resident sample of one hundred thirteen (113) residents (Residents #11, #15, #23, #73, #90, #96, #143, and #152). Residents voiced concerns related to missing laundry, housekeeping, nursing, food quality and temperature. However, the facility did not follow up with the Resident Council regarding the outcome of their concerns. The findings include: Review of the facility's policy, Resident Council Policy, reviewed 02/01/2016 and implemented 03/01/2016, revealed the resident council offers an avenue by which residents can have an active role in influencing decisions which will affect them. Participation involvement in the Resident Council gives the resident a sense of being in control, which results in a positive impact on their physical and mental health. The council group members, who voice a concern, expect a timely response about the resolution to their concern. This must happen. The administrator monitors this process. Review of the facility's Resident's Rights, policy, not dated, revealed residents have the right to a dignified existence. Protection and promotion of resident's rights will be maintained by the facility. The resident has the right to expect prompt efforts for the resolution of grievances. Review of the Neighborhood Association Meeting minutes dated 09/30/2020, revealed housekeeping concerns related to floors not mopped on the fourth and sixth floor. Residents on the fifth (5th) floor received clothing that did not belong to them. Third (3rd) and sixth (6th) floor residents complained of waiting too long for nursing to answer the call lights. On the fifth (5th) floor, one (1) resident was not able to locate staff on the night shift. Continued review revealed the fourth (4th) floor residents did not receive menus, food as ordered and their food was cold. Review of the Neighborhood Association minutes dated 10/30/2020 revealed fourth (4th) floor residents expressed a concern related to only allowing residents who smoked outside. A resident on the third (3rd) floor stated his/her clothes were returned from the laundry torn. A resident on the fifth (5th) floor reported missing clothes and his/her room was not mopped every day. Continued review revealed on the sixth (6th) floor, the food cart sat for a period before the food was delivered. Call lights were not answered in a timely manner on the third (3rd) and sixth (6th) floors. The fifth (5th) floor residents complained that there were no condiments on their trays and the food was cold. Two (2) residents on the sixth (6th) floor did not get the food they ordered from the menu on weekends. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Neighborhood Association minutes dated 11/30/2020 revealed the fifth (5th) and sixth (6th) floor residents had missing clothes. On the sixth (6th) floor the garbage was not taken out daily and the floor was not mopped. In addition, staff were loud at night and call lights were not answered in a timely manner. Further review revealed the third, fourth, and sixth floor residents did not receive condiments on dietary trays. A fifth floor resident did not receive his/her food ordered from the menu. Continued review revealed the third, fifth and sixth floor residents reported their food was cold. Review of the, I Would Like to Know (IWLTK) forms revealed these forms were used to ensure residents, family members, legal representatives and visitors had the opportunity to ask management questions or express their concerns. The forms provided for internal facility review and follow up with complainant for issues. The IWLTK forms were logged on the I Would Like to Know, Quality Assurance Tracking form. The complaint, person filing the complaint, responsible department head, resolution, and resident notification were documented on the tracking form. Interview with Resident Council Members (Residents #11, #15, #23, #73, #90, #96, #143, and #152), on 05/11/2021 at 10:06 AM, revealed the Resident Council met monthly before Covid -19. Continued interview revealed the residents' grievances were brought to the President of the Resident Council, and their concerns were given to the administrator. Interview revealed the residents were not aware of where the facility's State Survey Agency's survey results were posted. The Resident Council was not aware of the results or actions of the Administrator related to their concerns. Interview revealed the residents were not able to verbalize how issues were resolved or how the facility followed up on their concerns. The residents stated they did not recall receiving written notification of how grievances were resolved. Interview with Resident #23, on 05/11/2021 at 10:06 AM, revealed he/she was not sure when the Resident Council Meetings could resume. Resident #23 stated that in the past, department heads would attend the meeting and address concerns with the residents. However, the Council was not able to meet with the department heads since COVID19. Continued interview with the council member revealed their issues were not always resolved. For example, if they complained that the food was cold, they would say they were working on it, but it has not been resolved. Interview, on 05/11/2021 at 10:06 AM, with Resident #96 revealed, The aides do not come by and ask us about our showers. In addition, Resident #96 stated that his/her clothing was not received back from the laundry in a timely manner and clothes were left in a basket a week at a time before they were taken to the laundry. Continued interview with Resident #96 revealed, dirty clothes were supposedly picked up daily, and bags with names on them were used to hold dirty clothes. Resident #96 stated that he/she reported missing four (4) pair of pajamas for nine (9) weeks. Resident #96 stated that medications were not given on time by agency nurses. Interview, on 05/11/2021 at 10:06 AM, with Resident #23 revealed he/she had dirty clothes for three (3) weeks. Resident #23 stated that the agency nurses do not do dressing changes on time and do not give medications on time. Continued interview revealed the facility gave the residents a list of rules at admission, but there had not been a discussion of the rules and residents' rights since the resident was admitted to the facility. Resident #23 stated that he/she had reported a phone missing or stolen about two (2) or three (3) months ago, and now he/she keeps his/her valuables locked up. The resident stated the facility provided a lock box with a key. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Certified Nursing Assistant (CNA) #13, on 05/13/2021 at 10:38 AM, revealed soiled clothes sat in a bin for three (3) or four (4) days before the laundry picked them up. The CNA stated residents might get their laundry back in two (2) weeks. She stated the CNAs picked up residents' laundry bags once a week and laundry staff gathered them to wash. She stated the residents had only one (1) laundry bag and there was no bag to store soiled laundry until the bag was returned from the laundry. CNA #13 stated staff used a trash bag for additional soiled laundry. According to CNA #13, residents complained all the time about not getting their clothes back on time. She stated she reported missing clothes to the Unit Manager (UM) if she could not locate them. The CNA stated she would not want to wear a hospital gown all of the time. She stated it felt good when you could wear your own clothes. Interview with Activities' Director (AD), on 05/21/2021 at 11:00 AM, revealed she coordinated the resident council with the help of an assistant. The AD stated that she talked with individual residents to assess their concerns. Continued interview revealed she also interviewed the Resident Council President and the [NAME] President to identify additional issues reported by the residents. The AD stated that she took minutes during the Resident Council meetings. Further interview revealed AD visited the floors on the same day, once a month to assess residents for issues. The AD stated grievances and concerns were documented in the computer and a report was sent to activities, dietary, nursing, housekeeping, laundry and social services. She stated that residents filed grievances using the IWLTK forms and the forms were passed on to the department of concern. She stated the residents may also initiate a grievance with any staff member. The Activity Director stated she was not aware if residents could file anonymous grievances. She stated that Social Services was in charge of investigations for grievances, and the Administrator was the Grievance Coordinator. The AD stated she thought the director of the department, related to the concern, was responsible for communicating resolution of grievances to the individual resident. Interview with the Maintenance Director (MD), on 05/21/2021 at 2:00 PM, revealed residents reached out directly to maintenance staff to communicate issues. The Maintenance Director stated that a managers' meeting was held two (2) times a day, and issues were brought to the daily meeting. Additionally, he stated that the Nurse Managers could reach out directly to the Maintenance Director with issues. Continued interview revealed he did not receive Resident Council Minutes addressing resident issues. Interview with Social Service Designee (SSD) #2, on 05/21/2021 at 2:29 PM, revealed she had attended a Resident Council meeting one (1) time. SSD #2 stated she thought grievances went through the Activities Department. She stated she did not recall seeing the resident council minutes. The SSD stated that the AD went around and talked to residents about their concerns. In addition, SSD #2 stated that the I Would Like to Know Item Missing form was the last step of the grievance process and the form identified specifics of the grievance and recorded the outcome. Interview with the Director of Nursing (DON), on 05/21/2021 at 2:13 PM, revealed she was not aware of the current resident council process. The DON stated she had observed the Activity Director interview residents about their concerns. She stated she had not had any concerns come to her through the resident council minutes. The DON stated, the grievance form, I Would Like to Know, could be obtained at the front desk and residents could file grievances anonymously. Additionally, the DON stated, the Administrator was the Grievance Coordinator. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Administrator, on 05/21/2021 at 3:01 PM, revealed the Activities' Director coordinated and organized the resident council meeting and recorded the minutes during the meeting and gave them to her. Continued interview revealed the minutes were distributed to the appropriate departments if issues were identified. The Administrator stated the, I Would Like to Know form was available for filing grievances. She stated the residents could file grievances anonymously or put a name on the form. Further interview revealed the residents were educated on the grievance process at the time of admission and during the resident council meetings. Additionally, she stated staff were educated on the grievance process during orientation. She stated that Social Services, administration or any staff member may take the responsibility to handle a grievance and individual department heads were responsible for investigating the grievances. The Administrator stated she was the grievance official for the facility and tracked and trended grievances. Continued interview revealed when a problem was identified, a performance improvement plan, (PIP) was initiated. The Administrator stated a PIP for missing clothing was in place at this time and residents with missing items were informed a plan was in place. She stated that a log for grievances was completed by Social Services. The Administrator stated that the grievance process was decentralized at this time. She stated she interviewed residents to identify problems and the problems were then listed on the minutes. Additionally, she stated the problems were transferred to the IWLTK form if the resident desired to file a formal grievance. The Administrator stated the Resident Council minutes were delivered to the department heads and if there were recurring problems, a PIP was developed. She stated there was an ongoing PIP for dietary and laundry and Social Services provided feedback to the residents about the findings and outcomes related to their grievances.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34116 Based on observation, interview, record review, and review of the facility's policy it was determined the facility failed to ensure a safe, clean, comfortable, and homelike environment for seven (7) of twelve (12) shower rooms; four (4) of six (6) ice machines; broken outlet, soiled privacy curtains, and peeling/missing wallpaper. In addition, Resident #102's wall and bathroom door were heavily soiled with a black, brown, and red substance; and, there was debris scattered on the floor. The findings include: Review of the facility's policy, General Cleaning Policies and Procedures - Resident Room Clean, undated, revealed the purpose of the policy was to provide a clean, attractive and safe environment for residents, visitors and staff. The policy revealed housekeeping cleaned and disinfected rooms, to include bed rails, IV (intravenous) poles, doorknobs, wheelchairs, walkers, and all other high contact surfaces. The policy stated staff dust mopped the residents' rooms and bathroom floor; moved furniture and replaced after dust mopping; dusted under and behind the bed; and wiped walls around trash containers, light switches, and under soap dispensers. The policy further revealed it was the responsibility of housekeeping staff. Staff should conduct a general inspection, survey the area, pick up loose trash, and report all damage including walls, furniture, cubical and window curtains (note cleanliness), resident belongings, and sinks. Review of the facility's policy, Resident Rights, undated, revealed the facility provided a safe, clean, comfortable, homelike environment, allowing the resident the opportunity to use personal belongings to the extent possible. Observation of Resident #102's room, on 05/09/2021 at 10:30 AM, revealed the wall, bathroom door, and mirror adjacent to the bed was heavily soiled with a dried brown, red, and black substance; and torn, loose wallpaper near the ceiling. Further observation revealed the floor was soiled with a black substance and there was debris scattered on the floor and under the bed/furniture. Interview with Certified Medication Technician (CMT) on 05/09/2021 at 10:30 AM revealed the floor was sticky and the wallpaper looked like it was pulled from the wall. She stated the resident spat food and it looked like there was juice on the wall. The CMT stated housekeeping was responsible for cleaning residents' rooms daily; however, it did not look like they had cleaned the wall or swept the floor recently. Review of the clinical record revealed the facility admitted Resident #102, on 08/16/2018 with diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction, Bipolar Disorder, and Atrial Fibrillation. Review of the Annual Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of thirteen (13) and determined he/she was interviewable. Observation of Resident #102, on 05/12/2021 at 3:18 PM, revealed the resident was resting quietly in a low bed. Interview with the resident, during the observation, revealed the soiled wall and door made him/her feel bad. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Certified Nursing Assistant (CNA) #13, on 05/13/2021 at 10:38 AM, revealed the wall had stuff all over it like food. She stated the wall was nasty and the bathroom door looked dirty. The CNA stated she wiped the wall off whenever she saw it was soiled. According to the CNA, housekeeping staff did not stay long, there were lots of issues, and the facility was dirty. CNA #13 stated housekeeping staff sometimes had to split a floor to clean because they were short staffed. She stated one (1) person could only clean so much. The CNA stated the appearance of the wall and door was unacceptable because it was the resident's home. Interview with Dietary Aide #2, on 05/13/2021 at 11:45 AM, revealed she filled in for Housekeeping when they were short staffed. She stated the Director of Housekeeping needed someone to clean rooms for the day. She stated she was responsible for sweeping, mopping, wiping off counters, dusting furniture, and cleaning bathrooms, dining rooms, and hallways. Interview with Licensed Practical Nurse (LPN) #10, on 05/18/2021 at 3:15 PM, revealed she noticed the soiled wall and reported the issue to the former Unit Manager (UM). According to the LPN, the resident threw food and it looked like Housekeeping tried to clean it. Interview with UM #3, on 05/18/2021 at 3:30 PM, revealed she was aware of Resident #102's behavior with throwing food. She stated she reported the soiled wall/door to the Director of Housekeeping. She stated it was important to monitor for cleanliness because it was the resident's home. Interview with Housekeeper #3, on 05/13/2021 at 2:40 PM, revealed Resident #102 had an issue with throwing food and spitting on the wall. According to the Housekeeper, the bathroom door appeared soiled for about three (3) months and it looked like old food spattered on the wall. She stated she notified the Director of Housekeeping of the issue about a month ago. Housekeeper #3 stated the Director of Housekeeping came to look at the soiled wall/door and was supposed to get her some cleaner. She stated it was important to clean and disinfect every wall, door, and high touch area for infection control and safety of the resident. Interview with the Director of Nursing (DON), on 05/28/2021 at 11:44 AM, revealed she rounded on the units a couple of times a day and addressed any environmental issues immediately. The DON stated she noticed Resident #102's wall and bathroom door spattered with a substance and the floor needed cleaning. She stated she notified the Director of Housekeeping and the issue was corrected. The DON stated she was not aware of any grievances or concerns with cleanliness of the environment. Observation of room [ROOM NUMBER], on 05/10/2021 at 11:17 AM revealed the curtain was dirty in appearance with what appeared to be traces of blood. The wallpaper was coming off the walls and the floor appeared dirty with spots and debris. Observation of a shower bed in the hallway and interview with Certified Nurse Aide (CNA) #35, on 05/15/2021 at 9:15 AM, revealed the shower bed mattress was compromised with cuts. Additionally, there was debris located under the mattress including, a coin, a piece of fingernail or toe- nail and a dark substance on the surface, mold-like in appearance. She further stated she did not know how long the shower bed was dirty. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Unit Manager (UM) #4 and observation of the shower bed, on 05/15/2021 at 9:25 AM, revealed the shower bed had holes in the mattress. Continued interview revealed the shower bed mattress was dirty, and needed changing. Upon further observation and interview with UM #4 revealed under the shower bed mattress, a finger or toe nail clipping, loose dirt and debris. She further stated the staff should clean and wipe the shower bed between each resident and inspect the shower beds before each use. Observation of the ice machine at the fifth (5th) floor nurse's station area, on 05/12/2021 at 9:06 AM, revealed a dark substance in the grove inside of the lid and a slow dripping liquid substance dripping onto the floor from the bottom edge of the ice machine. Observation of the fifth (5th) floor dining room, on 05/04/2021 at 8:55 AM and on 05/17/2021 at 10:39 AM, revealed a tacky substance with a gripping sensation when walking near the storage room entrance. The floor surface appeared discolored with a dark substance. Observation of the fifth (5th) floor handrail on the even numbered hall, across from resident room [ROOM NUMBER], on 05/17/2021 at 10:36 AM, revealed a sharp nick like surface on the handrail support bar. Observation of resident room [ROOM NUMBER], on 05/12/2021 at 9:09 AM, revealed three (3) missing floor tiles by the air conditioner/window. Observation of the sixth (6th) floor shower room [ROOM NUMBER], on 05/12/2021 at 9:35 AM, revealed the first stall showerhead had water running and did not shut off. The sink contained ten (10) clean towels and five (5) washcloths. Observation of the sixth (6th) floor shower room [ROOM NUMBER], on 05/12/2021 at 9:46 AM, revealed the showerhead in the second (2nd) shower stall had water that continued to run and did not turn off. Further observation revealed black skid marks present on the floor with dirt and debris. Observation revealed an unknown brown substance on the floor by the sink (appearance of bowel movement (BM)). Used gloves remained on the floor with dirty wet washcloths. Continued observation revealed the white shelving unit had black, brown and orange loose dirt, debris and stains. Observation of the door to room [ROOM NUMBER], on 05/12/2021 at 9:49 AM, revealed the doorknob ring was loose and not attached. Continued observation revealed the baseboards were loose, and separating from the walls in the corridors. Observation of the spa on the fifth (5th) floor, on 05/12/2021 at 9:55 AM, revealed the showerhead was dripping water and would not turn off. The first stall was out of order and the water continued to drip from the showerhead. Observation revealed yellow water in the toilet, with the appearance of urine. Paper and debris were observed on the floor with a brown black substance. A gown was noted on the sink. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of room [ROOM NUMBER], on 05/14/2021 at 8:26 AM, revealed dirt and debris on the floor, behind the bed, and in the corners. The bedside table was covered in dirt and debris. The over-the-bed table had jagged edges, dirt and debris. Continued observation revealed the corners and edges of the closets with splintering wood. A protruding screw was coming from the wall located near the television. Multiple long black marks were observed on the walls. There were electrical conduit and a plug pulled away from the wall exposing red, black and white electrical wires. In addition, a brown triangular, bare foam-positioning pillow placed on bed 2 (two). The foam-positioning pillow appeared dirty and soiled with numerous chunks of foam missing. Continued observation of the third (3rd) floor, on 05/14/2021 at 8:26 AM, revealed the baseboards were pulling away from the walls. Food splatter and stains were located on the wallpaper under the handrails. Observation of the seventh (7th) floor area of the back room portion of the nurse's station, during interview with Unit Manager (UM) #1, on 05/12/2021 at 9:32 AM, revealed a dried whitish colored substance on the outer surfaces, and both sides of the ice machine used for residents. The UM stated the substance on the outer surface of the ice machine was the appearance of a corrosive substance related to water damage. She stated the outer corrosive substance had been on the outside for a long time. Continued observation revealed a slow drip on the bottom left side (when facing) of the ice machine. On the floor under and around the ice machine was the same whitish corrosive appearing substance in close proximity to the leak/drip location. UM #1 stated the ice machine needed a thorough cleaning. Continued interview revealed cleaning should take place residents would not get any dirt in their drinks. She stated nursing was not responsible for cleaning the ice machines. The UM stated she did not make observations of the ice machine or, make inspections as this was not in her role or responsibilities. Continued interview and observation revealed the microwave used for the residents on the unit had an area inside of the microwave that appeared compromised. She stated the right inner side of the cooking area appeared burnt, with a hole, and was possibly a safety hazard. She stated she had been informing the Administrator for the past three (3) months of the microwave needing replacement. Further observation of the microwave revealed the light colored manufactured surface across the bottom panel inside of the door opening was missing. The inside surface of the microwave was soiled with the appearance of dried food spillage. Interview with Housekeeper #1, on 05/12/2021 at 9:45 AM, revealed her responsibilities included cleaning the couches, beds, rooms, and refrigerators; however, she was not responsible for the ice machine. She stated the big resident refrigerator and staff refrigerator had not been cleaned for over a week. She stated her role was to clean the shelves, drawers, and other surfaces in the refrigerator. 30898 Observation, on 05/04/2021 at 12:10 PM, of the third floor odd side hallway revealed wallpaper in the hallway was missing and the drywall patched. On 05/15/2021 at 9:53 AM, the wall between the double doors and the door to the nutrition room had exposed drywall with a piece of cardboard taped to the wall with blue tape, from the handrail to the ceiling. The backboard of the handrail contained a black substance at the end where the handrail intersected with the wall with the double doors. The exposed drywall extended to the wall with the double doors from the floor to the ceiling, and approximately halfway over the double doors. The ceiling metal framing in that area had black and brown coloring, with the rest of the framing down the hall a beige tone. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/13/2021 at 11:09 AM, on 05/13/2021 at 3:35 PM, and 05/17/2021 at 9:34 AM, observations revealed the third floor spa room on the even hall had a broken tile on the right bottom side of the shower and black marks on the floor in front of the sink, toilet, and door. Observations of the third floor spa on the odd hall, on 05/13/2021 at 3:32 PM, and 05/17/2021 at 9:33 AM, revealed the two (2) showers had broken tiles to the right side of the wall at the corner. The broken tiles were the second and third tiles up from the floor. The right shower curtain had black mark substance on the bottom of the curtain. Interview with CNA #24, on 05/17/2021 at 1:48 PM, revealed maintenance was responsible for the broken tiles. She stated she did not notice the tiles before and it was unseemly looking. The aide stated the broken tiles was a sanitary issue for the residents. Interview, on 05/17/2021 at 2:18 PM, with Licensed Practical Nurse (LPN) #27 revealed housekeeping was responsible to clean the shower rooms every day. She stated no one alerted her there were broken tiles. The nurse stated a broken tile could graze a resident's skin or mold could grow. She stated there was a leak from the seventh floor down to the third floor about four (4) to five (5) months ago, where the drywall was exposed. Observation, on 05/13/2021 at 3:46 PM, 05/15/2021 at 9:47 AM, and 05/17/2021 at 8:53 AM, revealed the fourth floor spa room on the even hall had a black substance on the floor in front of the shower and on the shower curtain. Interview with Unit Manager (UM) #4, on 05/17/2021 at 9:48 AM, revealed housekeeping cleaned the shower room. She stated the black marks on the floor could be dirt. She stated maintenance was responsible for fixing chipped tiles. The UM stated she looked in the shower rooms. However, she did not see the broken tile or recall the black substance on the floor. She stated currently a housekeeper was not assigned to the fourth floor. On 05/17/2021 at 10:46 AM, interview with Certified Nurse Aide (CNA) #38 revealed she saw the black substance on the shower room floor before, and thought it looked like mold. She stated she had not noticed the broken tiles in the shower room. Observation of the fourth floor spa room on the even side, on 05/17/2021 at 1:24 PM, revealed a black substance on the floor. Interview, on 05/17/2021 at 1:33 PM, with Registered Nurse (RN) #5 revealed housekeeping was responsible to clean the shower room. She stated she did not know of the black substance before today. Interview with the Director of Housekeeping (DH) and the Maintenance Director, on 05/19/2021 at 8:45 AM, during the environmental tour revealed the DH stated the seventh floor dining room floor was sticky and he was unsure if it was the cleaning product. He stated the floor needed a spot mop as the sticky floor was not sanitary or homelike. The Maintenance Director stated the broken shower room tiles were the responsibility of the maintenance department, however there were only two (2) of them for the facility. He stated the broken tiles could be caused from the mechanical lift. Continued interview revealed the broken tiles was a sanitary issue as the washable surface was compromised. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During continued interview on 05/19/2021 at 8:45 AM, the HD and Maintenance Director stated the Dietary Department was responsible to clean the ice machines and refrigerators on the floors. The Maintenance Director stated the missing floor tiles in room [ROOM NUMBER] was due to a replacement of the air conditioner unit in August 2020. He stated he was looking for tile to match the floor. He stated there was a difference in the height of the floor at the missing tiles, around a couple of millimeters, however he did not think it was an issue, even for a resident who was barefoot. The HD and Maintenance Director stated they were not aware of the walls in room [ROOM NUMBER] until the previous week. The HD stated that he and housekeeping had scrubbed the wallpaper until it came off. Further interview on 05/19/2021 at 8:45 AM, with the HD revealed the handrail in the hallway near room [ROOM NUMBER] would not have been noted by housekeeping as they would have used a cloth to go over it when they cleaned it. The Maintenance Director stated it appeared like equipment had banged into the rail. He stated the handrail kept residents in balance and sharp edges could cut a resident The HD stated the black substance on the fourth floor shower room on the even side was not something that could be mopped up. He stated it was a cosmetic issue and was not very pretty. The Maintenance Director stated it looked like too much grout that had been there a long time. Interview with the HD, on 05/19/2021 at 8:45 AM, revealed the brown ceiling framing in the shower was rusted and needed to be replaced. He stated it would look better and be more sanitary. Interview, on 05/19/2021 at 8:45 AM, with the HD revealed housekeeping was responsible for maintaining the privacy curtain in room [ROOM NUMBER]. He revealed the curtain should be clean and replaced. The HD stated when housekeeping cleaned the wallpaper for room [ROOM NUMBER] it could break down the seal. The Maintenance Director stated he tried to keep the wallpaper glued, however he preferred a washable surface. Continued interview, on 05/19/2021 at 8:45 AM, with the Maintenance Director revealed the third floor hallway had a massive water leak about one (1) to two (2) months ago and the wallpaper was compromised. The Maintenance Director stated room [ROOM NUMBER]'s bed was placed against the wall, and when it was raised or lowered it would hit the outlet, which exposed the wires. He revealed he was unaware of the damaged outlet. He further stated the broken outlet could be a potential hazard to touch and should be covered. The Maintenance Director stated the exposed screw could grab at a resident's clothing. He stated the rough edges to the furniture was difficult to clean and needed to be replaced. The HD stated the privacy curtain needed to be washed and replaced as it was a sanitary issue and did not look great. He further stated the facility had extra privacy curtains. Interview with the Administrator, on 05/27/2021 at 2:21 PM, revealed she was aware of some issues with housekeeping and the environment. She stated the Director of Housekeeping was responsible for ensuring deep cleaning of rooms. She stated the facility conducted Guardian Angel rounds and she rounded with the UM's weekly to identify potential concerns. She stated the environment should be maintained to ensure it was homelike and safe.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety 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** 30898 Based on observation, interview, record review and review of the facility's policies it was determined the facility failed to ensure residents were free from abuse for seven (7) of one hundred-thirteen (113) sampled residents (Residents #161, #47, #74, #344, #345, #90 and 136). Resident #161 and Resident #47 related to resident to resident sexual abuse; Resident #74 related to verbal abuse; and, Resident #344, Resident #345, Resident #90 and Resident 136 related to resident to resident physical abuse. 1. On 03/19/2021, after the dinner meal, around 7:30 PM, Certified Nurse Aide (CNA) #36 left the unit to go on break. The CNA left Resident #161 in the dining room/dayroom unsupervised. CNA #35 was at the nurse's station and watched the camera monitor. However, the CNA left the nurse's station to assist another resident, and was gone from the monitor for about five (5) minutes. Upon CNA #35's return to the nurse's station, she observed on the camera monitor, Resident #47 next to Resident #161 in the dayroom. The lights in the dayroom had been turned off. CNA #35 observed Resident #161 with his/her hand on Resident #47's exposed genitalia, in the fourth floor dining room/dayroom. The facility did not assess Resident #161 and Resident #47 for capacity to consent to sexual contact with others to protect the resident(s) from further abuse. 2. Resident #74's bathroom overflowed, with water and feces all over the floor. Upon discovery of the bathroom, Licensed Practical Nurse (LPN) #11 cursed. Resident #74 and Resident #343 indicated they heard the nurse's comments. 3. On 05/05/2020, Resident #345 hit Resident #344 with a reacher multiple times and caused a skin tear to Resident #344's upper chest. 4. On 05/21/2021, Resident #136 was talking with a nurse when Resident #90 came over and also started talking to the nurse. Resident #136 began to disagree about staff, Resident #136 became upset and made a comment to Resident #90 about his/her mother. Resident #90 became upset and hit Resident #136 in the face with his/her fist. Immediate Jeopardy was identified on 05/17/2021 and determined to exist on 03/19/2021 in the areas of 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation, F600 Free From Abuse and Neglect at S/S of J and F607 Develop/Implement Abuse/Neglect, etc. Policies at S/S of J, 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F657 Care Plan Timing and Revision at S/S of J, 42 CFR 483.40 Behavioral Health, F745 Provision of Medically Related Social Services at S/S of J, and 42 CFR 483.70, Administration, F835 Administration at S/S of J. Substandard Quality of Care (SQC) was identified at 42 CFR 483.12, F600 Free from Abuse and Neglect, F607 Develop/Implement Abuse/Neglect, etc. Policies, and 42 CFR 483.40, F745 Provision of Medically Related Social Services. The facility was notified of the Immediate Jeopardy on 05/17/2021. An extended survey was conducted 06/30/2021 through 07/02/2021. The State Survey Agency validated the facility's Allegation of Compliance/Removal Plan and found the facility had removed the immediacy on 06/27/2021, as alleged. The findings include: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy, Abuse Prevention Program, updated 05/02/2017, revealed it was the policy of the facility to prevent resident abuse. Each resident received care and services in a person-centered environment in which all individuals were treated as human beings. Any incident or allegation that involved abuse or mistreatment resulted in an abuse investigation. Further review revealed the investigation gathered further facts prior to making a determination. If there was reasonable cause to suspect abuse, the Administrator or designee investigated the allegation. The final report included facts determined during the investigation and included a conclusion of the investigation based on known facts. Residents who allegedly mistreated another resident were immediately removed from contact with that resident during the investigation. The accused resident's condition was evaluated to determine the most suitable therapy, care approaches and placement, and considered his/her safety, as well as the safety of other residents of the facility. Continued review of the Abuse Prevention Program policy revealed sexual abuse included, but was not limited to, sexual harassment, sexual coercion, or sexual assault. The Administrator was the facility's Abuse Coordinator. The findings of the investigation were provided to the Administrator who either ruled-out or substantiated the allegation of abuse. Review of the facility's policy, Standard Supervision and Monitoring, dated 11/25/2011, revealed supervision and guidance to the resident was an essential part of nursing care in which standard approaches were successful in meeting the residents' physical and psychosocial needs. When either the staff nurse or psychosocial staff assessed a resident to have stable physical and psychosocial needs, regular rounds would be maintained to ensure the resident's needs were met. The resident would be visualized at a minimum every two (2) hours, as well as the start and end of shift and during meal times. At any time a resident could not be guided, supervised, or redirected during regular intervals of rounds, the resident may require one to one (1:1) supervision. Review of the facility's policy, Resident Behavior and Facility Practices, not dated, revealed residents had the right to be free from sexual abuse. The facility must implement procedures that protect residents from abuse. The facility did not provide a policy related to residents' capacity or incapacity to consent. The facility did not provide a policy related to Power of Attorney. The facility provided the resident's Brief Interview for Mental Status (BIMS) assessment from the Resident Assessment Instrument (RAI) as the reference the facility used to determine a resident's capacity to consent. Review of the Abbreviated Instructions for Conducting the BIMS, revised 10/2011, revealed a BIMS' score range of thirteen (13) to fifteen (15) was cognitively intact, eight (8) to twelve (12) was moderately impaired, and zero (0) to seven (7) was severe impairment. Review of the facility's contract with the Psychology (Psych) Consulting Group, dated 01/20/2020, revealed the psych group provided professional medical and psychological services including, but not limited to: Clinical Psychology, Psychiatry, and Gerontology. The psych group contracted with licensed health professionals and reviewed their professional credentials. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's contracted Consultant Group, dated 01/01/2021, revealed the Consultant Group provided assistance, consultation services, and training. Consultants were qualified by education, experience, training, professional licensure and/or certification. Services provided included Social Service Consultation and Social Service Interim. The Consultant Group provided the facility's QA Committee's written reports of activities, recommendations, plans for implementation, and continuing assessment, as appropriate. 1. Review of the clinical record for Resident #161 revealed the facility readmitted the resident on 10/09/2017. Current diagnoses included Hemiplegia affecting left non-dominant side, Cerebral Infarction, Cognitive Communication Deficit, and Vascular Dementia with Behavioral Disturbance. Review of Resident #161's Durable Power of Attorney (POA), dated 10/04/2011 revealed the resident appointed a POA as his/her true and lawful attorney to act in, manage, and conduct all my estate and all my affairs, for me and in my name, in the doing or executing of, all or any of the following acts, deeds, and things. Number thirteen (13) stated, authorized to take charge of my person in case of sickness or disability of any kind; to remove and place me in such hospitals or places as such attorney may deem best for my personal care, comfort, benefit, and safety; and to authorize such medical procedures, care, or attention as I may need. Review of Resident #161's admission documents revealed the resident's POA signed the facility's Admission Agreement, on 07/05/2016, and Advanced Directives, on 10/09/2017, with the designation of POA. Additionally, the POA signed the Kentucky Emergency Medical Services Do Not Resuscitate (DNR) Order, on 07/05/2016. Review of Resident #161's care plan revealed, on 04/13/2018, risk of falls included interventions not to leave the resident alone in his/her room when out of bed, keep him/her around the nurse's station. Review of a facility investigation revealed, on 04/05/2019, Resident #161 sat in his/her wheelchair (w/c) next to another resident in the common area in front of the fourth floor nurse's station. Resident #161's hand was on the other resident's exposed genitalia. The facility placed Resident #161 on one to one (1:1) supervision at that time. The facility assessed the resident's BIMS as a three (3), indicating the resident was severly cognitively impaired. Resident #161 could not recall the incident. The other resident reported Resident #161 rolled up to him/her in the w/c and reached out to hold his/her hand as the resident did many times with staff and residents. However, when the other resident reached for a drink on the table next to him/her, Resident #161 moved his/her hand into the other resident's pants. Further review of the comprehensive care plan for Resident #161 revealed the facility initiated a care plan for behavior of reaching out for others, on 04/06/2019. Interventions included to discuss the resident's behavior, explain/reinforce why the behavior was inappropriate and/or unacceptable if there was a concern, and intervene as necessary to protect the rights and safety of others. An additional intervention, related to falls, dated 05/01/2019, included not to leave the resident unattended in the dining room when out of bed. On 05/18/2020, the facility added an intervention for every hour safety checks related to the risk of falls care plan. Further review of the care plan revealed the facility included an intervention for Activities of Daily Living (ADL) Self Care Performance Deficits, on 05/29/2020, that the resident used a geri-chair while out of bed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Geriatric Visit Note revealed the Nurse Practitioner (NP) saw Resident #161, on 01/20/2021. The Review of Systems included Psychiatric, with reported Disorientation and Memory Loss; and, Neurological, with reported Memory Loss and Chronic Confusion. Additionally, review of the Psychiatric notation revealed the resident was oriented to person, had advanced dementia, and was disoriented to place, time, and situation. Review of a Psychology Progress Note, dated 01/26/2021, revealed the facility referred Resident #161 to the psychology provider for assessment, determination of care needs, and establishment of medically necessary and clinically indicated mental and behavioral health treatment. The resident's diagnoses included Dementia. The resident was moderately impaired for comprehension, executive function, insight, and judgement. The resident was oriented to person and situation, and had difficulty concentrating, with memory deficit immediate, memory deficit recent, and memory deficit remote noted. The resident had expressive communication difficulty during the session, which required additional prompting to accurately assess the resident's input. Additionally, the provider administered, with facility staff assistance, the Dementia Severity Rating Scale (DSRS), which the resident scored thirty-one (31) out of fifty-four (54), indicting moderate severity of symptoms. The resident had impairment to memory and orientation, and rarely made any decisions for himself/herself. Review of Resident #161's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for January 2021 revealed safety checks every hour every shift began 05/18/2020, with documentation three (3) times per day from 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM. The safety checks were discontinued (d/c) on 01/21/2021. Beginning 01/21/2021, the January, February, and March 2021 MAR and TAR documentation revealed safety checks every hour, with hourly documentation noted, for Safety check. Review of a Psychology Progress Note, dated 03/09/2021, revealed the resident was oriented to person and situation, had difficulty concentrating, and had memory deficits immediate, recent, and remote. The resident's comprehension, executive function, insight, and judgement were all noted as Moderate Impairment. Behavioral and psychological symptoms included impairment in memory, comprehension, executive functioning, insight, and judgement. Review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed Resident #161 with a BIMS' score of eleven (11). The facility assessed that the resident was totally dependent upon staff for transfers with two (2) person physical assist, and total dependence to move about the unit with one (1) person assistance. The resident had impairment on one (1) side for upper and lower extremities. Review of a facility incident report, completed by the Assistant Director of Nursing (ADON) dated 03/19/2021 at 10:10 PM, revealed staff observed Resident #47 standing with his/her genitalia exposed and standing by Resident #161. Resident #161 was unable to verbalize if anything occurred. Review of Resident #161's care plan revealed, on 03/19/2021, an intervention was added that he/she was not to be left alone in the dayroom. Review of the COVID-19 Testing Note revealed the Nurse Practitioner (NP) saw Resident #161, on 03/20/2021. The Note stated the resident had disorientation, memory loss, and chronic confusion. Resident #161 was oriented to person only and had advanced dementia. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Psychology Progress Note, dated 03/23/2021, revealed staff requested the visit due to possible sexually inappropriate behavior. The Assessment noted the resident's cognition as oriented to person and situation, difficulty concentrating, memory deficit immediate, memory deficit recent, and memory deficit remote. The resident's comprehension, executive function, insight, and judgement were all noted as moderate impairment. The Note further revealed the resident was minimally responsive and speech was noted for expressive aphasia. The resident did not endorse memory of the recent behavior in question and redirection/reorientation intervention was administered. Additionally, the note documented due to dementia, the resident did not have the capacity to make major decisions, including consent for relationships with other residents. Ongoing mental and behavioral assessment and treatments were clinically indicated and appropriate. Recommendations included further cognitive assessment, further assessment of mental and emotional status, and both supportive and cognitive-behavioral psychotherapeutic interventions. Current stressors that impacted function included cognitive decline. Further review revealed the resident's confusion and impaired verbal communication required simplified and careful vocabulary, repetition, and clarification. Review of a Psychiatric Progress Note, dated 03/30/2021, revealed Resident #161 was a poor historian due to cognitive/psychiatric impairment. Observation of Resident #161, on 05/06/2021 at 2:23 PM, revealed the resident was in a geri-chair at the fourth floor nurse's station. A pillow was under the resident's head. Staff asked the resident if he/she wanted to lay back more, the resident nodded and staff adjusted the back of the geri-chair. Observations, on 05/12/2021 at 3:26 PM; 05/13/2021 at 2:26 PM and 3:43 PM; 05/14/2021 at 2:27 PM; 05/16/2021 at 9:05 AM; and, on 05/18/2021 at 1:40 PM revealed Resident #161 in the geri-chair at the nurse's station. Further observations on 05/19/2021 at 10:54 AM, 06/02/2021 at 2:44 PM, and 06/03/2021 at 11:19 AM, 06/08/2021 at 1:51 PM, revealed Resident #161 in the geri-chair at the nurse's station. Attempted interview with Resident #161, on 05/06/2021 at 2:23 PM, revealed the resident did not respond. Observation of Resident #161, on 06/10/2021 at 8:27 AM, and on 06/14/2021 at 8:48 AM, revealed the resident was in bed, a meal tray was on the over bed table on the left side of the bed. Staff entered the room, sat the resident up in the bed, and began to feed the resident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview, on 04/29/2021 at 1:54 PM, with Certified Nurse Aide (CNA) #35 revealed on 03/19/2021 after dinner, sometime between 7:00 PM and 8:00 PM, CNA #36 left to go on break. CNA #35 stated she sat at the nurse's station and saw Resident #161 on the monitor from the camera in the dayroom, and saw Resident #47 in his/her doorway. CNA #35 stated she left the nurse's station, for about five (5) minutes, to assist another resident. She stated when she returned to the nurse's station, Resident #47 was no longer in his/her doorway. CNA #35 stated after a few minutes, she looked at the monitor and noticed the lights to the dayroom were off. Further interview revealed she saw Resident #47's face on the monitor, to the right of Resident #161, who was in a geri-chair, and his/her body moved back and forth. The aide stated at that time, CNA #36 returned from break and she asked her to check on the residents. CNA #35 also stated another resident, who was also in the dayroom reported to her that Resident #47 turned off the lights in the dayroom. The CNA stated Resident #161 would put his/her hand out and try to grab people, and put things in his/her mouth like a child. She further stated Resident #161 would use signs to communicate, such as put his/her hand to his/her mouth when hungry. Interview with Licensed Practical Nurse (LPN) #30, on 04/29/2021 at 2:54 PM, revealed she was the nurse for Resident #161 and was on break when Resident #161 and Resident #47 had sexual contact with the other, after dinner. The nurse stated she was unaware Resident #161 had a similar incident with another resident until the Power of Attorney (POA) informed her of the previous incident, when she notified the POA of this incident on 03/19/2021. The LPN stated Resident #161 said, It was wonderful, however the resident did not say what it was. LPN #30 stated Resident #161 could say if he/she was hungry or in pain. However, it was hit and miss how oriented the resident was and if he/she could carry on a conversation. On 04/29/2021 at 3:12 PM, interview with CNA #36 revealed when she returned from her thirty (30) minute break, CNA #35 asked her to check on Residents #161 and #47 in the dayroom, as she saw them on the monitor together. CNA #36 stated when she got to the dayroom, Resident #47 was on Resident #161's right side, and the lights were off. She stated Resident #161 had his/her hand on Resident #47's genitalia, and Resident #47 covered himself/herself with the pillow behind Resident #161's head. The CNA stated Resident #161 laughed and said it was wonderful. CNA #36 stated Resident #161 had a history of touching people and would reach out and grab people. She further stated Resident #161 could carry on a conversation; however, he/she had confusion. She further stated for Resident #161, staff had to be present when the resident was in the dining room, not just watch on the monitor, due to the resident being at risk for falls. CNA #36 stated Resident #161 could not move about on his/her own in the geri-chair and could not walk. Interview, on 04/29/2021 at 3:55 PM, with House Supervisor (HS) #1 revealed CNA #35 and CNA #36 told her Resident #161 and Resident #47 had sexual contact with each other. The HS stated Resident #161 did not speak a lot and could answer short questions, however the resident had confusion. She stated she was unaware of any increase in supervision for Resident #161 before this incident. On 04/29/2021 at 4:39 PM, interview with CNA #37 revealed she witnessed Resident #161 have previous similar sexual contact with another resident, with his/her hand on the other resident's exposed genitalia, about two (2) years ago. The aide stated Resident #161 was not to be left alone. She further stated when staff went on break, they told the other aides and nurse on the floor. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Registered Nurse (RN) #5, on 06/10/2021 at 10:29 AM, revealed Resident #161 could answer yes/no questions or shake his/her head. She stated the resident would hold his/her hand out, which could be misinterpreted by someone. She further stated she could not recall a time the resident told her no and she had never heard the resident say no. The RN stated she did not think Resident #161 would understand complexities. She further stated she did not think Resident #161 was able to understand what was involved in a sexual relationship. RN #5 stated Resident #161 needed his/her POA to make decisions as the resident was not capable to make decisions for himself/herself. On 04/30/2021 at 6:27 AM, interview with House Supervisor (HS) #2 revealed she was informed of a previous similar sexual contact incident between Resident #161 and another resident about one (1) to two (2) years ago. She stated Resident #161 had his/her hand on another resident's genitalia. HS #2 further stated Resident #161 was not cognitively intact then. She also stated Resident #161 should not be left alone in common areas and was at the nurse's station a lot. HS #2 revealed someone needed to keep an eye on Resident #161. She further stated if Resident #161 was left alone in the common area, inappropriate contact between Resident #161 and another resident could happen again. On 04/30/2021 at 9:09 AM, interview with Social Service Designee #2 revealed she was immediately informed that Resident #161 tried to touch Resident #47's exposed genitalia, while in the dayroom. She stated Resident #161 had previous sexual behaviors of public masturbation and sexual activity in the common area. She stated, however, Resident #161 had not previously touched another resident, and thought this was the first time the resident reached out. The Designee stated she could not recall if Resident #161 had any previous inappropriate contact with another resident. Interview, on 04/30/2021 at 9:27 AM, with the fourth floor UM revealed she was the UM on the fourth floor at the time of the incident between Resident #161 and Resident #47. She stated she was not aware of any prior sexual behaviors from Resident #161. The UM stated the facility already monitored Resident #161 due to being a high fall risk, and the resident was at the nurse's station when out of bed. She further stated Resident #161 was in a geri-chair and should not be left alone in the dayroom. The UM stated no resident should be left alone in the dayroom if he/she could not move back and forth on his/her own. She also stated if Resident #161 was in the dayroom, then staff should also be in the room as the resident was not alert and oriented and there were no call lights in the dayroom. On 04/30/2021 at 1:00 PM, interview with Social Service Designee #1 revealed Resident #161 was not able to self-propel or wheel him/herself around. On 04/30/2021 at 2:06 PM, interview with the Assistant Director of Nursing (ADON) revealed she was the facility's abuse coordinator and responsible for the facility's investigations. She stated she came into the facility and spoke to Resident #161, who smiled and said Resident #47 was tying his/her shoe. The ADON revealed Resident #161 was cognitively impaired. She stated Resident #161 denied anything occurred. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Continued interview, on 06/03/2021 at 9:44 AM, with the ADON revealed Resident #161 was not able to turn off the lights in the dayroom unless he/she sat near the light switch as the resident was in a geri-chair at the time of the incident and was not able to move around on his/her own. She stated she was not aware of the previous incident in which Resident #161 touched another resident's genitalia in 2019. The ADON further stated Resident #161 denied the incident with Resident #47 occurred, even when she (the ADON) told the resident staff witnessed the sexual contact. She revealed Resident #161 was welcome to have a relationship with others, as his/her BIMS was higher. She further stated Resident #161's BIMS score was high enough to provide consent. Additionally, the ADON stated she was unsure if the resident's POA gave permission for Resident #161 to have a sexual relationship. She stated Resident #161 had periods of confusion that fluctuated, dependent on the time of day. Additionally, she stated the facility placed Resident #161 on one (1) hour safety checks after the incident with Resident #47, to see what the resident was doing, where he/she was, and if the resident needed anything. Interview with the Physician, on 06/03/2021 at 9:17 AM, revealed Resident #161 had Dementia and was cognitively challenged. He recalled the resident had a POA who was very involved in the resident's care. The Physician stated psychiatric services was involved in Resident #161's care. He further stated Resident #161 was cognitively challenged and was not able to make a decision to engage in sexual behavior with another. On 06/03/2021 at 10:32 AM, interview with the Administrator revealed Resident #161 was not able to turn out the light in the dayroom. She stated she was unaware of the facility's root cause analysis of the incident between Resident #161 and Resident #47. However, she was sure the ADON or the former DON conducted one. She stated Resident #161 denied anything happened, and was capable to make decisions for himself/herself. The Administrator further stated Resident #161 had not been deemed incompetent by a court. She stated a durable POA would make decisions when a resident was not able to make decisions for himself/herself. The Administrator stated Resident #161's POA was notified any time there was a change in condition, change in medication, and when this incident with Resident #47 occurred. She stated Resident #161 was able to make decisions for himself/herself, including when to get up, when to go to doctor appointments, and if he/she wanted to come out of his/her room. The Administrator stated the resident made healthcare decisions, such as if he/she wanted lab draws or diagnostics. She also stated Resident #161 did not speak with her about the incident, and did not speak with those he/she was not comfortable with. She revealed Resident #161 could answer questions based on who conducted the BIMS' score, as he/she might not answer questions, which resulted in a lower score. Interview, on 06/03/2021 at 1:30 PM, with Resident #161's POA revealed she had been the resident's POA since 2011. She stated Resident #161 had advanced Dementia and was not able to make his/her own decisions. The POA stated the resident lived with her for several years before he/she was admitted to the facility. She further stated the resident was not able to say if he/she wanted to be in a relationship. The resident's POA stated Resident #161 could not recall what happened. The POA stated the resident had a habit to reach out to others and if he/she did that, someone else might take advantage of the situation. She stated Resident #161 did not begin conversations, but could answer yes/no questions. She stated the resident would smile or answer questions if he/she knew you. The POA stated she was very upset about what happened and Resident #161 should not have been left alone in the room. She stated the resident should not have been put in that situation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/03/2021 at 1:48 PM, interview with the former DON revealed the ADON reported to her when the incident occurred between Resident #161 and Resident #47. She stated she was informed no one saw anything. The former DON stated she was unaware of a previous similar incident with Resident #161 and another resident. She stated Resident #161's care plan stated not to leave the resident unattended in the dining room may have been a fall's intervention. However, she stated the purpose of the intervention was to keep the resident safe. Interview with the Administrator, on 06/03/2021 at 3:16 PM and 4:02 PM, revealed the facility followed the law related to the POAs. She stated the facility did not have a policy for POAs. She stated the facility followed the MDS and did not have a policy for the BIMS' assessment. The Administrator also stated the facility did not have a policy related to resident capacity to consent and the only consent the facility used was the consent signed on admission. She stated the facility assessed to determine if Resident #161 had the capacity to give consent to sexual contact based on the BIMS' assessment, and they generally used a score of nine (9) and above. However, she further stated some residents had BIMS' scores that fluctuated from assessment to assessment. On 06/03/2021 at 3:46 PM, interview with the ADON revealed it was hard to determine if the sexual contact between Resident #161 and Resident #47 was abuse or consensual. The ADON stated she was unaware the physician indicated Resident #161 did not have capacity to consent to a sexual relationship. She further stated if a resident did not have capacity to consent, the resident was not able to engage in sexual relationships. The ADON stated Resident #161 should not have been left in the backroom unattended. Interview, on 06/04/2021 at 3:19 PM and 4:52 PM, with the Administrator revealed the facility used a BIMS' score of eight (8) and above, not nine (9), to give consent. She stated the facility used a risk management company; however, they company did not provide information related to consent and intimacy. She stated the risk management company was involved in all reportable events. The Administrator stated Resident #161 had capacity to consent. However no one assessed if the resident wanted to be in a sexual relationship or have sexual contact. She stated the facility did not ask residents if they had a need or urge for sex. She further stated a BIMS of eight (8) to twelve (12) was moderately impaired, the resident may not know the month or year, but was still capable to make decisions based on their BIMS' score. On 06/07/2021 at 11:40 AM, interview with the Regional Director of Operations (RDO) revealed although the facility did not have a policy, it was a standard for residents with a BIMS of eight (8) and above, to allow the resident to consent, if the resident was interviewable. She stated Resident #161 had the right to make his/her own decisions, even though he/she had a POA. She further stated the facility did not have a policy for a resident to give consent, although the facility did not condone it. The RDO stated the residents did not have sex, and denied anything happened. She stated Resident #161's BIMS varied because if the resident did not like or know you, he/she would not answer. She further stated what occurred between Resident #161 and Resident #47 was not abuse as there was no psychosocial distress or injury. Interview with the DON, on 06/07/2021 at 12:10 PM, revealed a resident BIMS' score of eight (8) or above determined if a resident was capable to give consent. She stated the purpose of the BIMS score was to determine if the resident had stabilized cognition and a resident with a fluctuated BIMS' score would mean the resident had periods of confusion. She stated she was not the DON at the time of the incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Administrator, on 06/07/2021 at 1:58 PM, revealed the facility ensured a resident was capable of consent based on the BIMS' score. She stated at times Resident #161 would not talk to others and sometimes he/she would answer questions, scoring higher on the BIMS on some days than others. The Administrator revealed the facility was not able to determine if Resident #161 or Resident #47 initiated contact with the other. Interview with the ADON, on 06/08/2021 at 8:54 AM, revealed she spoke to psych, when they saw Resident #161 after the incident with Resident #47, who said he/she was not a threat to himself/herself or others. However, the ADON did not ask if the resident had capacity to consent and had not read the psych note. She stated based on the documentation by psych on 03/23/2021

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30898 Based on observation, interview, record review, and facility policy review it was determined the facility failed to develop or implement their policy related to facility abuse and neglect for two (2) of one hundred-thirteen (113) sampled residents (Residents #47 and #161) . The facility failed to develop a policy related to assessment for capacity to consent to sexual contact for Resident #47 and Resident #161. On 03/19/2021, Resident #47 and Resident #161 had sexual contact with each other. The facility assessed the resident Brief Interview for Mental Status (BIMS) scores after the incident, and used the BIMS' score results as a determination of capacity to consent to the contact. However, the facility did not have a policy to reference how to determine resident capacity, or when BIMS scores were used as the sole assessment for resident capacity. Immediate Jeopardy was identified on 06/17/2021 and determined to exist on 03/19/2021 in the areas of 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation, F600 Free From Abuse and Neglect at S/S of J and F607 Develop/Implement Abuse/Neglect, etc. Policies at S/S of J; 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F657 Care Plan Timing and Revision at S/S of J; 42 CFR 483.40 Behavioral Health, F745 Provision of Medically Related Social Services at S/S of J, and 42 CFR 483.70, Administration, F835 Administration at S/S of J. Substandard Quality of Care (SQC) was identified at 42 CFR 483.12, F600 Free from Abuse and Neglect, F607 Develop/Implement Abuse/Neglect, Policies, and 42 CFR 483.40, F745 Provision of Medically Related Social Services. The facility was notified of the Immediate Jeopardy on 05/17/2021. An extended survey was conducted 06/30/2021 through 07/02/2021. The State Survey Agency validated the facility's Allegation of Compliance/Removal Plan and found the facility had removed the immediacy on 06/27/2021, as alleged. The findings include: 1. The facility did not provide a policy related to a resident's capacity to consent, or residents who were not able to give consent to sexual contact with others. The facility did not provide a policy related to resident Durable Power of Attorney (POA). Review of the facility's policy, Abuse Prevention Program, updated 05/02/2017, revealed it was the policy of the facility to prevent resident abuse, neglect, and mistreatment. Each resident received care and services in a person-centered environment. Residents who allegedly mistreated another resident would be immediately removed from contact with that resident during the investigation. The accused resident's condition should be immediately evaluated to determine the most suitable therapy, care approaches and placement, considering his/her safety, and safety of other residents. Sexual abuse included, but not limited to, sexual harassment, sexual coercion, or sexual assault. Upon receiving information concerning a report of abuse, social services would monitor the resident's feelings concerning the incident as well as the resident's reaction to his/her involvement in the investigation. Review of the facility's policy, Assessments, dated 08/2017, revealed assessments would be completed when an event occurred that required an assessment by a qualified medical professional. An assessment would be completed based on the event and included Post-Behavior event. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Accident Incident Reporting Policy, not dated, revealed an immediate assessment of the resident would be completed when a resident was involved in an incident. A written report would be completed in the risk management section of the PCC for any resident involved in an incident while residing in the facility. When possible, a descriptive statement would be obtained from the resident or witness. A more extensive investigation was required for resident to resident altercation and suspected/alleged abuse. Based on the results of the investigation, the resident's care plan was revised as necessary to prevent or minimize further incidents when possible. Review of the facility's policy, Standard Supervision and Monitoring, dated 11/25/2011, revealed a proactive intervention that promoted enhanced physical and psychosocial well-being. The physician/psychiatrist would be notified for further evaluation and treatment to further assess and treat the resident if increased supervision and guidance was required. Review of the facility's policy, Resident Behavior and Facility Practices, not dated, revealed residents had the right to be free from sexual abuse. The facility must implement procedures that protect residents from abuse. Review of the facility's document Abbreviated Instructions for Conducting the BIMS (Brief Interview for Mental Status), revised 10/2011, revealed the intent was to determine the resident's attention, orientation, and ability to register and recall new information. For more in-depth instructions for completing the BIMS, refer to Chapter 3: MDS Items Section C: Cognitive Patterns. Repetition Of Three (3) Words Section determined if the resident was able to actively engage in a verbal interaction. Temporal Orientation (Orientation to Year, Month, and Day) section referred to the ability to place himself/herself in correct time. For the BIMS, it was the ability to indicate the correct date in current surroundings. The Recall section revealed residents with cognitive impairment could be helped to recall if provided clues. The Total Score revealed a BIMS score of thirteen (13) to fifteen (15) was cognitively intact, eight (8) to twelve (12) was moderately impaired, and zero (0) to seven (7) was severe impairment. Review of the clinical record revealed the facility readmitted Resident #161 on 10/09/2017. The resident's diagnoses included Vascular Dementia with Behavioral Disturbance, Cerebral Infarction, and Cognitive Communication Deficit. Review of Resident #161's care plan (CP) revealed the resident had Vascular Dementia, Cognitive Communication Deficit, and Cerebral Infarction diagnoses and was at risk for decline in cognitive function. Interventions, dated 04/03/2018, included: use task segmentation to support short-term memory deficits; discuss concerns about confusion, disease process, nursing home placement with the resident and family. Further review of the CP revealed Resident #161 exhibited behaviors of reaching out to others when seated in common areas. This behavior was related to the diagnosis of Vascular Dementia. An intervention, dated 04/06/2019, stated to intervene as necessary to protect the rights and safety of others, divert attention, and remove the resident from the situation and take to an alternate location. Continued review of Resident #161's CP revealed an intervention to offer choices daily (e.g. choice of clothing, food/drink, activity) and may need supervision/assistance with all decision making, initiated 10/24/2019. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Geriatric Visit Note for Resident #161 revealed, the Nurse Practitioner (NP) saw the resident on 01/20/2021. The NP noted the resident had disorientation, memory loss, and chronic confusion. The resident was oriented to person, disoriented to place, time, and situation, and had advanced dementia. Review of a Psychology Progress Note, dated 01/26/2021, revealed Resident #161 had a diagnosis of Dementia. The resident was moderately impaired in comprehension, executive function, insight, and judgement. The resident had difficulty concentrating and was oriented to person and situation. The resident's memory deficit included immediate, recent, and remote. Review of a Psychology Progress Note, dated 03/09/2021, revealed Resident #161 was moderately impaired in comprehension, executive function, insight, and judgement. The resident also had memory deficits. Review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed Resident #161 with a Brief Interview Mental Status (BIMS) of eleven (11), and moderate cognitively impaired. Review of a facility incident, dated 03/19/2021 at 10:10 PM, revealed staff observed Resident #47 next to Resident #161 with his/her genitalia exposed. Resident #161 was unable to verbalize if anything occurred. The incident report was not complete, with information missing related to Resident #161's mental status and if any predisposing factors were present related to the environment, physiological, or situational factors. Additional review of the CP for Resident #161 related to a diagnosis of Vascular Dementia and exhibited episodes of sexual behavior exposed himself/herself in common areas revealed, on 03/19/2021, the resident was not to be left alone in the dayroom. Record review revealed on 03/20/2021, revealed the NP saw Resident #161 for fatigue. The NP assessed the resident as disoriented, had memory loss, and chronic confusion. The note revealed the resident was oriented to person only, and had advanced dementia. Review of a Psychology Progress Note, dated 03/23/2021, revealed staff requested the visit due to possible sexually inappropriate behavior for Resident #161. The resident did not endorse any memory of the recent behavior and due to dementia, the resident did not have capacity to make major decisions, including consent for relationships with other residents. Continued review of the CP for Resident #161 revealed the facility added an intervention, on 03/24/2021, for every one (1) hour safety checks. Review of a Psychiatric Progress note, dated 03/30/2021, revealed Resident #161 was a poor historian due to cognitive/psychiatric impairment. Observation, on 05/06/2021 at 2:23 PM, of Resident #161 revealed the resident in a geri-chair at the fourth floor nurse's station, with a pillow under his/her head. Staff asked the resident if he/she wanted to lay back more. The resident nodded yes and staff adjusted the back of the geri-chair. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation of Resident #161, on 05/12/2021 at 3:26 PM, 05/13/2021 at 2:26 PM, 05/14/2021 at 2:27 PM, 05/16/2021 at 9:05 AM, 05/18/2021 at 1:40 PM, 05/19/2021 at 10:54 AM, 06/02/201 at 2:44 PM, 06/03/2021 at 11:19 AM, and 06/08/2021 at 1:51 PM, revealed the resident in the geri-chair at the nurse's station, with a pillow under his/her head. Attempted interview, on 05/06/2021 at 2:33 PM, with Resident #161 revealed the resident did not respond to the State Survey Agency (SSA) Surveyor. Interview with Certified Nurse Aide (CNA) #35, on 04/29/2021 at 1:54 PM, revealed Resident #161 would hold his/her hand out and tried to grab people. She stated like a kid, the resident grabbed things and tried to put things in his/her mouth. Interview on 04/29/2021 at 2:54 PM, with Licensed Practical Nurse (LPN) #30 revealed she was not aware Resident #161 had a prior incident with another resident until the resident's POA (Power of Attorney) told her. She stated Resident #161 would touch and grab people. LPN #30 revealed the resident would grab and rub others' hands. The nurse stated the resident could say he/she was hungry or hurting, however it was hit or miss how oriented the resident was. Interview, on 04/29/2021 at 3:12 PM, with CNA #36 revealed Resident #161 would reach out and grab people. She stated the resident grabbed her arm and rubbed it. The aide revealed the resident had confusion. Interview with House Supervisor (HS) #1, on 04/29/2021 at 3:55 PM, revealed Resident #161 had confusion and did not speak a lot. She stated the resident could answer short questions. On 04/29/2021 at 4:18 PM, interview with Certified Medication Technician (CMT) #5 revealed Resident #161 would reach out and grab people when they passed by, which was the resident's normal behavior. She stated she was not aware the resident had any prior sexual behaviors. Interview, on 04/29/2021 at 4:39 PM, with CNA #37 revealed she witnessed a similar incident with Resident #161 and another resident about two (2) years ago. She stated the resident was more cognitively intact then, than he/she was now. Interview with the Unit Manager (UM) for the fourth floor, on 04/30/2021 at 9:27 AM, revealed she was unaware Resident #161 had a similar prior incident with another resident. She stated Resident #161 should not be left in the dayroom alone as the resident was in a geri-chair and could not move back and forth on his/her own. The UM revealed Resident #161 was not alert and oriented times three (3), and there was no call light in the dayroom to let staff know if he/she needed something. Interview, on 04/30/2021 at 1:00 PM, with Social Service Designee (SS) #1 revealed she followed up with Resident #161 after the incident with Resident #47. She stated the resident could do better on the BIMS' score on one (1) day, but not as well on another day. The Designee stated the resident could let staff know if he/she was hungry, but used the bathroom on himself/herself and not say anything. She stated Resident #161 had some cognitive impairment. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/30/2021 at 2:06 PM, interview with the Assistant Director of Nursing (ADON) revealed she was the Abuse Coordinator for the facility and conducted the facility's investigations. She stated when she spoke with Resident #161 related to the incident, he/she stated that Resident #47 was just tying his/her shoe. The ADON revealed Resident #161 was cognitively impaired. Interview with the Director of Nursing (DON), on 05/14/2021 at 9:20 AM, revealed she had only been with the facility, and as DON, for about six (6) weeks. Interview, on 06/03/2021 at 9:17 AM, with Resident #161's Physician revealed the resident had Dementia, was cognitively challenged, and received psychiatric (psych) services. He revealed the resident did not have the ability to make a decision to engage in sexual behavior with another. Continued interview with the ADON, on 06/03/2021 at 9:44 AM, revealed Resident #161 denied anything occurred with Resident #47. She stated the resident had a higher BIMS and was welcome to have a relationship if it was okay with the responsible party. The ADON revealed the resident's BIMS was high enough to consent to the event. She further revealed the resident had a POA and was unsure if the POA gave permission for a sexual relationship for Resident #161. She stated the resident had periods of confusion that fluctuated depending on the time of day. On 06/03/2021 at 10:32 AM, interview with the Administrator revealed Resident #161 was still able to make decisions for himself/herself and had not been deemed incompetent. She stated a durable POA made decisions when a resident was not able to make decisions for himself/herself. The Administrator revealed Resident #161 decided when to get up, when to attend doctor appointments, and when to come out of his/her room. She further revealed the resident decided whether or not he/she wanted to have labs drawn. She stated Resident #161 did not speak with her and she thought the resident was embarrassed. The Administrator further stated the resident could answer questions based on who asked, as the resident did not talk to people he/she was not comfortable with. Continued interview with the Administrator, on 06/03/2021 at 2:18 PM, revealed the facility did not have a policy for resident BIMS's scores, resident's POA, or resident's capacity to give consent. She stated the only consent the facility had, was obtained when admitted . Additional interview with the ADON, on 06/03/2021 at 3:46 PM, revealed it was difficult to determine if the contact between Resident #161 and Resident #47 was consensual or abuse. She stated Resident #161 denied what occurred and had a BIMS over eight (8). The ADON revealed the resident came up with a good answer. She stated the POA would step in if a resident was not able to speak for himself/herself. She further stated if a resident was determined unable to give consent the resident would not be able to engage in sexual relationships. Interview, on 06/03/2021 at 4:10 PM with the Administrator revealed the facility assessed the resident's capacity to consent based on the resident's BIMS score. She stated a BIMS score of nine (9) and above was generally determined to have capacity to consent. On 06/04/2021 at 2:12 PM, interview with Social Service Designee #2 revealed the facility assessed residents' capacity to consent with the BIMS score. She stated a resident with a BIMS of eight (8) and above was able to make his/her own choices, even if he/she had a POA. The Designee revealed there may be some impairment, but the resident with a BIMS of eight (8) and above was able to make his/her own decisions about his/her care. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Administrator, on 06/04/2021 at 3:01 PM, revealed if a resident had a BIMS of eight (8) or greater the resident had the right to make his/her own decisions, even when the resident had Dementia. She stated the facility followed the criteria to determine the resident's BIMS score based on how the resident answered the questions correctly. The Administrator stated the facility used a BIMS of nine (9) to determine the resident could make decisions, that it was common practice, although the facility did not have a policy. However, on 06/04/2021 at 3:19 PM, the Administrator stated she wanted to change her answer from a BIMS of nine (9) to a BIMS of eight (8) and above to give consent. Continued interview, on 06/04/2021 at 4:52 PM, revealed the risk management consulting group did not provide any information on consent and intimacy. She stated the facility determined Resident #161 could give consent. She further stated a BIMS of eight (8) to twelve (12) was cognitively moderately impaired, the resident may not know the month or year however, they could still be capable to make decisions. The Administrator revealed she was unaware of any reference or source for what moderate impairment meant. Interview with the Regional Director of Operations (RDO), on 06/07/2021 at 11:40 AM, revealed Resident #161 was assessed to have a BIMS of nine (9) after the incident with Resident #47. The RDO stated a BIMS of eight (8) and above was interviewable and was standard across the board, and the facility did not have a policy. She stated the resident had the right to make his/her own decisions, did not engage in sex, and denied anything happened. The RDO further stated the facility did not have a policy on resident consent. On 06/07/2021 at 12:10 PM, interview with the DON revealed the assessment to determine a resident's BIMS score, with a BIMS of eight (8) and above, determined if a resident was capable to give consent. She stated she was unsure if the facility had a policy stating that a resident with a BIMS of eight (8) and above had capacity to consent. Additional interview with the Administrator, on 06/07/2021 at 1:58 PM, revealed the facility ensured a resident had the capacity to consent based on his/her BIMS score. She stated sometimes Resident #161 would answer the questions and score higher on the BIMS, and other days the resident would not talk. The Administrator revealed the Centers for Medicare and Medicaid Services (CMS) referred to the Resident Assessment Instrument (RAI) for level of cognition. Interview, on 06/11/2021 at 10:21 AM, with the ADON revealed she was unsure who assessed a resident's capacity to consent. She stated for a reportable incident she listened to the resident, and noted if the story changed. She also considered the resident's BIMS score when she made a determination as part of the investigation. The ADON was unsure if the facility had a policy related to consent; however the facility used the CMS guidelines, (specific guideline(s) not indicated), as a resource. On 06/11/2021 at 10:50 AM, interview with the DON revealed she was not familiar with the State Operations Manual (SOM) and did not want to speak to the document. She stated she was unsure if the facility had a policy for resident consent, and was unsure what resource was used to determine what the facility would use to determine capacity to consent. The DON stated the facility used the resident BIMS score to determine capacity to consent. On 06/11/2021 at 11:22 AM, continued interview with the Administrator revealed it was common sense to use the resident's BIMS score to determine capacity to consent. She stated the RAI manual determined a resident's cognition. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the DON, on 06/11/2021 at 11:31 AM, revealed the facility used the CMS guidelines and based on the resident's cognitive level, Resident #161 would know the risks and benefits of sexual contact. Interview with the Administrator, on 06/11/2021 at 11:45 AM, revealed the facility did not have a policy related to resident consent, or a resource for use of the BIMS score of eight (8) and above as consensual. She stated there was no risk or benefit to touching, and Resident #161 was able to make his/her decision through the BIMS score. Continued interview with the ADON, on 06/15/2021 at 3:58 PM, revealed only the resident BIMS score was used to determine capacity to consent. However, she stated as part of her investigation she reviewed the care plan (CP), diagnoses, history, and spoke with the resident. She revealed she used the facility's Abuse policy for the investigation. She revealed she was not aware of any policy for a resident who could not give consent. The ADON stated if a resident did not give consent and did not know what he/she was doing, it would not be abuse as it was unintentional. The facility took the following actions: 1. A physician assessed Resident #47 and Resident #161 to determine their capacity to consent to sexual activity. 2. A policy was written with reference to CMS guidelines, included resident rights, and included resident assessments if residents were able to consent to sexual contact. The regional team and risk management provided input, and approved by the Medical Director. 3. Social services assessed residents, by 06/24/2021, with a BIMS score, with an eight (8) or above and a desire to engage in sexual relationship with another consenting adult, and provided Safe Sex education to the resident. 4. Residents with a BIMS of eight (8) and above who expressed a desire for sexual contact were further assessed with a face-to-face interview with a physician for capacity to consent. 5. New admissions and re-admissions were assessed for capacity to consent and care plans reflected the resident's capacity to consent to sexual contact. The Director of Nursing (DON), Assistant Director of Nursing (ADON), and Social Service Director (SSD) monitored ten (10) medical records five (5) days a week for three (3) months, then weekly for six (6) months. Residents were reviewed on a rotating basis, included new and re-admissions, for capacity to consent defined per assessment, and care plans reflected the resident's capacity. 6. Clinical Quality Indicator (CQI) meetings, held Monday through Friday, revealed new and re-admissions and scheduled assessment for capacity to consent, within fourteen (14) days of admission. Care plan conferences would also review capacity to consent 7. A regional team member monitored facility policy on assessments and care plan for consent to sexual contact weekly for three (3) months. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. The Regional Director of Operations (RDO) trained the trainers (the DON and ADON), on 06/17/2021. The DON, ADON, or designee trained all staff in all departments, therapy staff, and agency staff, begun 06/21/2021, on the abuse policy, resident rights, consenting adult right to engage in sexual contact with another consenting adult, what was consent, who was assessed for consent, who assessed for consent and when, need for documented ability to consent. Staff completed a post-test, which required a passing score of 100% answers correct. No staff worked prior to receiving the training, after 06/24/2021, included new hire staff and agency staff. 9. The Quality Assurance Performance Improvement (QAPI) reviewed the audits weekly, then monthly, and included new and re-admissions assessments for consent to sexual contact, and a face-to-face interview with a physician for any resident who expressed desire for sexual contact with another consenting adult. 10. A regional team member would attend weekly QAPI meetings, then monthly for three (3) months. The State Survey Agency (SSA) validated the facility took the following actions: 1. Interview with the Assistant Director of Nursing (ADON), on 07/03/2021 at 4:19 PM, the DON, on 07/03/2021 at 5:35 PM, and the Administrator, on 07/03/2021 at 6:17 PM, revealed the physician attempted to assess Resident #47 for capacity to consent, however the resident walked away from the physician. The ADON stated a physician assessed Resident #161 who determined the resident could not consent to sexual contact due to cognitive impairment. 2. Review of the facility policy Consent for Sexual Contact, not dated, revealed residents with a Brief Interview Mental Status (BIMS) of eight (8) and above, who expressed a desire for sexual contact would be educated on safe sex practices, have a face-to-face session with a physician to determine if the resident had the capacity to consent, and the care plan would reflect the resident's capacity. Additionally, the resident would be asked to sign the Consensual Sexual Relationship Agreement. Interview with the Assistant Director of Nursing (ADON), on 07/03/2021 at 4:19 PM, the Director of Nursing (DON), on 07/03/2021 at 5:35 PM, and the Administrator, on 07/03/2021 at 6:17 PM, revealed the facility policy addressed factors to consider capacity to consent to sexual contact included the BIMS, the resident's diagnosis, and assessment by a physician. The DON stated the policy was implemented on 06/25/2021. The Administrator revealed the RDO and risk management was involved in the creation of the policy, and was approved by the Medical Director. 3. Review of resident BIMS assessments revealed BIMS assessments conducted through 06/25/2021. Review of the Consensual Sexual Relationship Agreement, not dated, revealed the resident and staff signed that the resident was assessed, capable of making decisions, and educated on safe sex practices. On 07/03/2021 at 4:19 PM, interview with the ADON, on 07/03/2021 at 5:35 PM, interview with the DON, and on 07/03/2021 at 6:17 PM, interview with the Administrator revealed social services assessed resident BIMS, and residents with a BIMS of eight (8) and above who indicated a desire for a sexual relationship were educated on safe sex 4. Interview, on 07/03/2021 at 4:19 PM, with the ADON, on 07/03/2021 at 5:35 PM, with the DON, and on 07/03/2021 at 6:17 PM, with the Administrator revealed residents with a BIMS of eight (8) and above who had a desire for sexual contact were assessed by a physician via a telehealth face-to-face for capacity to consent. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. Review of audits, dated 06/28/2021 through 07/01/2021, revealed ten (10) resident records reviewed daily. Interview with the ADON, on 07/03/2021 at 4:19 PM, and the DON, on 07/03/2021 at 5:35 PM, revealed she participated in monitoring ten (10) medical records five (5) days a week, to continue for three (3) months, and then ten (10) records weekly for six (6) months for completion of the resident assessment for completion of the resident BIMS assessment, desire for sexual contact, if the resident had a Power of Attorney (POA) or responsible party, a physician assessment for capacity to consent completed, and the care plan updated to reflect capacity to consent. Each resident on each floor would be rotated through, and included new and re-admissions. 6. Interview, on 07/03/2021 at 4:19 PM, with the ADON, on 07/03/2021 at 5:35 PM, with the DON, and on 07/03/201 at 6:17 PM, with the Administrator revealed the Clinical Quality Indicator (CQI) meeting met Monday through Friday and reviewed new and re-admissions, and scheduled capacity to consent assessment within eight (8) days. Care plan conferences would also review a resident's capacity to consent. 7. Interview with the ADON, on 07/03/2021 at 4:19 PM, and the DON, on 07/03/2021 at 5:35 PM, and the Administrator, on 07/03/2021 at 6:17 PM, revealed the Regional Director of Operations (RDO) would review the medical record audits of assessments weekly for three (3) three months. 8. Review of post-tests and training materials revealed the facility trained one hundred seventy-one (171) staff in the following departments: housekeeping, laundry, dietary, maintenance, nursing, social services, admissions, central supply, smoke monitors, and reception. Seventeen (17) staff needed to be trained, and were on leave or PRN status. Fifteen (15) therapy staff and forty-four (44) agency staff were trained. Review of a QAPI Committee Meeting Minutes, dated 06/17/2021, revealed the Administrator, DON, ADON, and the RDO by phone, discussed CMS guidelines, policies, and procedures to train staff with a post-test. Interview with Receptionist #2, on 07/02/2021 at 10:48 AM, Unit Manager (UM) #1, on 07/02/2021 at 10:54 AM, the Cook, on 07/02/2021 at 11:13 AM, Laundry Aide #3, on 07/02/2021 at 11:19 AM, Customer Service Representative, on 07/02/2021 at 11:24 AM, Housekeeper #4, on 07/02/2021 at 11:31 AM, Certified Nurse Aide (CNA) #38, on 07/02/2021 at 11:37 AM, Occupational Therapist (OT) #1, on 07/02/2021 at 11:47 AM, the Unit Secretary, on 07/02/2021 at 11:56 AM, House Supervisor #3, on 07/03/2021 at 3:22 PM, Licensed Practical Nurse (LPN) #3, on 07/03/2021 at 3:49 PM, LPN #43, on 07/03/2021 at 3:53 PM, CNA #56, on 07/03/2021 at 4:03 PM, CNA #43, on 07/03/2021 at 4:11 PM, revealed they were trained recently on abuse, resident rights, what was consent and how residents were assessed for consent and by whom, and right of consenting residents. Interview with the ADON, on 07/03/2021 at 4:19 PM, the DON, on 07/03/2021 at 5:35 PM, and the Administrator, on 07/03/2021 at 6:17 PM, revealed they were trained by the RDO on 06/17/2021, and they then trained staff, beginning 06/21/2021, with a post-test requirement of 100% to pass. 9. Review of QAPI discussion notes and sign in sheets, dated 06/24/2021 and 07/01/2021, revealed audits reviewed related to admissions and re-admissions for consent to sexual contact, which included further assessment and face-to-face interviews by a physician with residents. On 07/03/2021 at 4:19 PM, interview with the ADON, on 07/03/2021 at 5:35 PM, interview with the DON, and on 07/03/2021 at 6:17 PM, interview with the Administrator revealed audits for assessments of capacity to consent were reviewed in QAPI weekly, then monthly. She stated the RDO and Medical Director participated in the QAPI meetings. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	10. Interview with the DON, on 07/03/2021 at 5:35 PM, and the Administrator, on 07/03.2021 at 6:17 PM, revealed the RDO attended the weekly QAPI meetings, the most recent on 07/01/2021, either in person or by phone. On 07/03/2021 at 6:20 PM, interview with the RDO revealed she attended weekly QAPI meetings, by phone or in person. She stated she would participate for three (3) months. 43694 43708 44298 44299

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F 0609 Level of Harm - Actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34116 Based on interview, record review, and facility policy review it was determined the facility failed to ensure an allegation of abuse was reported for five (5) of one hundred thirteen (113) sampled residents (Residents #51, #54, #74, #92, and #146). Staff failed to report an allegation of staff to resident verbal abuse related to Resident #146. On 04/23/2021, the facility sent CNA (certified nursing assistance) #18 home related to sleeping and displayed behaviors of playing with resident items, going through resident's belongings, and laying across a sink. Staff stated the facility had them write witness statements related to the event. However, the facility had no documented evidence of staff statements and the incident was not reported to the State Survey Agency. On the night of 05/07/2021, Resident #92 reported to staff CNA #18 exhibited the behaviors above, but was allowed to complete the shift. The facility did not report the allegation of abuse/neglect until the morning of 05/08/2021, when additional resident, Resident #54, reported more behaviors from CNA #18, including the CNA showing residents her backside. Resident #51 reported to staff his/her concerns regarding treatment provided by a CNA but staff failed to report the allegation to management. Resident #74 reported to staff his/her concerns regarding language used by Licensed Practical Nurse #11 but the concern was not reported to management. The findings include: Review of the facility's policy, Abuse Prevention, updated 05/02/2017, revealed all personnel must promptly report any incident or suspected incident of resident abuse, mistreatment or neglect, including injuries of unknown origin. The policy defined verbal abuse as any use of oral, written or gestured language that willfully included disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability. The policy revealed any alleged violations involving mistreatment, abuse, neglect, misappropriation of resident property and any injuries of an unknown origin must be reported to the Administrator and Director of Nursing (DON). The policy revealed the person(s) observing an incident of resident abuse or suspecting resident abuse must immediately report such incidents to the Charge Nurse, regardless of the time lapse since the incident occurred. The Charge Nurse would immediately report the incident to the Administrator or to the individual in charge of the facility during the Administrator's absence. 1. Review of the clinical record revealed the facility admitted Resident #146 on 03/30/2021 with diagnoses that included Morbid (Severe) Obesity, Spinal Stenosis, and Chronic Pain Syndrome. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Louisville Rehabilitation and Nursing	1155 Eastern Parkway Louisville, KY 40217

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F 0609 Level of Harm - Actual harm Residents Affected - Few	Review of the Admission Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of fifteen (15) and determined he/she was interviewable. Observation of Resident #146, on 05/03/2021 at 5:35 PM, revealed the resident seated in bed, dressed and groomed. Interview during the observation, revealed the resident requested a muscle relaxer the evening of 04/30/2021; however, Licensed Practical Nurse (LPN) #39 stated there were none available. The resident stated later in the evening he/she asked LPN #32 for a muscle relaxer; the nurse told the resident he/she had to wait until 2:00 AM for a pain pill. The resident stated he/she explained to the nurse that he/she had already taken pain medication and needed a muscle relaxer for spasms/pain in his/her waist and legs. According to the resident, both nurses were rude, spoke to him/her like a child and caused him/her to cry. Resident #146 stated he/she dealt with the pain and cried himself/herself to sleep. Continued interview revealed Resident #146 reported the incident the next morning to the nurse who said she would report it. Resident #146 stated he/she reported the incident to Social Services Designee #2 the morning of 05/03/2021. According to the resident, the Social Services Designee stated she would look in to it. Review of the clinical record revealed a Physician's Order, dated 04/28/2021, for Cyclobenzaprine 10 mg tablet every 6 hours as needed for muscle spasms; and an order, dated 03/30/2021, for Hydrocodone-Acetaminophen tablet 7.5-325 mg every 6 hours as needed for pain. Review of the pharmacy Delivery Manifest, dated 04/27/2021 at 3:55 PM, revealed thirty (30) tablets of Cyclobenzaprine were delivered to the facility for Resident #146, and on 05/01/2021 at 4:58 AM, thirty (30) additional tablets of Cyclobenzaprine were delivered. Review of Resident #146's Medication Administration Record (MAR), dated April 2021, revealed the Cyclobenzaprine and Hydrocodone were not administered on 04/30/2021. Further review revealed the facility assessed the resident with a pain level of zero (0) out of ten (10) on the 3 PM-11 PM and 11 PM-7 AM shift; however, interview with the resident revealed he/she reported unrelieved pain to LPN #39 and #32. Review of the clinical record for Resident #149 revealed the facility admitted the resident on 04/01/2021. Review of the Admission Minimum Data Set (MDS), dated [DATE], revealed the facility assessed Resident #149 with a Brief Interview for Mental Status score of fifteen (15) and determined he/she was interviewable. Interview with Resident #149, on 05/10/2021 at 2:10 PM, revealed LPN #32 was disrespectful and hollered at Resident #146. According to the resident, Resident #146 was so upset he/she started crying. Interview with LPN #39 was attempted on 05/27/2021; however, the staffing agency did not provide a contact number. Interview with LPN #32, on 05/27/2021 at 4:11 PM, revealed her interactions with Resident #146 were cordial; however, she had apologized to the resident if she made (him/her) feel any kind of way. She stated she was not aware of any concerns regarding her interactions with the resident. (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	Review of the 2nd floor Staffing Assignment Sheet, dated 05/01/2021, revealed LPN #3 was assigned to Resident #146 on the 7:00 AM - 3:00 PM shift. Interview was attempted with LPN #3, on 05/27/2021 at 3:16 PM; however, the LPN did not return the call. Interview with Social Services Designee #2, on 05/25/2021 at 2:16 PM, revealed Resident #146 reported he/she could not get a muscle relaxer when requested. She stated the resident told her that a nurse was nasty towards him/her. According to the Social Services Designee, the resident stated it did not make them feel good because he/she had muscle spasms and pain. The Social Services Designee stated she reported the allegation to the 2nd floor Unit Manager (UM) and the Assistant Director of Nursing (ADON). She revealed she did not submit a written statement regarding the allegation and was not aware of the outcome of an investigation. Interview with the 2nd Floor Unit Manager (UM), on 05/28/2021 at 9:27 AM, revealed allegations of abuse should be reported to the ADON, DON and Administrator immediately to ensure the resident's well-being. He stated the Social Services Designee mentioned Resident #146's concern a little while back; however, he forgot to address it. Interview with the ADON, on 05/27/2021 at 9:50 AM, revealed staff were responsible for reporting an allegation of abuse immediately to their supervisor, ADON, Director of Nursing (DON), or Administrator to initiate an investigation and ensure resident safety. She revealed the Social Services Designee notified her of Resident #146's allegation on 05/25/2021 (25 days after the alleged incident) and she immediately went to speak with the resident. The ADON stated she questioned the resident regarding his/her stay and staff treatment; however, she did not interview specific to the allegation. She revealed the facility did not investigate the incident because the resident did not mention concerns with staff or indicate abuse occurred. Interview with Resident #146, on 05/27/2021 at 10:54 AM revealed the facility had not interviewed or followed-up with him/her regarding the incident. Interview with the DON, 05/28/2021 at 3:22 PM, revealed she was not aware of Resident #146's concerns with treatment by nursing staff. She revealed the ADON was responsible for notifying her and the Administrator for anything of concern and investigating the issue. The DON revealed the ADON interviewed Resident #146; however, the resident did not have any complaints. The DON revealed she was not aware of any issues with timely reporting of abuse allegations. Interview with the Administrator, on 05/28/2021 at 4:13 PM, revealed the facility investigated all issues that were concerning and could be considered reportable. She stated all issues were first reported to the ADON. The Administrator revealed the ADON initiated the investigation and reported the findings to her. The Administrator revealed the facility had not identified issues with reporting of abuse. 43708 (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	2. Review of the facility's policy, Resident Rights, undated, revealed residents had the right to be free from verbal, sexual, physical or mental abuse. In addition, the facility implemented procedures to protect residents from abuse, neglect or mistreatment. In the event of an alleged violation, the facility is required to report to the appropriate officials and promptly and thoroughly investigated. Through interview, State Survey Agency (SSA) revealed Certified Nurse Assistant (CNA) #18 was sent home on 04/23/2021 due to sleeping and related behaviors in front of residents. However, the facility had no report or documentation related to incident. Record review of time punches on 04/23/2021 revealed CNA #18 clocked in at 7:15 PM and clocked out 9:00 PM. Interview with CNA #18 on 05/27/2021 at 12:42 AM, revealed a Certified Medication Technician (CMT), unknown name, accused her of being on drugs about a month prior to SSA interview. The CMT reported CNA #18 was asleep at the sink and acting weird. Interview with CMT #1, on 05/27/2021 at 10:18 AM, revealed she was familiar with CNA #18. She stated CNA #18 wasn't there and indicated she should not have been working with the residents. She stated she observed CNA #18 acted as if she did not know what she was doing and was not acting how she should. CMT #1 explained she reported the behavior to LPN #10. CMT #1 indicated CNA #18 left early that day and she had not seen her since. CMT #1 additionally stated she was asked to write a statement and gave it to HS #1. Interview with LPN #10, on 05/26/2021 at 1:22 PM, revealed on 04/23/2021 CMT #1 reported weird behavior from CNA #18. LPN #10 explained, she approached CNA #18 and asked if she was okay. CNA #18 replied there was something in her eye and she had to take out her contact. LPN #10 also described CMT #1 had reported CNA #18 was looking for something on the floor and said she dropped an earring. LPN #10 then observed CNA #18 entered room [ROOM NUMBER], took linen and filled up the inside of sink to make it flush with counter, and laid her head down in the sink. LPN #10 told CNA #18, You can't be here and asked her what was wrong? CNA #18 said, Please don't send me home, I'm just tired and exhausted and haven't ate. Upon observation, LPN #10 stated she called HS #1 and she came to the 6th floor and walked her down. Additionally, LPN #10 stated CNA #18's shift started at 7:00 PM and she was sent home within hour or so. LPN #10 stated she wrote statement for the incident on 04/23/2021. Interview with HS #1, on 05/27/2021 at 3:34 PM, revealed on 04/23/2021 CMT #1 and an unnamed nurse on the sixth (6th) floor called HS #1 to report CNA #18 falling asleep, unknown time, in resident room and not acting quite right. HS #1 stated she went upstairs and interviewed CNA #18. CNA #18 reported she was just tired. HS #1 stated CNA #18 appeared tired upon observation. HS #1 called Assistant Director of Nursing (ADON) to inform her of observations. ADON advised let her go home due to resident safety. HS #1 additionally stated when staff is sleeping on the job, they are no good to the residents and accidents can easily happen. HS #1 said she did not evaluate or interview the residents at the time. However, indicated now in hindsight she should have talked to a few residents. Further stating, CNA #18 could have injured or potentially dropped a resident. HS #1 stated she asked staff to write statements related to their observations on 04/23/2021. HS #1 stated she placed the statements in the ADON box, mailbox behind the reception desk. (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	Interview with the DON and Administrator, on 05/26/2021 at 2:35 PM, revealed the facility had no witness statements from any staff related to CNA #18 being sent home on 04/23/2021. Both staff indicated CNA #18 had no write-up in personnel file. Interview with DON, on 05/28/2021 at 8:49 AM, revealed she was not familiar with CNA #18 behaviors on 04/23/2021; nor was she aware the facility sent CNA #18 home early. However, she stated it should have been reported. The DON indicated witness statements should be obtained from management staff, house supervisor, DON, ADON, and Human Resources (HR). The DON stated if staff was sent home early, she was notified by phone or text. DON stated the House supervisor had the authority to send staff home if resident care was comprised. Further stating HS #1 should have called her make aware of CNA #18's behaviors. She indicated CNA #18 clocked out at 9:00 PM on 04/23/2021. Interview with the Administrator, on 05/28/2021 at 11:57 AM, revealed she was aware CNA #18 was reported asleep the evening of 04/23/2021 and HS #1 made the decision to send CNA #18 home to get rest. She additionally stated HS #1 made rounds to ensure there was no negative impact on resident. Administrator stated if staff was found sleeping on job they would typically be sent home because its against policy. The SSA investigated an additional allegation related to CNA #18 that occurred on 05/07/2021. Observation and interview with Resident #54, on 05/08/2021 at 8:22 AM, revealed facility staff interviewed Resident #54 after he/she asked to speak with a supervisor during morning rounds. He/she described a CNA he/she had seen once before, unknown name, as thin, white, had brown hair in a bun, tall, and not typically on the floor. Facility identified the CNA to be CNA #18. Resident #54 stated her roommate, Resident #58, needed to be changed and CNA #18 was rude. CNA #18 started going through Resident #58's bag and played with his/her dolls. Resident #54 explained, CNA #18 set the dolls on the bed like she (CNA #18) was a little kid and was not playing with Resident #58. CNA #18 looked like she was on drugs and could barely keep her eyes open. Resident #54 recalled CNA #18 said, That's what happens when you go deep in thought. Resident #54 additionally explained CNA #18 started showing Resident #58 her tattoos on her bottom, belly, back, and legs. Resident #54 explained Resident #58 could not express herself verbally and this upset CNA #18. Resident #54 stated CNA #18 started cussing at Resident #58 and he/she started crying. Resident #54 reported no nurse came back into the room after evening medication pass on 05/07/2021. Record review and interview with Resident #92 on 05/26/2021 at 9:20 AM, revealed he/she was admitted to the facility on [DATE]. His/her quarterly MDS dated [DATE] revealed the facility assessed Resident #92 with a BIMS of 15, indicating he/she was cognitively intact. Resident #92 stated CNA #18 appeared higher than a [NAME]. Resident #92 stated he/she was walking down the odd side of the hall when CNA #18 came out of room [ROOM NUMBER] and was unsteady like she was drunk. Resident #92 reported the situation to the nurse, unknown name, on the floor. Record review and interview with Resident #67, on 05/25/2021 at 2:43 PM, revealed he/she was admitted to the facility on [DATE]. His/her annual MDS dated [DATE] revealed the facility assessed Resident #67 with a BIMS score of fourteen (14), indicating he/she was cognitively intact. Resident #67 remembered CNA #18, he/she stated it was strange she kept nodding off, and leaning over the bed. He/she further stated, I had to wake her up a couple times. (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	Record review and interview with Resident #96, on 05/26/2021 at 10:50 AM, revealed he/she was admitted to the facility on [DATE]. The facility assessed Resident #96 on 03/18/2021 with a BIMS score of fifteen (15), indicating he/she was cognitively intact. Resident #96 stated CNA #18 was acting like she was drunk. Resident #96 reported CNA #18 was going one room to another collecting garbage bags, she was swaying like she was on drugs. She came in to collect garbage and almost fell over. Record review revealed the facility admitted Resident #54 on 04/25/2019. The facility assessed Resident #54 on 02/25/2021 with a Brief Interview for Mental Status (BIMS) fifteen (15), indicating he/she was cognitively intact. Interview with LPN #15, on 05/26/2021 at 8:56 AM, revealed on the night of 05/07/2021, she was the nurse for both sides of the unit after 10:30 PM. She recalled complaints from staff and residents related to CNA #18. Resident #92 asked, Is that girl high? LPN #15 explained she reported the concerns related to CNA #18 to House Supervisor #1 around 8:00 PM or 9:00 PM. House Supervisor #1 and UM #1 came to the floor, talked to her, and said she was okay. LPN #15 stated CNA #18 seemed tired. Interview with LPN #14, on 05/25/2021 at 2:30 PM, revealed the morning of 05/08/2021, CNA #18 told LPN #14 she was tired. LPN #14 stated when she started her rounds residents complained of care. Resident #54 and Resident #67 complained about care or stated the CNA was nodding off. SSA attempted to call UM #1 for interview on 05/26/2021 at 2:54 PM, no answer. Review of the facility obtained statement from UM #1 on 05/08/2021 revealed she went to the sixth (6th) floor to meet HS #1 and assess CNA #18, untimed. She observed CNA #18 to be tired. However, no staff on the floor reported anything unsafe. They decided it was okay for CNA #18 to stay in the facility. Interview with House Supervisor (HS) #1, on 05/26/2021 at 3:09 PM and 05/27/2021 at 3:34 PM, revealed on 05/07/2021, LPN #15 called her to the sixth (6th) floor at 8:20 PM and reported a problem with CNA #18 appearing under the influence and sleepy. HS #1 interviewed LPN #15 who stated she was going off what residents reported to her. Further interview with CNA #18, on 05/27/2021 at 12:42 AM, revealed she worked for the facility full time for about 1.5 months and did not have any additional jobs. She stated on 05/07/2021 UM #1 came to the sixth (6th) floor to talk to her around 8:00-9:00 PM because someone had complained about her and said she was discombobulated and possibly on drugs. CNA #18 indicated she was informed of the investigation the morning of 05/08/2021 after her shift ended when she was approached by the ADON and spoke with the DON. The DON said they would conduct an investigation and drug test and CNA #18 was suspended for five (5) days. After five (5) days the facility said she could return to work, everything was fine. CNA #18 stated she returned to work on Saturday 05/15/2021. Further interview with DON, on 05/28/2021 at 8:49 AM, revealed the process of reporting staff behavior was dependent on who made the observation and what the behavior was to decide how to take action. The DON stated sleeping on the job would be cause to send staff home as sleeping could lead to residents not being taken care of, frustration with co-workers, and call lights not answered. DON stated she was made aware CNA #18 seemed impaired on 05/08/2021 at approximately 8:45 AM. (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	Interview with Administrator, on 05/28/2021 at 11:57 AM, revealed she was made aware of the events on 05/07/2021 around 8:00 PM or 9:00 PM. She stated UM #1 and HS #1 assessed CNA #18 and reported no unusual behavior. CNA #18 was allowed to continue to work. Administrator further stated she was not aware of any resident interviews that evening after the initial allegations. She additionally stated resident interviews were conducted the next morning. Further interview with the Administrator revealed the process of reporting staff behaviors was to report to next level supervisor. The supervisor would investigate and deem behaviors inappropriate or not. If found to be inappropriate, the supervisor would report to both DON and Administrator. 44299 3. Review of the facility's investigation revealed Licensed Practical Nurse (LPN) #11 provided a written statement on 03/30/2021 at 11:32 AM, which revealed LPN #11 admitted to yelling out F-Me after being notified by a CNA of an overflowing toilet, along with poop & water all over the floor. Interview with Registered Nurse (RN) #2, on 05/24/2021 at 2:12 PM, revealed Resident #74 was unable to get anyone to help him/her to empty the bedside commode, so Resident #74 emptied it himself/herself, which resulted in the toilet clogging up due to all of the toilet paper, etc. Further interview revealed an employee came in and said some rude things about the clogged toilet which Resident #74 overheard. Interview with Licensed Practical Nurse (LPN) #11, on 05/25/2021 at 11:51 AM, revealed that on the date of the incident, she was told that there was water on the bathroom floor. Upon entering Resident #74 bathroom, water and feces were found all over the floor. LPN #11 stated that she was completely shocked by the scene and that an expletive came out of her mouth. LPN #11 was escorted out of the building during her shift, when administration was informed of the statements made. LPN #11 stated she signed a statement of admission. Interview with Certified Nursing Assistant (CNA) #7, on 05/26/2021 at 1:49 PM, revealed Resident #74 took all of his/her paper towels off the sink and put them in the toilet and CNA #7 told LPN #11. While in the hallway CNA #7 heard LPN #11 say Shit, and Fuck I can't believe the toilet is overflowing. Then Resident #343 said something about hearing the comments as well. Interview with the Administrator, on 05/28/2021 at 10:20 AM, revealed after the allegation it was the expectation for the staff receiving that info to report it immediately. 4. Review of Resident #51's Care Plan dated 03/16/2020, indicated the resident was receiving care at the facility for restorative nursing and other services. The Care Plan stated Resident #51 wished to remain at the facility until his health improved and a safe discharge was arranged. Interventions included but were not limited to, meeting with the resident to discuss plans to return to the community with each full assessment. Review of the Minimum Data Set (MDS) dated [DATE] revealed that Resident #51 had a Brief Interview of Mental Status (BIMS) of eleven (11). Review of the Progress Note dated 05/06/2021, revealed that Resident #51 awas able to voice wants and needs with clear speech. (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	Review of investigation documents and employee statements revealed Resident #51 made a complaint of treatment to Licensed Practical Nurse (LPN) #3 on 05/04/2021 regarding the loud voice of a CNA. Interview with Resident #51, on 05/05/2021 at 1:44 PM, revealed the resident had a bad incident last night. Resident #51 stated Certified Nursing Assistant (CNA) #2, reportedly talked to Resident #51 like a child and kept yelling at him/her. Per Resident #51, CNA #2 told Resident #51 to get up and was real pushy and domineering. Resident #51 stated that he/she was not afraid of the CNA but did not want to be pushed around. Interview with Unit Manager (UM) #1, on 05/05/2021 at 3:24 PM, revealed the staff identified by Resident #51 was on the schedule last night as reported, but stated she had not received any incident reports or grievances from any residents. Interview with Unit Manager (UM) #1 on 05/07/2021 at 10:15 AM revealed the incident was under investigation. Interview with CNA #2, on 05/10/2021 at 10:22 AM, revealed she talked loudly because she was tone deaf. CNA #2 stated she was giving Resident #51 a shower and afterward Resident #51 asked for the CNA's name and the name of her Supervisor. Resident #51 informed CNA #2 that he/she was going to report her to LPN #3. Resident #51 said he/she was going to tell LPN #3 that she was yelling at him/her. Interview with Licensed Practical Nurse (LPN) #3, on 05/17/2021 at 10:17 AM, revealed Resident #51 told her that CNA #2 was talking loud to him/her in the shower room and he/she did not like it. LPN #3 did not feel that it was a reportable incident, so she did not say anything about it to the next nurse during shift report, because she forgot. LPN #3 stated that it slipped her mind. LPN #3 believed Resident #51 took offense because he/she felt like CNA #2 was yelling at him. If there was evidence of abuse or allegations, LPN #3 stated she was supposed to report to the Assistant Director of Nursing (ADON) within a two (2) hour window. Interview, on 05/18/2021 at 1:22 PM, with the Director of Nursing (DON) revealed she currently oversaw the investigation process. Staff were expected to report incidents and allegations immediately and the DON expected a thorough investigation to be completed. The DON stated resident complaints of yelling or harsh treatment by staff should be reported to the supervisor immediately. The supervisor should then report to the DON or ADON. LPN #3 should have reported the resident's complaint immediately. Any kind of distress could cause harm to the resident. The CNA should have been suspended immediately. Interview with the Administrator, on 05/28/2021 at 10:20 AM revealed if a resident informed staff he or she had issues with another resident or staff, it was the expectation for the staff receiving that info to report it immediately. LPN #3's statement that she forgot to follow up on the resident's complaint and failed to report the incident because she did not believe anything happened, was not acceptable and did not follow facility protocol. 43694 Based on interview, record review and review of facility policy it was determined the facility failed to report an injury of unknown origin within two hours to state agency for one (1) of one-hundred and nineteen (119) residents, Resident #87. (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	On 09/25/2021 during morning rounds Licensed Practical Nurse (LPN) #2 found Resident #87 with blood on the forehead and a laceration in which she was unable to determine how the resident got it. LPN #2 revealed she contacted the nurse supervisor on duty, LPN #3 and informed her resident had a cut. She then contacted the Nurse Practitioner (NP) and agreed to send resident out to the emergency room (ER). Resident #87 was treated with seven (7) sutures to the forehead and received a splint for a fractured pinky finger. The finding include: Review of the facility's Abuse Prevention Program policy dated 05/02/2017, revealed all personnel must promptly report any incident or suspected incident of resident abuse, mistreatment or neglect, including injuries of unknown origin. An injury should be classified as an injury of unknown origin when the source of the injury was not observed or known by any person, and the Initial Risk Management Investigation could not determine the cause of the injury. Additionally, any alleged violation involving an injury of unknown origin must be reported to the Administrator and Director of Nursing (DON). The person who witnessed the event must immediately report to the Charge Nurse (CN) and the CN must immediately report tot eh Administrator or designee. The CN must complete an incident report and obtain a written, signed and dated statement from the person who reported the incident. Review of Resident #87's clinical record revealed the facility admitted the resident on 07/09/2019, with multiple diagnosis, which included Alzheimer's Disease, Dementia with Behavioral Disturbances, anxiety, major depressive disorder, and cognitive communication deficit. Staff report Resident historically wandered into other resident's rooms, took items and got in their beds. Review of Resident #87's Quarterly Minimum Data Set (MDS) dated [DATE], revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of three (3) out of fifteen (15), and determined the resident was not interviewable. Resident #87 was assessed for bed mobility, transfers, walk in room, walk in corridor, locomotion on unit and off unit and to eat as supervision-oversight, encouragement and cueing with the assistance of one (1) staff member. Resident was assessed as two (2) staff physical assist to get dressed and for personal hygiene. Review of the facility Risk Management Investigation (RMI) #3221completed on 09/25/2021 at 7:15 AM, by LPN #2, revealed the location of the incident was unknown. The incident itself was documented as an injury of unknown origin. Review of discharge documents for 09/25/2021 revealed the ER doctor noted Resident #87 was seen in the emergency department and a face-to-face diagnostic evaluation was completed of the patient. The patient presented with a laceration above the left eye. The patient was found by staff with blood on his/her bed and a laceration above the eye. The patient did not know specifically what happened or how he/she got injured. The patient was a poor historian. Interview with LPN #2 on 09/30/2021 at 2:05 PM, revealed when she completed her morning rounds, she found Resident #87 in bed and noticed something on his/her head. Resident had blood on his/her face, on their pillow, on their hand and on the floor by the head area and she could not determine what happened. LPN #2 revealed she called the Nurse Practitioner (NP) and was told to use her discretion to determine if the resident needed to be sent to the ER. LPN #2 revealed the laceration to the resident's head was pretty wide open. Resident #87 was sent to the ER for the laceration and concerns about his/her pinky finger. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Louisville Rehabilitation and Nursing	1155 Eastern Parkway Louisville, KY 40217

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F 0609 Level of Harm - Actual harm Residents Affected - Few	Continued interview with LPN #2 on 09/30/2021 at 3:15 PM, revealed she was instructed by LPN #3 to complete the RMI. She further revealed she documented the incident as an injury of unknown origin not as a fall. LPN #2 revealed she had to return to the facility because she was unaware she was supposed to complete the RMI. She also revealed she did not tell LPN #3 it was a fall. LPN #2 also revealed she and a Certified Nurse Assistant (CNA) changed Resident #87's brief just before Emergency Medical Services (EMS) arrived because resident was wet. LPN #2 revealed she knew this incident was reportable because it was a head injury. Interview with LPN #3 on 10/08/2021 at 10:53 AM, revealed she reported this incident as a fall. She revealed she was contacted by LPN #2 and informed resident had fallen out of bed. She revealed based on her nineteen (19) years of experience and her knowledge about Resident #87, she determined the resident had a fall. LPN #3 revealed she was off the floor when the incident took place. When she went to assess resident, resident was in bed with his/her feet wrapped up in the sheets. She further revealed she texted the DON and told her she believed resident had an unwitnessed fall with an injury and resident was sent out to the ER. LPN #3 revealed she could not think of anything else it could be. She believed the resident fell and got up and back in bed. LPN #3 described a fall is when someone could not get up off the ground and an injury of unknown origin is when you did not know where the injury came from. However, she still believed the resident must had fallen. LPN #3 stated, I assumed it was a fall. Interview with DON on 10/08/2021 at 1:40 PM, revealed Resident #87's head wound was investigated as a fall. The DON revealed she conducted an interview on 09/27/2021 and she revealed there were two parts of a fall investi [TRUNCATED]

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34116 Based on observation, interview, record review, and facility policy review it was determined the facility failed to ensure allegations of abuse/neglect were thoroughly investigated for one (1) of one hundred thirteen (113) sampled residents (Residen #146). The findings include: Review of the the facility's policy, Abuse Prevention Program, updated 05/02/2017, revealed Supervisors would immediately inform the Administrator or in the absence of the Administrator, the person in charge of the facility of all reports of incidents, allegations or suspicion of potential mistreatment. The policy stated once the Administrator or designee determined that there was a reasonable cause for suspecting abuse, the Administrator or designee would investigate the allegation and obtain a copy of any documentation relative to the incident. Continued review revealed the Charge Nurse must complete an incident report and obtain a written, signed and dated statement from the person reporting the incident. The policy stated a completed copy of the incident report and written statements from the witnesses if any, would be provided to the Administrator within twenty-four (24) hours of the occurrence of such incident. Record review revealed the facility admitted Resident #146 on 03/30/2021 with diagnoses that included Morbid (Severe) Obesity, Spinal Stenosis, and Chronic Pain Syndrome. Review of the Admission Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of fifteen and determined he/she was interviewable. Observation of Resident #146, on 05/03/2021 at 5:35 PM, revealed the resident in bed dressed and groomed. Interview, during the observation, revealed the resident requested a muscle relaxer on 04/30/2021 for back and leg spasms. The resident stated Licensed Practical Nurse (LPN) #39 and LPN #32 did not administer the medication and spoke to him/her like a child. Resident #146 stated the interactions with the nurses caused him/her to cry. Continued interview revealed Resident #146 reported the incident to the nurse the next morning and to Social Services Designee #2 on 05/03/2021. According to the resident, the Social Services Designee stated she would look into it. Review of Resident #146 clinical record revealed a Physician's Order, dated 04/28/2021, for Cyclobenzaprine 10 mg tablet every 6 hours as needed for muscle spasms. Review of Resident #146's Medication Administration Record (MAR), dated April 2021, revealed Cyclobenzaprine was not administered on 04/30/2021. Further review revealed the facility assessed the resident with a pain level of zero (0) out of ten (10) on the 3 PM-11 PM and 11 PM-7 AM shift. However, interview with the resident revealed he/she reported unrelieved pain to both LPN #39 and #32. Review of the clinical record for Resident #149 (roommate of Resident #146) revealed the facility admitted the resident on 04/01/2021 with diagnoses to include Diabetes Mellitus. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Admission MDS, dated [DATE], revealed the facility assessed Resident #146 with a Brief Interview for Mental Status score of fifteen (15) and determined he/she was interviewable. Interview with Resident #149, on 05/10/2021 at 2:10 PM, revealed LPN #32 was disrespectful and hollered at Resident #146. According to Resident #149, Resident #146 became upset and cried. Interview with Certified Nursing Assistant (CNA) #48, on 05/10/2021 at 10:01 AM, revealed he noticed Resident #146 still up in the wheelchair when he went to break around 8:00 PM. He stated the resident reported he/she had pain and needed a muscle relaxer. The CNA stated he reported the resident's pain to LPN #39. Interview with LPN #39 was attempted on 05/27/2021. However, the staffing agency did not provide a contact number. Interview with LPN #32, on 05/27/2021 at 4:11 PM, revealed she was not aware of any concerns regarding her interactions with Resident #146. She stated her interactions with Resident #146 were cordial. However, she had apologized to the resident if she made (him/ her) feel any kind of way. Review of the 2nd floor Staffing Assignment Sheet, dated 05/01/2021, revealed LPN #3 was assigned to Resident #146 on 7:00 AM - 3:00 PM shift. Interview was attempted with LPN #3, on 05/27/2021 at 3:16 PM; however, the LPN did not return the call. Interview with Social Services Designee #2, on 05/25/2021 at 2:16 PM, revealed Resident #146 reported he/she could not get a muscle relaxer when requested and stated a nurse was nasty towards him/her. The Social Services Designee stated she reported the allegation to the 2nd floor Unit Manager (UM) and the Assistant Director of Nursing (ADON). She revealed she did not submit a written statement regarding the allegation and was not aware of the outcome of the investigation. Interview with the 2nd floor UM, on 05/28/2021 at 9:27 AM, revealed allegations of abuse should be reported to the ADON, DON and Administrator immediately to ensure the resident's well-being. He stated the Social Services Designee mentioned Resident #146's concern a little while back; however, he forgot to address it. He stated he believed the ADON began an investigation of the incident when it was brought up again this week. Interview with the ADON, on 05/27/2021 at 9:50 AM, revealed staff were responsible for reporting an allegation of abuse immediately to their supervisor, ADON, Director of Nursing (DON), or Administrator to initiate an investigation and ensure resident safety. She revealed the Social Services Designee notified her on 05/25/2021 (25 days after the alleged incident) of Resident #146's allegation and she immediately went to speak with the resident. The ADON stated she questioned the resident regarding his/her stay and staff treatment. However, she did not interview specific to the allegation. She stated the facility did not investigate the incident because the resident did not mention concerns with staff or indicate abuse occurred. Interview with Resident #146, on 05/27/2021 at 10:54 AM revealed the facility had not interviewed or followed-up with him/her regarding the incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON, 05/28/2021 at 3:22 PM, revealed the facility was responsible for interviewing resident(s) and staff to determine exactly what occurred and decide if it would be an investigation event. She stated an investigation would include interviewing residents with a BIMS of eight (8) or above regarding mistreatment; skin assessments of residents with a BIMS' score of seven (7) or below to assess for injury; and interviewing staff and the alleged perpetrator. She stated the facility also removed staff from direct care if they were the perpetrator. The DON stated the ADON was responsible for conducting the investigation. Further interview with the DON revealed she was not aware of Resident #146's concerns with treatment by nursing staff. The DON revealed the ADON was responsible for notifying her and the Administrator for anything of concern and investigating the issue. However, the resident did not have any complaints when interviewed by the ADON. Interview with the Administrator, on 05/28/2021 at 4:13 PM, revealed the facility investigated all issues that were concerning and could be considered reportable. She stated all issues were first reported to the ADON. The Administrator revealed the ADON initiated the investigation and reported the findings to her. Continued interview revealed the facility had not identified issues with investigations of abuse. 43708 Surveyor [NAME] Based on interview, record review and review of the facility's policy it was determined the facility failed to thoroughly investigate an injury of unknown origin for one (1) of one-hundred and nineteen (119) sampled residents, Resident #87. The facility failed to investigate to determine the origin of Resident #87's right pinky fracture and laceration to his/her forehead. The findings include: Review of the facility's policy, titled Abuse Prevention Program revised 05/02/2017, revealed all personnel must promptly report any incident or suspected incident of resident abuse, mistreatment or neglect, to include an injury of unknown origin. An injury of unknown origin should be classified as an injury of unknown origin when the source of the injury was not observed or known by any person and the initial Risk Management Investigation (RMI) did not determine the cause of the injury. Continued review of facility's policy, titled Abuse Prevention Program, revealed for any incident which involved suspicion of abuse, neglect or mistreatment, the Administrator or designee would gather further facts prior to determination of an abuse investigation being investigated. Once determined by the Administrator there was reasonable cause for suspected abuse the Administrator or designee would investigate the allegation. The investigation team would follow the investigation procedures outlined in the facility policy. Per policy, the Charge Nurse (CN) must complete an incident report and obtain a written statement, signed and dated by the person who reported the incident. Additionally, the final investigation report would be completed within the required timeframe allowed by the Kentucky Cabinet for Health and Family Services of the reported incident. It would be the responsibility of the Administrator or Designee to forward a final written report of the results of the investigation and any corrective action to the local Office of Inspector General. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Page nine (9) of facility's policy titled, Abuse Prevention Program revised 05/02/2017, revealed after notification of alleged abuse or neglect, the Administrator or person in charge of the facility shall immediately commence an investigation for the incident reported. Review of Resident #87's clinical record revealed the facility admitted the resident on 07/09/2019, with diagnoses of Alzheimer's Disease, Dementia with Behavioral Disturbances, Anxiety, Major depressive disorder, and Cognitive communication deficit. LPN #2, LPN #3, LPN #5, LPN #40, LPN #46, Unit Manager (UM) #1, and Social Service Desginee #1 and #2 reported Resident #87 had a history of wandering into other resident's rooms, took items from other residents' rooms and got in other residents' beds. Review of Resident #87's Quarterly Minimum Data Set (MDS) dated [DATE], revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of three (3) out of fifteen (15), and determined the resident was not interviewable. Resident #87 was assessed for bed mobility, transfers, walk in room, walk in corridor, locomotion on the unit and off unit and to eat as supervision-oversight, encouragement and cueing with the assistance of one (1) staff member. Resident was assessed as two (2) staff physical assist to get dressed and for personal hygiene. Continued review of the Resident #87's MDS assessment, dated 06/13/2021, revealed the resident was not steady on his/her feet but could stabilize without staff assistance to move from a sitting to standing position, to walk, could turn around, move on and off the toilet, and could transfer from surface-to-surface. Resident #87 not noted to have any upper or lower body extremity impairments. Resident #87 did not require the use of any mobility devices. The resident was noted to be frequently incontinent of bladder and always incontinent of bowels. Review of Resident #87's Progress notes, dated 09/25/2021 at 9:49 AM, completed by Licensed Practical Nurse (LPN) #2 revealed she entered resident's room during morning rounds and noticed blood on resident's forehead above left eye. Area was cleaned and once the blood was cleaned up, open area measured two (2) and 1/4 inch by 1/2 inch with minimal bleeding. Neuro checks and vitals within normal range. No increased fatigue or confusion noted from baseline. Able to follow simple commands. Area dressed with 4x4 and tape. When cleaning the blood from hands, LPN #2 noticed right fifth (5th) digit swollen and bruised. Bruise also found on right forearm. Provider called and supervisor notified. Emergency Medical Services (EMS) called and resident transferred to the emergency room for further evaluation. Review of Facility RMI #3221 dated 09/25/2021 at 7:15 AM, completed by LPN #2 revealed she was unable to determine where and how Resident #87 was injured. LPN #2 labeled the incident as an injury of unknown origin. She entered the nursing description as, when doing morning rounds and vitals, she noticed that resident had dried blood on their forehead, arm, bedding and floor. Vitals and neuro checks completed at that time. All within normal limits. Blood cleaned off of resident and noticed resident had a gash on his/her forehead left side also right arm was bruised and fifth (5th) digit very swollen and bruised. On call Nurse Practitioner (NP) called and orders given to send out if LPN #2 felt it was necessary. EMS and supervisor called. Resident sent to emergency room for further evaluation. LPN #2 noted resident's description as unable to describe. Immediate action taken listed as area cleaned and dressed. Vitals and neuros done. EMS called. Resident sent to emergency room . Resident stated, That's where I fell and pointed to the floor scant area of dry blood noted on the floor. Resident was able to get self, up off the floor and ambulate per self. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/09/2021 at 4:20 PM, the Director of Nursing (DON) admitted she went back and edited the report. The DON wrote the part where resident said, I fell right there, she wrote that whole part. The DON went on to explain, There were some parts of the form you cannot edit and the RMS did not show who edits the report. Interview with LPN #2 on 09/30/2021 at 2:05 PM, revealed on 09/25/2021 when she conducted her morning rounds she found Resident #87 in bed and noticed something on the resident's head. When she looked closer she could see there was blood on resident's face, hand, pillow and on the floor by the head of the bed and could not determine where it came from. LPN #2 revealed she called the NP and was told to use her discretion about sending the resident to the emergency room . LPN #2 revealed resident's injury was pretty wide open still and decided to send resident to the ER. LPN #2 revealed she was also concerned about resident's pinky and elbow, she thought resident's pinky was jammed. Continued interview with LPN #2 on 09/30/2021 at 3:15 PM, further revealed she was called back to the facility to complete the RMI. She revealed she documented the incident as an injury of unknown origin and discussed it with LPN #3 as an injury of unknown origin. LPN #2 revealed she did not say resident fell . She revealed when she talked with the NP she informed the NP what she saw and the NP told LPN #2 to use her judgement. LPN #2 stated, LPN #3 documented it as a fall and was the one to report to the DON. She revealed the DON told LPN #3 what needed to be done. LPN #2 revealed she was unaware it was her responsibility to complete the RMI and that was why she had to return to the facility to complete the form. Interview with LPN #3 on 10/08/2021 at 10:53 AM, revealed when the incident with Resident #87 happened she was down on the first floor. She revealed LPN #2 called and informed her that resident had fallen out of the bed. LPN #3 went up to see Resident #87, resident was in bed, on his/her right side and resident's finger was swollen. LPN #3 revealed resident's feet were wrapped around the blankets and she determined resident had an unwitnessed fall. She stated, When a resident had a head wound the facility would send them to the hospital to get them examined. LPN #3 revealed LPN #2 made contact with the NP and any nurse is able to contact her. LPN #3 stated, I believe I texted the DON that resident had an unwitnessed fall with an injury and was sending her to the emergency room . She revealed she took resident's vitals and did a change in condition and LPN #2 called the family and the doctor. However, the facility provided documentation showing LPN #3 contacted resident's family. Continued interview with LPN #3 on 10/08/2021 at 10:53 AM, further revealed she could not think of anything else that could have caused resident's injury and she believed resident had fallen and got back in bed, based on her nursing history. LPN #3 explained a fall was when someone was on the floor and could not get up and an injury of unknown origin as an injury unknown where it came from. LPN #3 revealed even after all of the information provided to her, she would still call this incident a fall. She stated, Based on my knowledge, nineteen (19) years here, I assumed it was a fall. LPN #3 revealed LPN #2 would be the one responsible to do the investigation and then pass it on to her. LPN #3 revealed she would send a message to the DON and the DON would deal with it on Monday when she arrived to work. Interview with the DON on 10/08/2021 at 1:40 PM, revealed a head wound would be investigated as a fall and there were two (2) parts of the investigation which lead to a fall. The DON revealed she would go to the environment to see what could be changed. She revealed there was blood on Resident #87's bed, linen and on the floor and resident motioned to the floor. The DON revealed when resident motioned he/she said, that is where I fell . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued interview with the DON on 10/08/2021 at 1:40 PM revealed the DON stated, I am not going to speculate someone pushed him/her, when that is not what the resident said, I cannot say what LPN #2 did or did not see. I am not able to change the report from an injury of unknown origin to a fall. The DON also revealed the floor nurses did not do investigations. She also stated she was not sure what the policy said about reporting an injury of unknown origin but thought it would be within two hours. The DON stated, It was found to be a fall and that is why it was not reported to the Office of Inspector General (OIG). Interview with the Administrator on 10/09/2021 at 4:30 PM, revealed an injury of unknown origin was an injury that could not be determined how it was caused. She revealed all injuries were to be investigated and the investigation should take place as soon as the facility was aware. She revealed once an injury was found to be an injury of unknown origin it should be reported to the OIG and all proper authorities. The Administrator revealed if a staff member was unhappy with the outcome of an investigation that staff member should take it up to the Administrator herself. In continued interview with the he Administrator on 10/09/2021 at 4:30, she stated, An injury of unknown origin we look at the situation and decide it was a an injury of unknown origin, it would be reported immediately, with five (5) nurse assessments we can determine it was a fall and the resident stated it was a fall. The Administrator revealed she was present with the DON on 09/27/2021 and they conducted this investigation together. The facility provided a timeline of events however, they failed to provided five (5) nurse assessments, a root cause analysis or a completed investigation into this event.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43328 Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure accuracy of resident assessments for one (1) of one hundred-thirteen (113) sampled residents (Resident #109). The facility assessed Resident #109 as moderately vision impaired with corrective lenses. The findings include: Review of the facility's policy titled, Assessments dated August 2017 revealed assessments of residents took place timely, at the appropriate time and were accurate. Assessment findings were used as reference for care and treatment of the residents to include care planning and the MDS (Minimum Data Set). Further review revealed assessments were completed upon admission, readmission, quarterly, and when a significant change of condition occurred. Review of the facility's policy titled, Baseline Care Plan/Comprehensive Care Plans, revised 03/23/2021, revealed the Comprehensive Care Plan further expanded on the resident's risks, goals and interventions using the Person-Centered Plan of Care approach for each resident that included measurable objectives and timetables to meet the resident's medical, nursing, physical functioning, mental and psychosocial needs. The interdisciplinary staff developed quantifiable objectives along with appropriate interventions in an effort to achieve the highest level of functioning and the greatest degree of comfort/safety and overall well-being attainable for the resident. As the resident remained in the nursing home, additional changes will be made to the comprehensive care plan based on the assessed needs of the resident. Review of the facility's policy titled, Standard Supervision and Monitoring not dated, revealed supervision and guidance to the resident was an essential part of nursing care in which standard approaches were successful in meeting the resident's physical and psychosocial needs. Review of the facility's policy titled, Change in Resident's Condition or Status, not dated, revealed the facility ensured the resident's attending physician and representative would be notified of changes in the resident's condition or status. A significant change was a decline or improvement in the resident's status that; will not normally resolve without intervention by staff implementing standard disease related clinical interventions; impacted more than one area of the resident's health status; and, required interdisciplinary review and/or revision of the care plan. Record review revealed the facility admitted Resident #109 on 04/19/2017 with diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction, Contractures, Chronic Obstructive Pulmonary Disease (COPD), Falls, Peripheral Vascular Disease, Low vision Right Eye Category 1, Blindness Left Eye Category 3. Review of Resident #109's Minimum Data Set (MDS), dated [DATE], revealed under Section B, Hearing, Speech, and Vision, the facility documented the resident's vision as moderately impaired, not able to see newspaper headlines but can identify objects. Under Section C, Cognitive Patterns the Brief Interview for Mental Status (BIMS) score was fifteen (15) and the facility determined the resident was interviewable. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Opthamologist Visit Note dated 04/06/2021 revealed the resident's ocular history included Cataract of the left eye, Glaucoma of right eye: severe, Glaucoma of left eye: mild Phthisis bulbi (ocular condition characterized by severe eye damage/end stage) of right eye. Review of the Activities Care Plan documented 05/07/2018, revealed Resident #109 had some loss of visual function, but was able to see and self-propel on and off the unit. Further review of the care plan revealed the facility assessed the resident to be at risk for decreased vision related to glaucoma. The care plan was last updated 11/26/2018. Interventions included give eye medications as ordered, explain what was happening during procedures, keep clutter to a minimum in room and off floor to prevent falls; and, be sure to put the glasses on the resident during AM care. Interview, on 05/05/2021 at 2:18 PM, with Resident #109 revealed he/she was blind and staff parked his/her wheel chair where they wanted and then would leave. The resident also stated he/she must remember where everything was located in his/her room. Resident #109 stated he/she had a hard time finding the call light to call staff for assistance to the bathroom. Observation, on 05/06/2021 at 9:30 AM, revealed Resident #109 in his/her room up in a wheelchair. Further observation revealed the resident had food around his/her mouth from breakfast. Resident #109 was mobile per wheelchair in the room using his/her right hand stretched out to feel his/her way around the room. Continued observations revealed the resident bumped into the bedside table and against the wall at the foot of the bed. Further observation revealed the resident pedaled across the room and bumped into the back of his/her roommate's wheel chair. Observation, on 05/06/2021 at 12:10 PM revealed Resident #109 in his/her room, up in the wheelchair moving in circles around the room with his/her hand extended to feel along the furniture and walls. While moving about the room Resident #109 bumped into the walls and bed side table repeatedly. Observation, on 05/06/2021 at 12:14 PM, revealed Certified Nursing Assistant (CNA) #25 placed a lunch tray on the bedside table and offered to cut the meat, and informed Resident #109 that the meat was meat loaf. Observations revealed the CNA did not orient the resident to the plate or utensils. Regular silverware was on the tray. Observations revealed the resident began to eat his/her meal-using his/her hands, eating bites of meat with his/her fingers, then scooping bites of mashed potatoes and green beans into his/her mouth with his/her fingers. Observation on 05/06/2021 at 2:30 PM, revealed Resident #109 in his/her room in a wheelchair circling around reaching/feeling his/her way around the room with his/her right hand extended. The resident's television remote was lying on the floor. Continued observation of Resident #109 revealed he/she was unable to use the call light to notify staff that he/she needed help. The resident was observed to turn on the overhead light instead of activating the call light. Interview, on 05/14/2021 at 10:30 AM, with Resident #109 revealed he/she had lived at the facility for six (6) years and could see light to the left, but could not see shapes. In addition, Resident #109 stated staff told him/her where the food was on the plate, and handed the fork and spoon to him/her to eat. Resident #109 stated, at one time he/she wore glasses but could no longer see with them. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued interview with Resident #109, on 05/14/2021 at 10:30 AM revealed the way he/she identified the location of his her room was the change in light at the end of the hall. Resident #109 stated he/she could not see to get anywhere and was totally dependent on staff for dressing, toileting, and transfer. Interview with Licensed Practical Nurse (LPN) #27, on 05/14/2021 at 10:30 AM, revealed Resident #109 required total care; a lift to get out of bed; assistance with feeding; and, help pushing and moving around the floor. LPN #27 stated Resident #109 had left sided weakness and she thought the resident was partially blind. The LPN stated the degree of visual impairment was documented in the medical record and the care plan. Interview with Unit Manager (UM) #5, on 05/14/2021 at 10:40 AM, revealed Resident #109 needed supervision while eating and required extensive assistance with ADL (activities of daily living). Further interview with UM #5, revealed Resident #109 reported to her that he/she was legally blind. The UM stated it depended on what the resident was doing, as far as determining the assistance needed. She stated the resident could pedal himself/herself from the room to the smoking porch. UM #5 stated she had not observed the resident bumping into the walls or his/her roommate. She stated she had observed Resident #109 go into other residents' rooms while trying to find his/her room. Interview with CNA #25, on 05/14/2021 at 10:45 AM, revealed Resident #109 required set up for meals and queuing, but was a feeder. CNA #25 further stated she thought Resident #109 had visual impairment but could maybe see a little out of the right eye. Additionally because of his blindness, the resident was at risk for falls or injury. Interview with Registered Nurse (RN) #4, on 05/15/2021 at 9:40 AM, revealed she was aware Resident #109 had a degree of blindness. However, she was not familiar with the resident's plan of care. Interview, on 05/18/2021 at 10:13 AM, with Social Service Designee (SSD) #2 revealed she had observed Resident #109 scoot along and use the handrail to find his/her way down the hall. Interview, on 05/26/2021 at 9:48 AM with the Minimum Data Set Director (MDSD) revealed she managed all assessments and assigned alerts to nursing to evaluate for quality measure issues. She stated that each discipline was responsible for initiating, reviewing, and updating care plans. The MDSD stated the initial MDS, performed at admission, identified what the resident triggered. She stated she had not assessed Resident #109, but had seen the resident in the hallways. Continued interview revealed that Nursing Leadership notified her that Resident #109's vision had deteriorated and a referral was made to therapy to assess the resident's mobility. The MDSD stated Resident #109 had a care plan for vision. She stated she explained to the resident what was going on during procedures, administered eye medications as ordered by physician, kept the clutter in the room to minimum, and to be sure to wear his/her eye glasses. Interview on 05/27/2021 at 10:05 AM with the Director of Nursing (DON) revealed the resident had trouble seeing. The DON stated she observed the resident feeling along the wall and counting rooms on the way back to his/her room. She stated the resident was aware when he/she pasted his/her room because the lighting changed and it was darker. The DON further commented that Resident #109's MDS assessment showed his/her vision was moderately impaired. However, Resident #109 should have been assessed as severely impaired. The DON stated she did not think the vision assessment fit the resident. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator, on 05/28/2021 at 11:41 AM, revealed resident care was driven by the MDS assessment. She stated, Resident #109 wanted to remain as independent as possible and did not want staff to feed him/her. She stated she was not aware of issues with Resident #109's care at this time.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34116 Based on observation, interview, record review, and facility policy review it was determined the facility failed to ensure resident care plans were implemented for seven (7) of one hundred thirteen (113) sampled residents (Residents #75, #123, #130, #146, #179, #344 and #345). 1. The facility failed to implement the transfer care plan for Resident #123 during a maxi-lift transfer. The facility assessed the resident for extensive assist with two plus (2+) persons with physical assistance, however one (1) staff member completed the Maxi-lift transfer. The resident was later found with a leg fracture. 2. The facility failed to implement the care plan to manage pain for Resident #146. The resident reported pain, however facility staff did not address the resident's pain as noted in the care plan. 3. The facility failed to implement care plan interventions related to falls for Resident #130. Between March and [DATE], the resident fell four (4) times, two (2) of which resulted in leg fractures. 4. Resident #344 and Resident #345 engaged in a physical altercation with each other and led to a skin tear on Resident #344's chest. The facility failed to implement care plan interventions for Resident #345 who had a history of physical aggression before the altercation occurred. 5. The facility failed to implement care plan interventions for Resident #75 related to wandering into other resident rooms and for falls related to his/her length of pants. Observations revealed the resident wander into other resident rooms and non-resident areas unseen by staff, and the resident's pants legs dragged the floor. 6. The facility failed to implement care plan interventions for Resident #179 related to falls and skin care. The care plan noted use of fall mats and use of arm sleeve protectors and kerlix, however observations revealed the fall mat not in place. The findings include: Review of the facility's policy Baseline Care Plan/Comprehensive Care Plans, revised [DATE], revealed it was the policy of the facility to ensure that every resident had a Baseline Care Plan completed and implemented within 48 hours of Admission. The policy revealed the Comprehensive Care Plan would further expand on the resident's risks, goals and interventions using the Person-Centered Plan of Care approach for each resident that included measurable objectives and timetables to meet the resident's medical, nursing, physical functioning, mental and psychosocial needs. The facility did not provide a policy for Care Plan Implementation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy, Management of Pain, undated, revealed as part of a comprehensive approach to pain assessment and management, pain would be considered the fifth vital sign at the facility, along with temperature, pulse, respiration, and blood pressure. For the purpose of the policy, pain was defined as whatever the experiencing person said it was, existing whenever the experiencing person said it did. The policy revealed pain would be assessed and managed in a timely fashion, especially if it was of recent onset. The physician would be notified of the resident's complaint of pain when not relieved by medication as ordered by the physician. The policy revealed thorough communication with the physician would ensure an appropriate pain management plan. Further review of the policy revealed pain monitoring would be documented on the back of the Medication Administration Record (MAR)/pain flow sheet the effectiveness of pain medication. Effectiveness should be measured ,d+[DATE] hours after administration. 1. Review of the clinical record revealed the facility admitted Resident #146 on [DATE] with diagnoses that included Morbid (Severe) Obesity, Spinal Stenosis, and Chronic Pain Syndrome. Review of the Admission Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of fifteen (15) and determined he/she was interviewable. Review of the Care Plan, initiated [DATE], revealed Resident #146 had chronic pain related to spinal stenosis and morbid obesity. The goal of the care plan revealed the resident would not have an interruption in normal activities due to pain. Interventions included administering analgesia per the physician's orders and notifying the physician if interventions were unsuccessful or if the current complaint was a significant change from past experience of pain. Observation of Resident #146, on [DATE] at 5:35 PM, revealed the resident seated in bed dressed and groomed. Interview, with Resident #146, during the observation revealed the resident requested a muscle relaxer on [DATE] for back and leg spasms. Interview with Resident #146 revealed Licensed Practical Nurse (LPN) #39 and LPN #32 did not administer the medication because they said it was not available. The resident stated he/she dealt with the pain and cried himself/herself to sleep. Review of Resident #146 clinical record revealed a Physician's Order, dated [DATE], for Cyclobenzaprine 10 mg tablet every 6 hours, as needed for muscle spasms. Review of the pharmacy Delivery Manifest, dated [DATE] at 3:55 PM, revealed thirty (30) tablets of Cyclobenzaprine were delivered to the facility for Resident #146. Further review of the pharmacy Delivery Manifest, dated [DATE] at 4:58 AM, revealed thirty (30) additional tablets of Cyclobenzaprine were delivered. Review of Resident #146's Medication Administration Record (MAR), dated [DATE], revealed the facility did not administer Cyclobenzaprine on [DATE]. Further review revealed the facility assessed the resident with a pain level of zero (0) out of ten (10) on the PM-11pm and 11pm-7am shift; however, interview with the resident revealed he/she reported unrelieved pain to both LPN #39 and #32. Interview with Certified Nursing Assistant (CNA) #48, on [DATE] at 10:01 AM, revealed Resident #146 reported he/she had pain and needed a muscle relaxer around 8:00 PM. The CNA stated he reported the resident's pain to LPN #39. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #39 was attempted on [DATE]; however, the staffing agency did not provide a contact number. Interview with LPN #32, on [DATE] at 4:11 PM, revealed she administered the resident's muscle relaxer and pain medication in a timely manner; however, she did not document the administration in the MAR. In addition, the LPN stated she was responsible for assessing the resident's pain level, documenting in the MAR, and following up every thirty (30) minutes to determine if the medication was effective. The LPN revealed she reassessed the resident for effectiveness of the medication; however, she did not document the findings. The LPN revealed she did not notify the physician about Resident #146's pain because she felt like it was not debilitating. Interview with LPN #32, on [DATE] at 4:11 PM, revealed the care plan was the blueprint of treatment and guided care for the resident. She stated she implemented Resident #146's care plan; however, she did not document the care provided. According to the LPN, if it was not documented then it was not done. Interview with UM #7, on [DATE] on 9:27 AM, revealed residents should be assessed every shift for pain and medicated accordingly. He further revealed the nurse was responsible for implementing non-pharmacological interventions and notifying the physician if medications were not effective. Further interview with UM #7, on [DATE] at 10:39 AM, revealed the care plan was individualized to manage and address resident care needs. He revealed Resident #146's care plan was not implemented if the intervention(s) were not provided. Further interview with the Director of Nursing, on [DATE] at 2:56 PM, revealed all staff providing resident care were responsible for implementing interventions according to the care plan. She further revealed the Unit Manager was responsible for monitoring resident care to ensure the care plan was implemented. Interview with the Administrator, on [DATE] at 5:13 PM, revealed the facility had not identified any issues with implementation of care plans. 28733 2. Review of the facility Long Term Care Facility Self-Reported Incident Form, dated [DATE], revealed Resident #123 sustained an injury of unknown source. The resident remained non-verbal and unable to communicate how the injury occurred. In addition, the resident had Immobility Syndrome with contractures in his/her right hand. The facility determined the resident had a closed, non-displaced fracture (broken) tibia/fibula (both bones in the lower leg) located in the right leg. The facility initiated an investigation. Continuous observation of Resident #123 while in room and just outside of the door, on [DATE] at 9:12 AM through 11:02 AM, revealed the head of the bed was elevated with the resident's head and shoulders slid over and at an angle without body alignment, while lying in bed. The position remained unchanged. Observation of Certified Nurse Aide (CNA) in the corridor near the room entrance, revealed the CNA did not check in on the resident while in the room location. Observation revealed Licensed Practical Nurse (LPN) entered the room and approached the roommate without any encounter with Resident #123. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident #123, on [DATE] at 9:29 AM, revealed the resident was awake, and non-verbal when greeted. The bed was in a low position with the head of the bed elevated. Review of Resident #123's clinical record revealed the facility admitted the resident, on [DATE], with diagnoses of Cerebral Palsy, Aphasia, and Severe Intellectual Disabilities. Review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility was unable to assess Resident #123 with a Brief Interview Mental Status (BIMS); however, they completed the staff assessment for mental status. The facility assessed the resident was severely impaired. Review of the facility's functional status assessment in Section G revealed the resident's bed mobility and transfers were coded three (3) for extensive assistance. Continued reviewed of Section G's functional status revealed the facility coded the resident as three (3) and required two plus (2+) staff with physical assistance. Review of the facility's pocket sheet for Resident #123, not dated, revealed he/she was transferred by use of a Maxi-lift with two (2) staff. In addition, bed mobility was identified as extensive with two (2) persons. Interview with Nurse Aide (NA) #2, on [DATE] at 10:20 AM, revealed the aide was familiar with Resident #123's care and frequently cared for the resident. She revealed she was assigned to Resident #123 on [DATE]. She stated she requested transfer assistance from the aide assigned to the odd side hall; however, the aide was not able to assist. She revealed the need to provide Resident #123 with his/her shower; therefore, she proceeded to transfer the resident independently, without the second person. NA #2 revealed the kardex (CNA care plan) and the pocket sheet identified the resident was a two (2)-person transfer. She stated Resident #123 had been a two person lift and extensive assist of two (2) persons with bed mobility, and nothing had changed with the use of two (2) persons. NA #2 stated she transferred the resident from the bed to the shower chair in preparation for the resident's shower. Upon completion of the shower, Resident #123 returned to his/her room and transferred back to bed using the maxi-lift. NA #2 stated after the resident was dressed for the day, she again independently transferred the resident from the bed to the wheelchair. She stated she transferred the resident a total of four (4) times by herself during the shift on [DATE]. She stated the transfer with the maxi-lift required two (2) people for the resident's safety. She stated she needed to get a second aide, a nurse or call for help from another floor. Interview with Certified Nurse Aide (CNA) #56, on [DATE] at 3:36 PM revealed she was familiar with the needs of Resident #123. She had provided care and assisted the resident assigned staff with transfers. She stated the resident was care planned for the Maxi-lift when transferred from the bed to the wheelchair. She stated she assisted his/her assigned staff with a transfer from the wheelchair to the bed a couple of days before the injury to his/her leg was identified. She stated the maxi-lift needed two (2) persons when transferring residents to ensure the resident remained safe during the transfer. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #123's self-care deficit care plan revealed Cerebral Palsy, Aphasia, Heart Failure, Severe Intellectual Disabilities, Osteoarthritis, and Contracture to the right hand and knee, dated [DATE]. The goal revealed the resident will have all needs met per staff through next review, date initiated [DATE]. Care plan interventions included skin inspection daily with care required with observations for redness, open areas, scratches, cuts, bruises and report to the nurse, requires total assistance with personal hygiene care, dependent on staff for dressing, turning and repositioning in the bed, and requiring the Maxi-lift for transfers, date initiated [DATE]. Review of Resident #123's risk for falls care plan, initiated on [DATE], revealed risk related to cognitive impairments, communication impairment, decreased safety awareness, requires activity of daily living (ADL) assistance for transfers and mobility related task, with a goal for the resident to have a safe environment maintained through the next review. Interventions included frequent rounds to check on resident, keep bed in low position and sit at nurses station when up, initiated [DATE]. Interview with Resident #162, on [DATE] at 9:13 AM revealed he/she was Resident #123's roommate for a long time. Resident #162 stated his/her roommate was unable to speak, but communicated by pointing his/her finger. He/she stated facility staff used the lift to transfer Resident #123. She revealed NA #2 and two (2) more transfer the resident by themselves without a second person. He/she revealed staff continued this practice after the resident broke his/her leg. Resident #162 stated they get behind the bed and pull the resident up in the bed. Sometime they leave the bed to high, and call the staff back to lower the bed. Review of Licensed Practical Nurse (LPN) #41's Nurses Notes for Resident #123, dated [DATE] at 2:37 PM, revealed she was called to the room and noticed the resident's right lower extremity (RLE) discolored and with edema. The nurse identified facial grimacing identified when touched. An x-ray of the resident's right leg was ordered, and to continue to follow-up. interventions included anticipate and meet individual needs of the resident, initiated [DATE]. Frequent rounds to check on resident, keep bed in low position and sits at nurse's station when up, date initiated [DATE]. Interview with Licensed Practical Nurse (LPN) #41, on [DATE] at 10:32 AM, revealed she was the assigned nurse on [DATE], the day Resident #123's leg was identified with yellowish bruising and swelling by the Certified Nurse Aide (CNA). Further interview revealed the facility assessed Resident #123 for two-(2) person transfer with the mechanical lift. She revealed she had never seen any of the staff use the mechanical lift. She stated she was unable to recall if any CNAs requested assistance with the resident's transfers. She stated she had worked the previous weekend and Monday. However, she was not notified of any injuries. She stated on the Monday before the injury was identified, Resident #123 was at the nurse's station for a long time. She stated the resident's x-rays revealed a fractured right leg (fibula/tibia). Interview with the Director of Nursing (DON), on [DATE] at 1:22 PM revealed the Unit Managers (UM) were responsible to ensure each CNA completed tasks required in the residents' care plans. She stated the UMs updated staff on care plan revisions on each unit and updated the pocket (information) sheets. The pocket information sheets were provided to the CNAs with resident details required on the kardex. The Minimum Data Set (MDS) nurse relayed information to the UM, when the UM did not attend the care plan meeting. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the facility's Long Term Care Facility, Self-Reported Incident Form, dated [DATE], revealed an altercation between Resident #344 and #345. Continued review of the facility's investigation and the written statement of CNA #21, dated [DATE] at 6:30 PM, revealed she responded to Resident #344's call light and the resident reported injury to his/her chest. CNA #21 documented that Resident #344 reported his/her roommate (Resident #345) beat him/her with a stick. CNA #21 stated Resident #344 lifted his/her gown and she observed a bruise on his/her abdomen and a large skin tear bleeding on his/her chest. Attempted interview with Resident #345; however, the resident was discharged , on [DATE]. Review of Resident #345's clinical record revealed the facility admitted the resident on [DATE] with the diagnoses of Cerebral Infarction (Stroke) secondary to an Embolism of the Bilateral Vertebral Arteries, Aphasia (speech/language disorder), and Cognitive Communication Disorder. Attempted review of Resident #345's Quarterly Minimum Data Set (MDS) assessment; however, it was not provided with the facility's investigation. The facility's investigation identified the resident's Brief Interview Mental Status (BIMS), not dated, revealed the resident with moderate cognitively impaired, scoring eleven (11). Review of Resident #345's behavior care plan, initiated [DATE] and without revision identified, revealed he/she had episodes of being verbally aggressive toward other resident and exhibits physical aggression toward roommate. Interventions included intervene as necessary to protect the rights and safety of others, approach and speak in a calm manner, divert attention, remove from situation and take to an alternate location as needed, date initiated [DATE]. Educate resident on possible outcomes of not complying with care, date initiated [DATE]. Review of Resident #345's eInteract SBAR Note, dated [DATE] at 7:00 PM, revealed the physical assessment identified physical aggression. Review of the Resident #345's Nursing Progress Note, dated [DATE] at 7:19 PM, revealed Resident #345 became upset with Resident #344 when he/she was getting up in wheelchair on his/her own without assistance. Continued review revealed Resident #345 struck Resident #344 on the chest with a reacher a few times, leaving injuries. Review of Resident #344's closed clinical record revealed the facility admitted the resident, on [DATE] with diagnoses of Vascular Dementia with Behavioral Disturbance, Cognitive Communication Deficit and Metabolic Encephalopathy. Further review of the facility's Provisional Report of Death, dated [DATE] at 6:15 PM, revealed Resident #344 was deceased . Review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed Resident #344 with a Brief Interview Mental Status (BIMS) of ten (10), with moderate cognitively impaired. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #344 risk for falls related to decreased safety awareness care plan, revealed the resident required activities of daily living (ADL) assistance for transfers and mobility related tasks, impaired range of motion, and loss of functional movement of joints, and decreased strength and endurance, initiated [DATE]. Interventions included transfers with extensive assist of one (1) person for stand and pivot, initiated [DATE]. Additional intervention, initiated on [DATE], included maxi lift with two (2) assist for all transfers. 43708 4. Review of the clinical record revealed, the facility admitted Resident #75 on [DATE] and readmitted the resident on [DATE] with diagnoses including Alzheimer's disease, Down Syndrome, Moderate Intellectual Disabilities, Bi-polar Disorder, and Obsessive Compulsive Disorder (OCD). Review of the Quarterly Minimum Data Set (MDS) dated [DATE], revealed the facility assessed Resident #75 with a Brief Interview for Mental Status (BIMS) of four (4), indicating the resident was severely impaired. Review of Resident #75's Behavior Care Plan, initiated [DATE], revealed the resident exhibited episodes of wandering the halls and trying to get on the elevator, episodes of clogging up the sink and toilet in the room causing water to flood the floor, and wandered into other resident rooms and took items. The care plan desired outcome for the focus was Resident #75 would exhibit less than two (2) described behaviors daily through next review. Interventions included: approach resident warmly and positively, assist him/her in selection of appropriate coping mechanisms; if resident was unwilling to leave an area such as a closed room or come inside the building, offer orange soda or ice cream as an incentive; observe and document his/her behavior and report any changes to physician; observe resident frequently when in room and educate not to place items in the sink related to possible negative outcome; and redirect as needed. Review of Resident #75 Comprehensive Care Plan, initiated [DATE], revealed the resident was at risk for falls related to cognitive disorder and impaired Activities of Daily Living (ADLs). Interventions, revised [DATE], revealed to ensure his/her pants were rolled up if too long. Review of the CNA pocket information sheet, undated, revealed Resident #75's special instructions included half (,d+[DATE]) side rails, living environment clutter free, non skid socks, Q1H (every one hour) safety checks, assist with toileting, encourage resident to lay down in bed when sleepy. Review of Resident #75's progress notes, dated [DATE] at 1:54 PM, revealed the IDT (Interdisciplinary Team) met and discussed the resident's previous fall event. On [DATE], Resident #75 ambulated with a staff member behind him/her and witnessed the resident fall. The resident's pants were too long and he/she tripped on them. The care plan and Kardex were updated for intervention to include ensure pant legs were adjusted/rolled up. Observation of Resident #75, on [DATE] at 3:05 PM, revealed the resident wandered the halls and attempted to open a locked door at the end of the hall. Observation, on [DATE] at 9:44 AM, revealed Resident #75 ambulated to the employee lounge. No staff was present in hall, Resident #75 opened the lounge door approximately three (3) inches where staff was visible in the gap in door. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 9:45 AM, Observation of Resident #75 revealed the resident at the end of the odd side of the hall. He/she opened the break room door and looked inside the break room beside the chapel. Observation, on [DATE] at 9:50 AM, revealed Resident #75 turned the doorknob to the chapel. Observation of Resident #75, on [DATE] at 3:28 PM, revealed the resident in the employee breakroom standing behind the door by the trashcan. Housekeeper #3 noted he/she would get into the trash sometimes. Dark brown matter was noted under the fingernails of Resident #75's right hand. Observation of Resident #75 on [DATE] at 8:58 AM, revealed the resident walking the halls looking into rooms. On [DATE] at 10:34 AM, observation of Resident #75 revealed the resident entered room [ROOM NUMBER], opened the bathroom door, stood at the bathroom vanity, touched and picked up linen on sink counter. On [DATE] at 10:42 AM, Resident #75 exited room [ROOM NUMBER]. No staff was present to redirect Resident #75 at the time of the observation. Observation, on [DATE] at 9:11 AM, revealed Resident #75 wore nonskid socks and checkered flannel pants dragging the floor. The resident walked in and out of room [ROOM NUMBER], and proceeded to the breakroom. He/she opened the breakroom door and entered the breakroom at 9:14 AM. Interview with CNA #13, on [DATE] at 10:56 AM, revealed she tried to redirect Resident #75 when he/she entered resident's rooms. CNA #13 stated Resident #75 wandered the halls daily and would enter other resident rooms at times. In addition, she stated the facility provided staff with CNA pocket information sheets which reflected a brief care plan and safety areas of things to watch for each resident. Interview with CNA #39, on [DATE] at 9:24 AM, revealed the facility gave CNA pocket sheet information sheets to all CNAs on the floor. CNA #39 stated she was told Resident #75 would need to be watched and redirected throughout the day. However, it was not communicated Resident #75's pant legs should be rolled up to prevent falls, nor were there special instructions on the CNA information sheet to reflect Resident #75's pant leg should be rolled up. Interview with CMT #1, on [DATE] at 9:15 AM, revealed she was familiar with Resident #75. She explained Resident #75 was care planned for wandering. She stated this was achieved by monitoring to keep up with him/her and redirection if needed. SSA asked CMT #1 if she was aware of where Resident #75 was currently. CMT #1 looked down the hallway, looked into resident rooms and proceeded to the staff breakroom. She opened the staff break room door and redirected Resident #75 out of the breakroom at 9:17 AM. CMT #1 further stated Resident #75 should not be in the breakroom. She revealed Resident #75 could put something in his/her mouth or hurt himself/herself. CMT #1 also stated Resident #75's pants were too long, adding it's the only pair of clean pants the resident had. CMT #1 revealed Resident #75's pants should not drag the floor as the resident could fall. Interview with LPN #17, on [DATE] at 3:03 PM, revealed she was not told of any interventions for wandering residents in report. LPN #17 stated she was able to access care plans in the computer and could also access CNA pocket information sheets to obtain information. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #12, on [DATE] at 3:05 PM, revealed she monitored residents that wandered closer. She stated every once in a while she had seen Resident #75 in the staff bathroom or staff breakroom. LPN #12 additionally stated she watched Resident #75 closely; We need to know where (he/she) is at all times. Interview with LPN #14, on [DATE] at 11:44 AM, revealed she had not seen Resident #75 in other resident rooms. However, she stated, I try to intervene, to keep (him/her) from entering other resident rooms. LPN #14 further stated redirection was effective. The nurse revealed if Resident #75 wandered into other residents' rooms, another resident could cause Resident #75 harm or injury. Interview with Unit Manager (UM) #3, on [DATE] at 3:16 PM, revealed the facility monitored falls by adding a care plan intervention anytime someone fell . She added each fall was individual and each had a different intervention. UM #3 also addressed wandering behaviors and stated each resident had the right to wander. She stated, Resident #75 had a WG (wanderguard device) bracelet and staff checked placement of the bracelet every shift. She revealed nurses and staff knew to monitor Resident #75. UM #3 further stated it was hard to ensure Resident #75 did not go into other resident rooms; however, it did happen. She revealed when it did occur, staff redirected him/her out of the rooms. Interview the DON, on [DATE] at 3:11 PM, revealed the care plan was a plan of care directed to each resident. The DON stated the nurse, MDS, UM, and dietary had assessed the residents to revise care plans. She explained the CNAs had access to the Kardex, and their pocket information sheet should reflect the Kardex. She stated if changes were made to the care plan, the UM would update the pocket information sheet for the CNAs. Interview with the Administrator, on [DATE] at 4:13 PM, revealed the facility had frequent fall residents. She stated a new care plan intervention was initiated with every fall. 44298 5. Review of clinical record revealed the facility admitted Resident #179 on [DATE] with diagnoses of Cerebral Palsy, Contracture of Right Shoulder, Left Shoulder, Right Elbow, Left Elbow, Right Wrist, Right Hand, Left Hand, Left Wrist, and Unspecified Convulsions. The facility assessed the resident as severely cognitively impaired. Review of Resident #179's care plan (CP) revealed the resident was dependant on staff for all Activities of Daily Living (ADL) care needs on daily basis. The resident was at risk for falls, required ADL assist for transfers and mobility related tasks. CP interventions included placement of bilateral floor mats next to the bed, initiated [DATE]. The CP also noted Resident #179 was at risk for potential skin failure from moisture, friction, and shearing. Interventions included float heels while in bed, initiated [DATE], and wrap bilateral lower extremities (BLE) with kerlix from toes to knees for protection during transfers, initiated [DATE]. Observation, on [DATE] at 8:03 AM, revealed bilateral floor mats were not in place for Resident #179. Observation, on [DATE] at 10:13 AM, revealed Resident #179 in his/her bed with his/her eyes closed, clothes and bed linens looked clean, hair appeared clean, and the room was clean with no odors. Bilateral floor mats were not present. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:40 AM, observation revealed no placement of bilateral fall mats by Resident #179's bed. Observation, on [DATE], at 9:50 AM, revealed Resident #179 in his/her bed. Bilateral floor mats and hand splints were not present. On [DATE] at 2:25 PM, observation revealed Resident #179 in his/her bed, awake, with a splint on his/her left hand. Bilateral floor mats were not in place. Observation, on [DATE] at 8:15 AM, revealed Resident #179 in his/her bed, awake. Bilateral floor mats and the hand splint were not in place. Observation of Resident #179, on [DATE] at 8:35 AM, revealed the resident in his/her bed with his/her eyes closed. Bilateral floor mats were not in place. Observation, on [DATE] at 10:15 AM, revealed Resident #179 in his/her bed The bilateral floor mats were in place, however the splint was off his/her hand. Interview with Family Member #7, on [DATE] at 2:45 PM, revealed there was a huge lack of communication with the facility. Resident #179 was supposed to have splints on his/her hands every day and the facility failed to put them on. Interview with CNA #47, on [DATE] at 3:30 PM, revealed he/she was familiar with Resident #179's Care Plan (CP). Resident #176 sat in his/her wheelchair in the hallway. According to the CP, he/she was to have sleeves on his/her legs or kerlix during transportation to protect the resident's skin; however the sleeves or kerlix were not present. According to CNA #47, the CNA Care Card failed to indicate the sleeves for Resident #179's legs. The Unit Manager (UM) updated Resident #179's CP. On [DATE] at 10:05 AM, interview with CNA #19 revealed the fall mats were placed on the side of Resident #179's bed where he/she tended to fall. CNA #19 did not look at the assignment sheet at the beginning of his/her shift. Resident #179 had the floor mat placed only on the right side of his/her bed. Interview with Unit Manager (UM) #4, on [DATE] at 10:10 AM, revealed the CP was updated at least weekly, or when new orders were received. According to UM #4, Resident #179's CP included an intervention for bilateral floor mats to prevention injury if the resident fell . UM #4 stated she failed to follow the resident's CP and did not know why the floor mat was placed only on the right side of Resident #179's bed. On [DATE] at 10:15 AM, interview with LPN #3 revealed Resident #179 could fall, hit the floor and get hurt if there were no bilateral flo [TRUNCATED]

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30898 Based on observation, interview, record review, and facility policy review it was determined the facility failed to ensure resident care plans were revised/updated for seven (7) of one hundred-thirteen (113) sampled residents (Residents 32, 47, 74, 87, 130, 159, 161). 1. On 03/19/2021 around 7:30 PM, staff found Resident #161 with his/her hand on Resident #47's exposed genitalia. The residents were in the dining room/dayroom area, the lights were off, and no staff were in the room. Resident #161 had a similar incident in 2019, with his/her hand on another resident's exposed genitalia while in a common area, however the resident's care plan was not revised to reflect sexual contact with another resident after the 2019 incident occurred. 2. The care plan for Resident #47 revealed the facility revised the resident's care plan for exposure of his her genitalia, after the sexual contact incident with Resident #161 occurred, on 03/19/2021. However, Resident #47's care plan did not reflect that sexual contact with another resident occurred. 3. Resident #130 had four (4) unwitnessed falls between March 2021 and May 2021, with two (2) falls resulted in major injury. Resident #130 received treatment for a fractured tibia when hospitalized on [DATE], The care plan interventions put in place after the initial fall with significant injury included staff to assist with toileting, dated 03/15/2021, and prompt response to calls and call light dated 04/12/2021. The Physician, on 05/07/2021, ordered Physical Therapy (PT), however therapy services were not initiated until 05/18/2021. On 05/16/2021 at 2:30 AM, Resident #130 had an unwitnessed fall. Resident #130 received treatment for a fracture of the femur of the right leg when hospitalized on [DATE]. 4. The facility identified, on 05/08/2021, a new Stage II pressure ulcer (PU) to the right buttock of Resident #159. During observation of a skin check for Resident #159, on 05/17/2021 at 9:21 AM, revealed an open area on the right upper buttock. The comprehensive care clan for Resident #159 revealed he/she was at risk for developing impaired skin integrity. The most recent update for this focus was initiated on 02/13/2019 to turn and reposition resident every two (2) hours, however the care plan was not revised for an actual wound. 5. The facility assessed Resident #32 at risk for falls with care plan risk of falls, initiated on 03/07/2019, interventions included keep the call light in reach and encourage resident to use it for assistance, gripper tape next to the bed, gather information on past falls and attempt to determine the root cause of the fall, and intervene to prevent reoccurrence. The resident fell again on 02/25/2021, 04/20/2021, 04/21/2021, and on 04/23/2021, After each of these three (3) falls, the care plan was revised based on incomplete incident reports and Root Cause Analysis to prevent future falls. 6. Resident #74's comprehensive care plan, initiated 03/03/2021, included the resident would be able to make basic needs known by speaking/ hand gestures/ process of elimination/ call to family for translation until effective communication could be created. However the resident did not have a communication board, which staff interviews revealed was not used, and was not discontinued until the re-certification survey. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. Resident #87 had a history of wandering into other resident rooms and took other resident belongings. On 02/01/2020, Resident #69 pushed Resident #87 to the floor, as Resident #87 sat in Resident #69's seat. On 02/27/2020, Resident #87 wandered around the unit all night and into other rooms. On 04/18/2020 Resident #87 wandered into another resident room and took the other resident's cookie. However, the CP was not revised until 11/10/2020, with an intervention for psychiatric services as needed. On 03/10/2021 the resident wandered into other resident rooms, and on 04/02/2021 the resident wandered into other resident rooms, got into their beds, and took their belongings. On 04/22/2021, the resident was yelling in another resident's room and removed all the blankets from one (1) of the beds. The CP interventions were not revised after 04/02/2021 for these behaviors. Immediate Jeopardy was identified on 05/17/2021 and determined to exist on 03/19/2021 in the areas of 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation, F600 Free From Abuse and Neglect at S/S of J and F607 Develop/Implement Abuse/Neglect, etc. Policies at S/S of J, 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F657 Care Plan Timing and Revision at S/S of J, 42 CFR 483.40 Behavioral Health, F745 Provision of Medically Related Social Services at S/S of J, and 42 CFR 483.70, Administration, F835 Administration at S/S of J. Substandard Quality of Care (SQC) was identified at 42 CFR 483.12, F600 Free from Abuse and Neglect, F607 Develop/Implement Abuse/Neglect, etc. Policies, and 42 CFR 483.40, F745 Provision of Medically Related Social Services. The facility was notified of the Immediate Jeopardy on 05/17/2021. An extended survey was conducted 06/30/2021 through 07/02/2021. The State Survey Agency validated the facility's Allegation of Compliance/Removal Plan and found the facility had removed the immediacy on 06/27/2021, as alleged. The findings include: Review of the facility's policy, Baseline Care Plan Assessment/ Comprehensive Care Plans, revised 03/23/2021, revealed the comprehensive care plan would include measurable objectives and timetables to meet the resident's medical nursing, mental, and psychosocial needs. Additional changes would be made to the comprehensive care plan based on the assessed needs of the resident. The MDS staff would attend the morning CQI meetings where an in-depth review of the twenty-four (24) hour report since the prior morning meeting were reviewed and discussed as well as other pertinent circumstances regarding the residents. They will then see that the care plans for those residents were revised and updated as necessary. 1. Review of Resident #161's clinical record revealed the facility readmitted the resident on 10/09/2017. The resident's diagnoses include Hemiplegia affecting left non-dominant side, Vascular Dementia, and Cognitive Communication Deficits. Review of the care plan for Resident #161 revealed he/she was at risk for falls related to history of falls, cognitive impairment, and decreased safety awareness. Interventions included not to leave the resident alone in his/her room when out of bed, to keep him/her around the nurse's station, initiated 04/13/2018. Review of the facility's investigation revealed on 04/05/2019, Resident #161 was in the common area in front of the nurse's station and had his/her hand on another resident's exposed genitalia. Review of the incident report revealed Resident #161 was confused, had impaired memory, and oriented to himself/herself only which was within the resident's normal limits. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review revealed the care plan also included the resident exhibited behaviors related to reaching out for others when seated in common areas and included an intervention, dated 04/06/2019, to intervene as necessary to protect the rights and safety of others and remove from the situation and take to an alternate location as needed. Additional intervention included if reasonable and appropriate, discuss the resident's behavior, explain/reinforce why behavior was inappropriate and/or unacceptable to the resident if there was a concern, initiated 04/06/2019. Further review of the care plan for Resident #161, initiated 05/01/2019, revealed do not leave unattended in the dining room when out of bed. Further review of the care plan (CP) for Resident #161 revealed the resident was at risk of decline in cognitive function and had a diagnosis of Vascular Dementia. An intervention, dated 10/24/2019, included the resident may need supervision/assistance with all decision making, and encourage and praise when decisions were made. The comprehensive CP revealed, on 05/29/2020, the resident used a geri-chair when out of bed. Review of the Quarterly Minimum Data Set (MDS) for Resident #161, dated 03/16/2021, revealed the facility assessed the resident with a Brief Interview Mental Status (BIMS) of eleven (11). The MDS noted the resident was totally dependent on staff for transfers, and to move about the unit with one (1) person assistance. The resident had impairment on his/her upper and lower extremities on one (1) side of the body. Further review of the care plan for Resident #161 revealed the resident exhibited episodes of sexual behavior and exposing himsself/herself in common areas. Interventions included remove the resident from public area and provide privacy of his/her own room when sexual behaviors were present and not be left alone in the dayroom, dated 03/19/2021. Additional intervention, dated 03/24/2021, included every one (1) hour safety checks. Observation of Resident #161, on 05/06/2021 at 2:23 PM, revealed the resident in a geri-chair at the fourth floor nurse's station. A pillow was under the resident's head. Staff asked the resident if he/she wanted to lay back more, the resident nodded and staff adjusted the back of the geri-chair. Observations, on 05/12/2021 at 3:26 PM, 05/13/2021 at 2:26 PM and 3:43 PM, 05/14/2021 at 2:27 PM, 05/16/2021 at 9:05 AM, 05/18/2021 at 1:40 PM, 05/19/2021 at 10:54 AM, 06/02/2021 at 2:44 PM, 06/03/2021 at 11:19 AM, 06/08/2021 at 1:51 PM, revealed Resident #161 in the geri-chair at the nurse's station with a pillow under the resident's head. Attempted interview with Resident #161, on 05/06/2021 at 2:23 PM, revealed the resident did not respond to the State Survey Agency (SSA) surveyor. Attempted interview, on 06/02/2021 at 2:44 PM, with Resident #161 revealed he/she nodded his/her head when the SSA surveyor asked how he/she was doing, with no other response from the resident. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview, on 04/29/2021 at 2:54 PM, with Licensed Practical Nurse (LPN) #30 revealed she was the nurse assigned to Resident #161 when he/she had sexual contact with Resident #47, on 03/19/2021. She stated she worked with Resident #161 in the past, however she was not aware of the incident Resident #161 had with another resident in 2019 until Resident #161's family informed her of the incident. The LPN revealed she worked for the facility about four (4) years on different floors. She stated she did not update the resident's care plan, it was the responsibility of MDS department to update the care plan. Interview with House Supervisor #1, on 04/29/2021 at 3:55 PM, revealed she worked for the facility about one (1) year, and had worked previously through an agency. She revealed she was unaware of sexual behaviors from Resident #161 before, and had worked with the resident in the past. House Supervisor #1 stated she was not aware of any increased monitoring or supervision for Resident #161 in the past. She stated she did not update the resident's care plan, the nurses were responsible to update them. Interview with House Supervisor #2, on 04/30/2021 at 6:27 AM, revealed she worked for the facility about twenty-four (24) years and was aware Resident #161 touched another resident's genitalia about one (1) to two (2) years ago. She stated Resident #161 was monitored after that incident, and was not cognitively intact at the time. House Supervisor #2 revealed Resident #161 was at the nurse's station a lot and should not be left alone in common areas. She stated she did not update Resident #161's care plan, as it was the responsibility of the Unit Manager, ADON, or DON. She revealed staff needed to watch Resident #161 when he/she was in the back common area to keep an eye on the resident after the first incident. The Supervisor stated if the resident was left alone, the incident that occurred of inappropriate contact could happen again. She further stated she was unsure if the nurses were trained to update the care plan, and she had not been trained to update the care plan. Interview, on 04/30/2021 at 2:06 PM, with the ADON revealed everyone who participated in the morning meeting was responsible to update the care plan. She stated care plan updates were discussed and updated as a team. The ADON revealed she, Social Services, or MDS would make the updates. She stated the purpose of the care plan was to identify risk or how to properly care for a resident. She further stated nurses were trained how to update the care plan, however for the situation such as what occurred between Resident #47 and Resident #161, the morning team would update the care plan instead of the nurses. On 05/17/2021 at 3:05 PM, interview with the MDS Director revealed care plans were updated when there were any changes to a resident's status, such as medication changes, by the entire IDT team during the morning Clinical Quality Indicators (CQI) meetings five (5) days a week. She stated they reviewed the twenty-four (24) hour report and new orders, and everyone was responsible to update the care plan in a reasonable time. Continued interview with the ADON, on 06/03/2021 at 9:44 AM, revealed she updated the care plan for Resident #161, although she was unaware of the similar incident in 2019 between Resident #161 and another resident. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview, on 06/03/2021 at 1:48 PM, with the former Director of Nursing (DON) revealed she thought Resident #161's care plan intervention not to leave him/her unattended in the dining room was related to a risk for falls. She stated the only sexual behaviors she was aware of, from Resident #161, was related to the resident would place his/her hands in his/her pants. The former DON revealed the resident's previous sexual behaviors occurred before she worked at the facility, and did not recall a prior incident of sexual contact with another resident. Interview with ADON, on 06/08/2021 at 8:54 AM, revealed Resident #161's care plan intervention, dated 03/19/2021, stated the resident was not to be left alone in the dayroom so staff could intervene if the resident exhibited episodes of sexual behavior. On 06/08/2021 at 9:36 AM, interview with the Administrator revealed the intervention not to leave Resident #161 alone in the dayroom was no longer relevant as it was no longer an issue. Interview, on 06/08/2021 at 11:02 AM, with Unit Manager (UM) #4 revealed the care plan, for Resident #161, intervention not to leave alone in the dayroom was to keep an eye on the resident so a similar situation that occurred would not happen again. Interview with the DON, on 06/08/2021 at 11:53 AM, revealed Resident #161's care plan intervention, dated 03/19/2021, was out in place for the resident's safety pending the outcome of the facility's investigation. She stated once the investigation was unsubstantiated, the intervention should have been removed from the care plan, and updated with a different intervention. The DON revealed the resident's care plan for sexual activity included an intervention to remove from public areas and provide privacy of his/her own room when sexual behaviors were present, however this did not reflect if the resident was or was not capable to give consent which was based on BIMS' scores. On 06/15/2021 at 1:52 PM, interview with UM #4 revealed she was not aware if Resident #161 had any sexual behaviors prior to the incident with Resident #47. She stated she was unaware of the purpose of the intervention for Resident #161 to remove from public areas when sexual behaviors were present. Interview with House Supervisor #1, on 06/15/2021 at 2:49 PM, revealed she did not work with Resident #161 and was not aware of the resident's capacity to consent to sexual contact. She stated she was unaware of the reason the resident had a care plan intervention to remove and provide privacy for sexual behaviors. The Supervisor revealed she heard the resident messed with him/himself/herself, although she had never seen the resident exhibit any sexual behaviors before. Interview, on 06/15/2021 at 3:04 PM, with Social Service Designee #2 revealed Resident #161's care plan intervention to provide privacy of his/her own room may have been related to the incident two (2) years ago with another resident, however staff reported the resident masturbated. She stated she was told to add to the resident's care plan not to leave him/her alone in the dayroom after the incident with Resident #47, although she could not recall who instructed her to add the intervention. The Designee revealed she added the intervention as Resident #161 should not be left alone in the dayroom to make sure what occurred did not happen again, to keep the resident safe. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/15/2021 at 3:30 PM, interview with LPN #30 revealed Resident #161's care plan intervention to provide privacy in his/her own room when he/she had sexual behaviors was related to the resident was seen with his/her hand down his/her brief. She stated she was told the resident was known to masturbate, and was unaware of a similar incident prior to this incident. Interview with the ADON, on 06/15/2021 at 3:58 PM, revealed she was unaware of Resident #161's sexual behaviors that led to the care plan intervention to remove from public areas and provide privacy. She stated during her investigation of the incident between Resident #47 and Resident #161, she discovered Resident #161 had a similar prior incident which would be relevant to the investigation with Resident #47, as she reviewed the resident care plan in her investigation. 2. Record review revealed the facility admitted Resident #47 on 06/11/2020. Resident #47's diagnoses included Personal history of Transient Ischemic Attack (TIA), Cerebral Infarction without residual effects, and Dementia with Behavioral Disturbance. Review of the care plan, dated 08/03/2020, for Resident #47 revealed the resident had episodes of verbal aggression toward another resident with interventions to assess the resident's understanding of the situation and psychiatric consult as indicted. Additional intervention added, on 02/10/2021, included redirect as needed. Review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed Resident #47 as severely cognitively impaired with a Brief Interview Mental Status (BIMS) of seven (7). Review of a Psychiatry Progress note, dated 03/19/2021, revealed the resident had Dementia, was confused, and insight was impaired. The note documented the resident was oriented to person, place, and situation on this day. The resident was severely impaired in executive function, insight, and judgement. Resident #47 had a memory deficit, both recent and remote. Review of a facility incident report, dated 03/19/2021 at 10:03 PM, revealed Resident #47's genitalia was exposed and he/she stood in front of Resident #161. Resident #161 was unable to verbalize what occurred. Resident #47 stated he/she came from the bathroom and forgot to zip his/her pants. The facility immediately placed Resident #47 on one to one (1:1) supervision with staff. Review of the Psychology Report, dated 03/22/2021, revealed Resident #47 had a diagnosis of Vascular Dementia and recent cognitive impairment. Facility staff requested follow up and reported the resident was recently discovered to have his/her private area out in front of another resident in the common room. The resident was moved to another floor. Resident #47 stated nothing occurred in the common room with the other resident. The note further revealed the resident's comprehension, executive function, insight, and judgement were noted Severe Impairment. The note documented the resident had memory deficit, both recent and remote. The resident did not endorse he/she made any advances toward the other resident. Further review of Resident #47's care plan revealed the resident had episodes of exposing him/herself in common areas with an intervention, added on 03/24/2021 and discontinued on 06/11/2021, for the resident to remain on one (1) hour safety checks. The care plan did not reflect the resident was involved in a sexual contact incident with another resident. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation of Resident #47, on 04/28/2021 at 2:04 PM, revealed the resident sat in a chair with a cell phone in his/her doorway on the third floor. Interview with Resident #47, on 04/28/2021 at 2:04 PM, revealed no other residents had touched him/her inappropriately. On 04/29/2021 at 1:26 PM and 05/06/2021 at 2:32 PM, observation revealed Resident #47 sat in a chair in his/her doorway and listened to music on a cell phone. Observation, on 05/07/2021 at 1:18 PM, of Resident #47 revealed the resident stood in his/her doorway. On 05/14/2021 at 3:37 PM and 05/17/2021 at 1:56 PM, continued observation revealed the resident exited the elevator and ambulated independently. On 05/18/2021 at 9:35 AM, observation revealed Resident #47 ambulated with a cane toward his/her room. Further observation, on 06/08/2021 at 1:53 PM, revealed Resident #47 ambulated independently from the direction of the elevator toward his/her room. Observation of Resident #47, on 06/14/2021 at 8:54 AM, revealed the resident in the therapy room with staff on the fourth floor, which was at the end of hall that Resident #161 resided. The resident utilized an exercise bike that worked both upper and lower extremities. Interview with Registered Nurse (RN) #30, on 04/29/2021 at 2:54 PM, revealed she was the nurse for Resident #47 at the time of the incident. She stated she did not update the resident care plan after the sexual contact with Resident #161. The nurse revealed the MDS Coordinator usually updated the care plan. On 04/29/2021 at 3:55 PM, interview with House Supervisor #1 revealed she did not update Resident #47's care plan after he/she had sexual contact with Resident #161. She stated the nurse was responsible to update the care plan. Interview, on 04/30/2021 at 6:27 AM, with House Supervisor #2 revealed she did not update the care plan for Resident #47. She stated the Unit Manager (UM) or Assistant Director of Nursing (ADON) was responsible to update the care plan. The Supervisor further stated she was unsure of the nurses were trained to update the care plan, and she had not been trained to update the care plan. On 04/30/2021 at 9:09 AM, interview with Social Services Designee #2 revealed she updated Resident #47's care plan after the incident with Resident #161. She stated Resident #47 did not have prior sexual behaviors. Interview with Social Services Designee #1, on 04/30/2021 at 1:00 PM, revealed Social Services Designee #1 was responsible to update the residents' care plans for any behaviors. She stated the MDS department may also update the care plans related to behaviors. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview, on 04/30/2021 at 1:33 PM, with MDS Coordinator #2 revealed MDS staff was responsible for the resident's care plan when the resident was first admitted to the facility. She stated the nurses were responsible to update the care plan if the MDS Department was not there at the time of day. She revealed she did not update Resident #47's care plan, which should have been completed the night of the incident. MDS Coordinator #2 stated the care plan should be updated to ensure the resident's needs were met, for the resident's safety. She further stated the care plan informed staff how to care for a resident. On 04/30/2021 at 1:46 PM, interview with the MDS Director revealed if a resident had sexual behaviors, the facility would care plan for those behaviors. She stated the nurses were trained how and when to update the care plan. Interview, on 04/30/2021 at 2:06 PM, with the ADON revealed she was initially informed Resident #47 exposed himself/herself to another resident in the common area dining room/dayroom. She stated Resident #47 reported to her that nothing happened and he/she forgot to zip his/her pants after exiting the bathroom. The ADON revealed everyone in the morning meeting was responsible to update the resident care plan. She stated the team discussed the care plan together and updated the care plan as a team. She revealed she (the ADON), MDS, and Social Services could update the care plan. Additionally, the ADON stated the nurses were trained how to update the care plan and would update the care plan when needed. She revealed, however, the nurses would not update the care plan for a reportable incident such as the incident between Resident #47 and Resident #161, that it was reviewed and updated together. She stated the purpose of the care plan was to identify the risk or how to properly care for the resident. Continued interview with the MDS Director, on 05/17/2021 at 3:05 PM, revealed the morning meeting reviewed the twenty-four (24) hour report, nurse's notes, and any new activity/orders and reviewed the resident's care plan for appropriate interventions. She stated they were all responsible to update the care plan in a reasonable time. The MDS Coordinator stated new interventions put into place may not be listed on the care plan. Interview with the ADON, on 06/03/2021 at 9:44 AM, revealed the facility placed Resident #47 on one (1) hour safety checks after the incident with Resident #161 to look at his/her emotional needs, where he/she was, and what he/she was doing. She stated staff checked on the resident for emotional upset and documented on the Medication Administration Record (MAR). Interview with the former Director of Nursing (DON), on 06/03/2021 at 1:48 PM, revealed the ADON informed her staff did not witness any sexual acts occur between Resident #47 and Resident #161, and no one visually saw anything occur. She stated the purpose of the care plan was to keep the resident safe. On 06/03/2021 at 3:46 PM, additional interview with the ADON revealed the root cause analysis determined what and how an incident occurred to prevent it from happening again. She stated she was unable to substantiate or un-substantiate what occurred between Resident #47 and Resident #161, it was undetermined as the residents denied anything occurred although staff witnessed sexual contact between the residents. Continued interview with the ADON, on 06/08/2021 at 2:04 PM, revealed she determined through her investigation there was sexual contact between Resident #47 and Resident #161. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview, on 06/08/2021 at 2:38 PM, with the Administrator revealed the facility investigation determined Resident #47 and Resident #161 did not have sexual contact with the other. Interview with Unit Manager (UM) #7, on 06/11/2021 at 4:25 PM, revealed he just began to help cover UM duties for part of the third floor, which included Resident #47, around 06/07/2021. He stated Resident #47 was on one (1) hour safety checks to check the resident for verbal aggression or exposing himself/herself. The UM revealed Resident #47's care plan did not identify he/she engaged in sexual contact with another resident. He stated the facility used agency nurses and CNAs, and if an agency staff worked with Resident #47 and did not know Resident #47, the agency staff may not know he/she had a history of sexual contact with another resident if it was not documented. Additionally, he stated Resident #47 could move about after the one (1) hour safety check and had the potential to offend again. Continued interview with Social Services Designee #2, on 06/11/2021 at 5:00 PM, revealed she discontinued Resident #47's one (1) hour safety checks on this day as she forgot to remove the intervention after psych saw the resident. She stated the one (1) hour safety checks were to check to make dsure the resident was safe, where he/she was supposed to be, and doing anything he/she was not supposed to do. The Designee revealed the resident's care plan did not have information that the resident had sexual contact with another resident, and she was not sure how she missed it. She further revealed agency staff would not know Resident #47 had sexual contact with another resident if it was not on the care plan, however she was not sure if anything would come of it. The Designee stated she was unsure if agency staff would know what to look for when they conducted the one (1) hour safety checks. Interview with the ADON, on 06/11/2021 at 5:20 PM, revealed she added to Resident #47's care plan that he/she exposed himself/herself the night of the incident with Resident #161. She stated Social Services Designee #2 did not update the care plan to include sexual contact with another resident as the facility unsubstantiated the incident. On 06/14/2021 at 10:30 AM, interview with MDS Coordinator #1 revealed Social Services was responsible for the care plans related to behaviors and cognition. She stated the entire Interdisciplinary Team (IDT) could update the care plan. She stated she was aware of the incident between Resident #47 and Resident #161. The MDS Coordinator revealed she did not update Resident #47's care plan, however she would expect to see care plans updated with what was going on for a resident. She stated Resident #47's care plan did not reflect sexual contact with another resident, only that he/she exposed himself/herself in a common area. She further stated when staff conducted Resident #47's one (1) hour safety checks, they checked if the resident was okay, if he/she was agitated, and if the resident needed anything. Interview, on 06/14/2021 at 1:14 PM, with the DON revealed the purpose of Resident #47's one (1) hour safety checks was to look for anything that may pose a safety threat to the resident or other residents, such as falling, wandering into other resident rooms, elopement, or go anywhere there was a potential for injury. She stated the facility used agency nurses and CNAs. The DON revealed the one (1) hour safety checks did not specifically have to be related to sexual behaviors, and staff did not look for any one (1) certain thing. She stated Social Services was responsible for the resident's care plan related to behaviors. She further stated the IDT reviewed care plans anytime there was a change in status. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Administrator, on 06/14/2021 at 1:53 PM, revealed the purpose of Resident #47's one (1) hour safety checks was to ensure he/she did not exhibit any behaviors that might have needed to be reported. On 06/15/2021 at 3:58 PM, interview with the ADON revealed the care plan for Resident #47 should have been updated to include sexual contact with another resident. She stated the purpose was so all staff would be aware to look for signs and symptoms and intervene as necessary. She further stated they were all responsible to update the care plan. The ADON revealed if the care plan was not updated to reflect Resident #47 had sexual contact with another resident, he/she could expose himself/herself to another resident, or touch another resident. 3. Review of the clinical record revealed the facility admitted Resident #32 on 02/22/2019. The resident's diagnoses included Dementia without Behavioral Disturbances, Anxiety Disorder, Hypertension, and Overactive Bladder. The facility assessed the resident, 02/18/2021, with a Brief Interview Mental Status (BIMS) of fifteen (15). Review of Resident #32's care plan for risk of falls, initiated on 03/07/2019, revealed interventions that included keep the call light in reach and encourage resident to use it for assistance, gripper tape next to the bed, gather information on past falls and attempt to determine the root cause of the fall, and intervene to prevent reoccurrence. The care plan for ADL self-care deficit, dated 03/07/2019, noted the resident ambulated independently and an intervention to provide assistance with mobility as needed. An additional intervention, dated 01/20/2020, included supervision - set-up for transfers, and the resident used bi-lateral 1/2 bed side rails for positioning related to muscle weakness and chronic pain. Review of a facility incident report, dated 02/25/2021, revealed Resident #32 fell when he/she reached for items on the nightstand and was on the floor next to his/her bed. The resident thought he/she lost his/her balance when he/she reached for the items, and the facility educated the resident on the importance and safety to utilize the call light for

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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** 34116 Based on interview, record review, and review of the facility's policy it was determined the facility failed to identify resident needs and provide related services for one (1) of 113 sampled residents (Resident #15). The facility failed to identify Resident #15's pacemaker and ensure it was monitored for function. The findings include: The facility did not provide a policy for Quality of Care. Review of the facility's policy, Quality Processes, undated, revealed quality of resident care was of the utmost importance. The policy stated providing quality resident care required systematic monitoring and evaluation of processes to ensure quality standards were being met. Review of the facility's policy, Assessments, dated August 2017, revealed it was the policy of the facility to ensure that assessments of the residents took place timely, at the appropriate time and were accurate. The policy stated assessment findings were used as a reference for care and treatment of the residents that included care planning and the Minimum Data Set (MDS). Review of the clinical record revealed the facility readmitted Resident #15 on 06/02/2020 with diagnoses that included Hypertensive Heart Disease with Heart Failure, Chronic Kidney Disease (CKD) Stage 3, and Type 2 Diabetes Mellitus. Continued review revealed the facility originally admitted Resident #15 on 12/17/2019. Review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed Resident #15 with a Brief Interview for Mental Status (BIMS) score of fourteen (14) and determined the resident was interviewable. Interview with Resident #15, on 05/11/2021 at 10:06 AM, revealed the facility was not checking his/her pacemaker. Further interview with the resident, on 05/20/2021 at 11:45 AM, revealed he/she had not had his/her pacemaker checked during the two (2) years he/she lived at the facility. Review of Resident #15's Admission Assessment, dated 06/02/2020, revealed the former Assistant Director of Nursing (ADON) assessed the resident and indicated the resident did not have a pacemaker. However, review of the Hospital Discharge Summary, dated 06/02/2020, revealed Resident #15 had a surgical history that included a Cardiac Pacemaker Placement (Medtronic dual chamber) on 03/14/2014. Interview with the former ADON was attempted, on 05/27/2021 at 9:26 AM; she did not return the call. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Registered Nurse (RN) #8, on 05/20/2021 at 9:35 AM, revealed she was not aware of Resident #15's pacemaker and stated there were no Physician's Orders to check for function. She stated the resident had restrictions to the left upper extremity; however, she did not know why. The RN stated the nurse admitting the resident was responsible to review the H and P (History and Physical) for the medical history. She stated the interdisciplinary team (IDT) reviewed new admissions during the daily clinical meeting to verify accuracy of the record. RN #8 stated it was important to monitor the pacemaker to ensure it functioned appropriately. Interview with Unit Manager (UM) #4, on 05/20/2021 at 11:15 AM, revealed the nurse was responsible for a head to toe assessment and review of the medical history when completing the Admission Assessment. According to the UM, the nurse could identify the presence of a pacemaker by resident interview and/or by assessment of skin integrity. She stated the nurse could also obtain a history from the responsible party if a resident was not interviewable. The UM revealed the IDT reviewed all new admission records to ensure all consents, physician's orders, and paperwork were completed and accurate. However, she was not aware of Resident #15's pacemaker until notified by the State Survey Agency. Further interview with the Unit Manager (UM), on 05/26/2021 at 3:40 PM, revealed the resident's last pacemaker check was November 2019. Interview with the MDS Director, on 05/27/2021 at 9:31 AM, revealed a pacemaker would be included as a diagnosis in the clinical record. However, the facility overlooked Resident #15's diagnosis of pacemaker. She stated the facility pulled diagnoses from the Discharge Summary, History and Physical and Physician's Orders for new/readmissions; and reviewed Physician's Orders for new diagnoses during the daily stand up meeting. She further stated the MDS staff reviewed a diagnoses report and Physician's Notes to ensure accuracy of the comprehensive assessment. According to the Director, they were not perfect and sometimes things were missed. Interview with the Director of Nursing (DON), on 05/28/2021 at 11:44 AM, revealed the IDT reviewed the discharge summary of new/readmissions to ensure Physician's Orders were accurate; medications included the proper diagnoses; and, appointments and transportation were scheduled as needed. However, the team did not review the medical history for diagnoses. She stated the primary nurse was responsible for the admission assessment and review of the discharge summary to ensure any implantable devices were identified. The DON stated it would be important to be aware of a pacemaker to determine the care needs of the resident that included monitoring for potential malfunction and contraindications for magnetic resonance imaging (MRI). She stated the facility was responsible for ensuring the pacemaker was monitored. The DON stated she was not aware of any issues with pacemaker checks. Interview with the Advanced Practice Registered Nurse (APRN), on 05/27/2021 at 1:53 PM, revealed she was not aware of Resident #15's pacemaker. She stated the frequency of monitoring was dependent upon the type of device and discretion of the physician. She stated the resident had not mentioned the pacemaker. Interview with the Administrator, on 05/28/2021 at 4:13 PM, revealed the nurse and the DON were responsible for ensuring accuracy of assessments and Physician's Orders. She stated the facility had not identified any issues with the accuracy of admission assessments. The Administrator stated staff were instructed to decrease potential exposures to 15 minutes or less when the facility was a red zone for COVID-19; so she was sure there were some things missed during the assessment process. 43694 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review it was determined the facility failed to ensure resident received treatment and care in accordance with professional standards of practice for one (1) of one-hundred and nineteen (119) residents, Resident #87. Resident #87 suffered laceration above the left eye, which resulted in a trip to the emergency room (ER) and seven (7) sutures. Upon return to the facility, the facility did not ensure recommendations from the hospital were followed. Additionally, Resident #87's sutures were not removed by 10/02/2021 as ordered. The finding include: The facility did not provide policy for resident's return from the hospital. Review of Resident #87's clinical record revealed the facility admitted the resident on 07/09/2019, with multiple diagnosis, which included Alzheimer's Disease, Dementia with Behavioral Disturbances, anxiety, major depressive disorder, and cognitive communication deficit. Staff report Resident historically wandered into other resident's rooms, took items and got in their beds. Review of Resident #87's Quarterly Minimum Data Set (MDS) dated [DATE], revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of three (3) out of fifteen (15), and determined the resident was not interviewable. Resident #87 was assessed for bed mobility, transfers, walk in room, walk in corridor, locomotion on unit and off unit and to eat as supervision-oversight, encouragement and cueing with the assistance of one (1) staff member. Resident was assessed as two (2) staff physical assist to get dressed and for personal hygiene. Review of Resident #87's discharge paperwork from emergency room (ER) visit on 09/25/2021 revealed wound care instructions were not followed or implemented by the facility. The resident was sent back to the facility with wound care instructions to wash the wound once daily with mild soap and water. To lightly pat dry with clean towel or paper towel. To place bacitracin, triple antibiotic ointment or Vaseline on the wound. To place new nonstick gauze and tape or Band-aid over it. Review of an order the facility Nurse Practitioner (NP) put in place on 10/01/2021 revealed staff were to monitor left orbital laceration every shift. Notify provider with any discharge, edema, signs and symptoms of infection or suture displacement. Review of Resident #87's Care Plan revealed last review was conducted on 09/01/2021. Observed Resident #87 on 10/04/2021 at 10:53 AM on the first floor of the building with two (2) Certified Nursing Assistance (CNA)'s as they waited for the elevator. Resident #87 was observed to still have the sutures in his/her wound. Two (2) CNA's confirmed resident's sutures were still there. Observation of Resident #87 on 10/04/2021 at 1:10 PM, resident was in bed on his/her right side. Nurse Consultant Investigator (NCI) confirmed resident still had seven sutures in their wound and they were not removed on 10/02/2021 as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Licensed Practical Nurse (LPN) #48 on 10/01/2021 at 9:28 AM, revealed she was unable to find any order to explain or direct care for Resident #87's wound. LPN #48 looked in the computer system and only found an order for suture removal on 10/02/2021. LPN #48, stated she was very embarrassed but there was no information in the Electronic Medical Record (EMR) about how to care for resident's wound. Interview with LPN #46 on 10/03/2021 at 2:30 PM, she revealed Resident #87 should have had a wound treatment in orders, she herself had not provided care for the wound but revealed the nurse who took care of that resident would provide care. Interview with Director of Nursing (DON) on 10/08/2021 at 1:40 PM, revealed when a resident returned from a hospital visit that was more than twenty-four (24) hours it is like a new admission. However, if under twenty-four (24) hours, or just an emergency room visit, that was not a new admission. The DON revealed the primary nurse on duty was responsible to process the paperwork that came back with the resident. Interview with the facility Medical Director (MD) on 10/09/2021 at 3:30 PM, revealed when there were recommendations sent back with the resident from the hospital they should be put in as orders. The facility also had a wound care nurse who could look at the resident. The MD further revealed something like this usually would be put in the care plan. He revealed the facility always had different nurses, lots of agency there. He said typically any recommendations would be carried over as an order. He stated, This is nursing 101. No interview with the administrator on this tag

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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** 44299 Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to ensure residents were free from accidents and hazards for five (5) of one hundred thirteen (113) sampled residents (Residents #130, #32,#109, #75 and #). Resident #130 sustained multiple falls including falls with fractures. Resident #32 related to multiple falls. Resident #109 related to smoking, and Resident #75 related to unsupervised wandering behaviors, and risk for falls. The findings include: Review of the facility's policy, Incidents/Accidents/Falls, not dated, revealed in section eleven (11) that all falls had a site investigation by appropriate staff in an effort to define the root cause of the fall. This provided information to enable staff to roll out interventions to prevent another similar occurrence. Each resident fall needed a new intervention rolled out with therapy involvement to some degree. Section twelve (12) of the policy revealed some occurrences required a more extensive investigation process. These included but were not limited to falls with significant injury and any fracture. Review of the facility's policy Baseline Care Plan Assessment/ Comprehensive Care Plans, revised 03/23/2021, revealed in section nine (9), the facility may need to review the care plans more often based on changes in the resident's condition and/or newly developed health/psycho-social issues. Review of the facility's policy titled, Resident Rights, undated, revealed residents had the right to receive services with reasonable accommodations to individual needs and interests. 1. Review of Resident #130's clinical record revealed the resident had four (4) unwitnessed fall incidents between March 2021 and May 2021. Two (2) of the four (4) falls resulted in major injury. Resident #130 received treatment for a fractured tibia during the hospitalization on [DATE]. Resident #130 received treatment for a fracture of the femur on the right leg during the hospitalization on [DATE]. Review of Resident #130's Care Plan identified the following interventions put in place after the initial fall with significant injury, which included staff to assist with toileting, dated 03/15/2021, and prompt response to calls/call light dated 04/12/2021. Review of Nursing Progress Notes revealed on 05/04/2021 at 2:00 AM, Resident #130 had an unwitnessed fall next to his/her bed. Resident was diagnosed with a Urinary Track Infection (UTI) and returned to the facility with antibiotics per progress note 05/08/2021. Review of IDT (Inter-Disciplinary Team) Meeting note revealed during 3rd shift hours Resident #130 tried to ambulate to the bathroom from the bed without assist, fell and hit his/her head. Further review of Progress Notes revealed on 05/16/2021 at 2:30 AM, Resident #130 had an unwitnessed fall with baseline confusion noted. Staff assisted the resident off the floor and to the bathroom. On 05/24/2021 at 2:30 AM, Resident #130 had an unwitnessed fall near his/her closet door. Observations noted the closet door was adjacent to the resident's bathroom. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of admission records dated 09/25/2020 revealed Resident #130 had a diagnosis of Irritable Bowel Syndrome with diarrhea and Insomnia. Clinical records revealed the resident was incontinent of bowel and bladder. Interview with Licensed Practical Nurse (LPN) #1, on 05/08/2021 at 6:49 AM, revealed she was present and sought medical attention for the resident following his/her fall on 05/04/2021. LPN #1 stated Resident #130 had a history of falls occurring maybe once every month and a half. Interventions in place included checking on the resident every hour, assist to bathroom, and use of wheelchair. Interview with Resident #130, on 05/08/2021 at 8:06 AM, revealed he/she fell while going towards his/her bathroom door on 05/04/2021. Resident #130 stated he/she fell more than anyone (he/she) knew. Resident #130 stated he/she hit his/her head and received treatment for a UTI at the hospital. The resident stated he/she knew he/she was supposed to call staff for help when he/she needed to get up or go to the bathroom. The resident stated he/she had a call button that he/she used to call for help. The resident stated he/she had to have someone with him/her when taking a shower and when going to the bathroom. The resident indicated falls generally happened when he/she was attempting to go to the bathroom on his/her own. Interview with Registered Nurse (RN) #1, on 05/10/2021 11:15 AM, revealed Resident #130 had no symptoms of UTI prior to hospitalization . RN #1 found the resident on the floor near the bathroom on 05/04/2021 and the resident's frequency of falls had increased. RN #1 stated she believed Resident #130 was sent to the 7th floor secured Memory Care unit from the 3rd floor, due to falls, wandering into other rooms, and trying to escape. The resident reportedly fell about three (3) months ago and broke his/her leg. Interview with Licensed Practical Nurse (LPN) #1, on 05/17/2021 at 1:05 PM, revealed Resident #130 had been falling more often. LPN #1 stated, every other week he/she has been falling in the past month. Resident #130 got out of bed in the middle of the night and he/she became disoriented. LPN #1 stated the facility may not have made changes to his/her plan for the recent fall because the Unit Manager was out. LPN #1 was not sure who was responsible for updating the plan in the manager's absence. Interview with Physical Therapist (PT) #6, on 05/18/2021 at 9:36 AM, revealed Resident #130 discharged from therapy services on 04/27/2021. PT staff educated Resident #130 on risks of self-ambulating, but PT #6 understood Resident #130 may not remember the education given. Interview with the Director of Nursing (DON), on 05/18/2021 at 1:22 PM, revealed she was aware of Resident #130 frequent falls and fall with significant injury. Interview with the MDS Director #12, on 05/20/2021 at 2:50 PM, revealed it was the resident's right to get up and go to the bathroom on his/her own, however, the facility was responsible for resident care and safety. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with Resident #130 on 05/28/2021 at 1:54 PM revealed the resident fell again around 2:30 AM on Monday 05/24/2021, at which time the resident sustained a broken hip. Resident #130 revealed he/she was trying to get to the bathroom when the fall occurred. Resident #130 revealed staff checked on him/her about three (3) to four (4) times a day, to see if he/she needed to go the bathroom. Resident #130 pushed the call button before getting up to go to the bathroom, but sometimes staff took forever to come. Prior to the fall this week, no one was coming in to check on Resident #130 every thirty (30) minutes or every hour, according to his/her account. MDS INFORMATION Interview with Certified Nurse Assistant (CNA), #1 on 05/28/2021 at 2:04 PM, revealed CNA #1, assigned to Resident #130's hall, was not sure if Resident #130 was supposed to be on frequent hourly checks as noted in the resident's medical chart and care plan. Interview with Licensed Practical Nurse (LPN) #40, on 05/28/2021 at 2:20 PM, revealed Resident #130 was a fall risk. Resident #130 cried out around 2:30 AM, when LPN #40 went in and discovered Resident #130 sitting on the floor by the closet, near his/her bathroom. Interview with the Administrator, on 05/28/2021 at 10:20 AM, revealed it was the facility's responsibility to ensure care plans and physician orders were followed. 30898 2. Review of the clinical record revealed the facility admitted Resident #32 on 02/22/2019. Diagnoses included Dementia without Behavioral Disturbances, Anxiety Disorder, Hypertension, and Overactive Bladder. The facility assessed the resident on 02/18/2021, with a Brief Interview Mental Status (BIMS) of fifteen (15) and determined the resident was interviewable. Review of the facility's care plan for risk of falls, initiated 03/07/2019, revealed the resident had a history of falls in the facility and included interventions for gripper tape to the right side of the bed, ensure call light was in reach and encourage to use it for assistance, anticipate and meet resident needs, and complete the Fall Risk, per the facility's protocol. Additionally, the care plan identified that Resident #32 had Activities of Daily Living (ADL) self care deficits and included interventions to supervise transfers and the resident ambulated independently. Review of the facility's incident report, dated 02/25/2021, revealed Resident #32 was discovered on the floor next to his/her bed. The resident thought he/she lost his/her balance when he/she reached for the items from the nightstand. The facility educated the resident on the importance and safety to utilize the call light for assistance. The report was incomplete, missing information related to the resident's mental status, any predisposing physiological factors. Predisposing Environmental Factors were marked as None. However the report did not reveal the distance from the bed to the nightstand, or the items the resident reached for. The facility's Root Cause Analysis (RCA) of the fall, dated 02/25/2021, revealed the Nursing Progress Note of the fall with the same information as the report. The RCA did not reveal what led to the resident's inability to reach the items on the nightstand, which led to the fall. The care plan for Resident #32 revealed no new interventions implemented for the resident's fall risk after the fall occurred on 02/25/2021. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's incident report for Resident #32, dated 04/20/2021, revealed the resident laid on the floor at the third floor smoking patio. The resident stated he/she fell when he/she turned to sit on the concrete bench in the smoking area. The report was incomplete, with Other (Describe) marked as Predisposing Situation Factors, however no other descriptive information was documented. The facility's RCA, dated 04/21/2021, revealed the Nursing Progress Note of the fall documented the fall was witnessed. The Note further revealed Resident #32 stumbled on the smoke patio ramp. The RCA did not document the type of footwear the resident wore, or what may have led the resident to stumble. Review of Resident #32's care plan revealed the facility revised the care plan, on 04/21/2021, with interventions to encourage proper positioning when attempting to sit down and ask for assistance when sitting down. Review of an incident report, dated 04/23/2021, revealed Resident #32 laid on the floor on his/her side at the foot of the bed and his/her pants around the ankles. The resident stated he/she stood up to put on his/her pants and fell . The report noted the resident was clean and dry, and continent of bladder and bowel. The report was incomplete, with information missing related to Predisposing Environmental Factors. There was no information about the resident's footwear or the immediate environment around the resident, such as clutter, wet floor, furniture, or uneven walking surface. The facility's RCA revealed the Nursing Progress Note, dated 04/23/2021, documented the nurse educated the resident. The care plan, revised 04/23/2021, revealed an added intervention included to encourage to use the call light for transfer/ambulation assist. Continued review of Resident #32's care plan revealed an intervention to encourage to use the call light for transfer/ambulation assistance was added, dated 04/23/2021. Review of the facility's incident report, dated 04/29/2021, revealed staff found Resident #32 on the bedroom floor entangled in bed sheets. The resident stated he/she tried to get up. The facility staff educated the resident about wearing nonskid footwear and gave the resident his/her call light. The report was incomplete, with no information marked for Predisposing Situation Factors. The facility's RCA revealed the Nursing Progress Note, dated 04/29/2021, documented the resident was entangled in his/her sheets when staff found the resident on the floor and the resident said he/she tried to get up. The RCA did not indicate if the resident had on any footwear or the type of footwear, or if the call light was in or out of reach at the time of the fall. The care plan, revised 04/30/2021, revealed an added intervention of safety awareness education as needed. On 04/30/2021, further review of the care plan revealed an intervention added for safety awareness education as needed for Resident #32. Observation of Resident #32, on 05/04/2021 at 3:42 PM, revealed the resident in bed, wore eyeglasses, a rollator near the bed, and non-skid strips on the floor on the side of the bed. Observation, on 05/17/2021 at 1:58 AM, revealed Resident #32 ambulated with his/her rollator to the nurse's station. The resident then left the rollator and drug a chair from the nurse's station over to another resident in the common area at the nurse's station, sat down, then moved his/her rollator in front of him/her. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with Resident #32, on 05/04/2021 at 3:42 PM, revealed he/she fell out of bed a few nights ago, and was dizzy for a few minutes. The resident revealed he/she got a new rollator, which replaced a wobbly walker from physical therapy. Interview with Certified Nurse Aide (CNA) #26, on 05/14/2021 at 10:00 AM, revealed when she came in to work a couple of weeks ago, Resident #32 fell and had already gotten up off the floor. She stated the resident does pretty good to walk. The aide stated the resident was sometimes mixed up. The CNA stated the resident told her he/she fell and the aide reported to the nurse. The aide further stated the resident did not use the call light a lot of times, as he/she liked to do for himself/herself. On 05/14/2021 at 10:14 AM, interview with Licensed Practical Nurse (LPN) #27 revealed Resident #32 was a little confused at times. She stated the resident was independent walking with episodes of falls. The nurse further stated the resident was noncompliant with using the rollator, and needed reminding to get his/her walker, or staff would bring the walker to the resident. The LPN revealed when a resident fell , the computer system had a risk management incident report that should be completed, and went to the Director of Nursing (DON), and was reviewed with the care plan in the morning meeting. Interview, on 05/14/2021 at 1:38 PM, with LPN #33, revealed she did not recall Resident #32's fall. However, she recalled the resident did not use any assistive devices. She stated the resident would ask for help and did not have any issues with noncompliance by the resident. Interview with LPN #23, on 05/14/2021 at 3:13 PM, revealed she was the nurse on duty when Resident #32 fell at the smoking patio. She stated the resident did not usually go to the smoking patio, but decided to go on that day for fresh air. The nurse revealed the staff at the smoke patio told the resident to sit on the bench and the resident tripped over his/her own feet and fell . LPN #23 stated the resident walked independently at the time and did not have a rolling walker. The nurse stated the fall documentation needed to be completed, as the purpose was to communicate from one (1) shift to the next. She stated leadership updated the care plans when they completed their risk management changes in the computer. On 05/14/2021 at 3:25 PM, interview with Unit Manager (UM) #6 revealed she was the nurse assigned to work with Resident #32 when the resident fell on [DATE]. She stated the fall occurred early in the morning with CNA #26. She stated they found the resident sitting on the floor in his/her room, with his/her feet intertwined in the sheets. The LPN revealed the resident said he/she tried to get up to go to the bathroom. The nurse stated Resident #32 was independent with walking and transfers, and did not use an assistive device at the time of the fall. Interview with the MDS Director, on 05/17/2021 at 3:05 PM, revealed she was familiar with Resident #32 but could not recall the resident's falls. She stated when a resident fell an incident report was completed. The Director revealed she was not aware of any issues with the incident reports not being completed. She stated the incident reports questions included what the resident was doing, if there was something medical going on such as a urinary tract infection (UTI), and if there were any medicine changes. She stated the facility should determine what the resident tried to do to ensure safety interventions were appropriate. The MDS Director stated they reviewed falls every day and conducted a root cause analysis (RCA) in the morning meeting and determined then what interventions were appropriate. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview, on 05/19/2021 at 2:56 PM, with the Director of Nursing (DON) revealed she had been with the facility about six (6) weeks. The DON revealed she reviewed the incident reports, risk management investigations, for any type of event that may have occurred. She further revealed the resident's nurse was responsible to complete the incident report. She stated the Interdisciplinary Team (IDT) discussed resident falls to determine the root cause of the event. The DON revealed the IDT decided what interventions were best for the resident to prevent the event from reoccurring. She stated she was unsure if the facility had a falls program. She further stated her expectation when a resident fell , the fall investigation would be thoroughly complete. The DON revealed the incident report did not carry over to the twenty-four (24) hour report. 43328 3. Review of facility policy titled, Smoking Policy, not dated, revealed the facility allowed smoking for residents, staff and visitors in designated areas. Smoking activity must be fifteen (15) feet from any doorway, window or vent system. The facility kept all residents' smoking materials. All staff members received education on the smoking policy and smoking assessments during general orientation. The policy further stated residents were to be assessed for smoking upon admission and educated on smoking practices, and in addition assessed quarterly, annually, or after an unsafe smoking episode, or a change of condition. The Social Service Designee (SSD) conducted the smoking assessment. The care plan and Certified Nursing Assistant (CNA) assignment sheet were reflective of the resident's needs as far as safe smoking. The admitting nurse may complete the smoking assessment if SSD was not available. Review of the facility's policy titled, Standard Supervision and Monitoring not dated revealed, the facility recognized supervision and guidance to the resident was an essential part of nursing care in which standard approaches were successful in meeting the resident's physical and psychological needs. Review of facility's document titled. 3rd floor smoking privileges and restrictions, dated 05/23/2017, revealed the designated smoking area as the third (3rd) floor patio. Residents were assessed to wear a smoking apron and must have it on prior to lighting a cigarette. Continued review of the document revealed no assigned seating in the smoking area, cigarettes and trash placed in appropriate containers, and residents may not wait in line for the smoking patio to open. The policy continued to state no verbal or physical altercations to occur among residents while on the patio. Review of the position description titled Smoking Monitor not dated, revealed the purpose of the smoking monitor was to provide each resident with a safe smoking environment, and monitor residents during smoking hours. In addition, the smoking monitor ensured supervision of residents at all times while on the smoking patio. Record review for Resident #109, revealed the facility admitted the resident on 04/19/2017 with diagnoses that included Hemiplegia and hemiparesis following Cerebral Infarction, Contractures, Chronic Obstructive Pulmonary Disease, Atherosclerotic heart disease, Falls, Peripheral Vascular Disease, Low vision Right Eye Category 1, Blindness Left Eye Category 3. Review of the Minimum Data Set (MDS) revealed the facility assessed the resident with a BIMs score of ten (10) and determined the resident with mild cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #109's Care Plan initiated 05/15/2018 and updated 04/12/2021, revealed Resident #109 was to wear a smoking apron, provided with a copy of the smoking policy, could smoke in a designated area, and undergo a smoking assessment quarterly and as needed. Review of the Smoking Policy and care/safety of smoking residents, revealed Resident #109's signature present. Interview on 05/06/2021 10:15 AM, with Resident #109, revealed the smoking times were 9:00 AM, 1:00 PM, 3:00 PM and 6:00 PM. Resident#109 continued to explain the staff covered him/her with a smoking apron and kept an eye on residents. Resident #109 reported he/she had to wear a smoking apron because of burning a hole in his/ her clothing a while ago. Interview on 05/15/2021 at 8:30 AM, with Resident #109, revealed staff assisted him/her to and from the smoking porch. However, when returning from the porch the smoking monitor positioned his/her wheel chair in front of the elevators and nurses' station. Resident #109 stated he/she must find his/her way back to the room by feeling along the hall way, sometimes staff took the resident back to his/her room. Observation, on 05/12/2021 at 9:30 AM, revealed Resident #109 on the smoking patio wearing a smoking apron, however, the apron was not fully covering the resident's legs. Further observation revealed the Smoking Monitor was seated at the card table inside the building. Observation revealed Resident#109 on the porch out of direct view of the monitor with his/her back facing the window. Observation, on 05/12/2021 at 9:37 AM, revealed a Restorative Assistant (RA) wheeled Resident #109 from the smoking porch to the third (3rd) floor elevators, leaving the smoking porch unattended for approximately thirty (30) seconds. Interview, on 05/14/2021 at 1:27 PM, with Smoking Assistant (SA), revealed groups come in and cigarettes were distributed. Residents can have three (3) cigarettes during the smoke break. Further interview revealed there were three (3) smoke breaks a day. The Scheduler informed the SA, which residents needed special precautions like a smoking apron. SA continued, Resident #109 was blind and she positioned Resident #109 to face toward her and placed a smoking apron on the resident. The SA continued to explain, Resident #109's aid or nurse returned him/her to their room. However, sometimes she had to leave the porch to take Resident#109 back to the nurse's station and it might take around thirty (30) seconds. The SA explained that the purpose of having a smoking aid was to make sure everybody was safe and six (6) feet apart. Observation on 05/14/2021 at 1:27 PM, revealed an SA seated at card table while residents were on the smoking patio out of direct view of the SA. Interview, on 05/14/2021 at 2:25 PM, with the Scheduler revealed nursing informed her if a resident had special needs related to smoking. The Scheduler continued stating the role of the SA was to pass out cigarettes, and in addition, the SA was trained on the smoking apron, fire blanket and observation. Furthermore, the SA needed to stand outside on the patio with the residents and not leave the area while residents were smoking. Observation, on 05/15/2021 at 9:00 AM, revealed the smoking patio was open, with four (4) residents waiting to enter the smoking patio and nine (9) residents on the deck with two (2) smoke attendants. Resident #109 was on the smoking patio with his/her back to window and wearing a smoking apron. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Observation, on 05/16/2021 at 10:00 AM, revealed one (1) resident on the smoking patio outside under the awning, lightly raining. Observation revaled a resident in the corner, wearing a smoking apron. The Ssmoking attendant was observed on the porch on the other side of the table texting on a phone. Continued observation revealed a resident was out of her line of vision. Interview, on 05/16/2021 at 10:00 AM, with CNA #33 revealed she usually stood at the door to observe residents but, she was texting a co-worker. Interview, on 05/18/2021 at 9:57 AM, with the Social Service Designee (SSD), revealed the role of the attendant was to ensure safety and assist the residents with smoking. Furthermore, the attendant should be observing all residents on the patio at all times for safety, social distancing, and smoking practices. SSD #2 stated a resident smoking should be positioned on the patio in a way that they that could be seen. The nurse obtained the resident contract and provided education for smoking during the admission process. SSD #2 stated she had not reviewed the smoking policy nor received any training related to residents that smoked in the facility. SSD #2 stated she was not aware of training for the smoking attendants. SSDv#2 stated if the smoking policy was not followed it could affect the resident's safety and if the attendant was distracted it could be a problem for resident safety. Interview on 05/19/2021 at 9:14 AM, with Registered Nurse (RN) #5, revealed she had not been oriented to the smoking apron or smoking safety for residents. However, if she identified burns on a resident she assessed the patient, interviewed them, and informed the nurse manager. RN #5 stated that smoking monitor was assigned to the smoking patio to make sure everyone was safe, socially distanted, and distributed cigarettes. Interview, on 05/18/2021 at 3:49 PM, with the Director of Nursing (DON) revealed she was not aware of the process around smoking and supervision on the smoking patio. Furthermore, the DON stated she had not received orientation to the facility's smoking procedure. The DON stated a smoking monitor attended to the residents on the smoking patio to ensure safety while residents smoking. She stated residents not monitored on the smoking patio were at risk for injury. Interview on 05/20/2021at 9:51 AM, Administrator (ADM) revealed all smokers were supervised in the designated smoking area on third floor patio. Further interview with ADM revealed a smoke attendant provided assistance, lit the residents' cigarettes, and ensured residents wore a smoking apron if indicated. The ADM stated the smoking attendant should not be on the phone while observing smoking residents and the smoking monitor needed to have the ability to lay eyes on the resident frequently. 43708 4. Review of the facility policy, Standard Supervision and Monitoring, undated, revealed the facility recognized supervision and guidance to the resident was an essential part of nursing care. At any time the resident was being supervised and required redirection, the direct care staff member may need to redirect the resident through verbal and/or physical guidance and/or care. Review of the facility policy, Incidents /Accidents/Falls, undated, revealed based on the results of the incident/accident/fall the resident's care plan was addressed to ensure appropriate interventions were in place. In addition, the CNA information sheet was updated as indicated to reflect the plan of care. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the clinical record revealed, the facility initially admitted Resident #75 on 02/08/2012 and readmitted the resident on 11/26/2020 with diagnoses including Alzheimer's disease, Down Syndrome, moderate intellectual disabilities, Bi-polar Disorder, and Obsessive Compulsive Disorder (OCD). Review of the Quarterly Minimum Data Set (MDS) dated [DATE], revealed the facility assessed Resident #75 with a BIMS score of four (4), indicating the resident was severely cognitively impaired. Review of Resident #75's behavior care plan revealed a focus care plan with a diagnosis of Bipolar disorder and Obsessive Compulsive Disorder (OCD) with episodes of hoarding, name calling, episodes of refusing required care such as by mouth meals, snacks, medications, showers, changing clothes, vaccinations, blood pressure checks. Resident exhibited episodes of wandering the halls and trying to get on the elevator. Resident exhibited episodes of clogging up sink and toilet in room causing water to flood the floor. Resident wandered in to other resident's rooms and took items, he/she refused care or refused to allow staff to take vital signs. Interventions included to approach resident warmly and positively, assist him/her in selection of appropriate coping mechanisms; if resident was unwilling to leave an area such as a closed room or come inside the building, offer orange soda or ice cream as an incentive; observe and document his/her behavior and report any changes to physician. Other interventions included observe resident frequently when in room and educate not to place items in the sink related to possible negative outcome; redirect as needed. Review of Resident #75 comprehensive care plan initiated 06/06/2018 revealed a focus, resident was at risk for falls related to cognitive disorder and impaired Activities of Daily Living (ADLs). Interventions, revised 05/07/2021, revealed staff were to ensure the residents pants were rolled up if too long. Review of the CNA information sheet, undated, revealed Resident #75's special instructions included half (1/2) side rails, living environment clutter free, non skid socks, Q1H (every one hour) safety checks, assist with toileting, encourage resident to lay down in bed when sleepy. Review of Resident #75's Physician's Orders revealed an active order effective 12/04/2020 at 3:00 PM to monitor resident for wandering every shift. Observation of Resident #75, on 05/06/2021 at 3:05 PM, revealed the resident wandered the halls and attempted to open the locked door at the end of the hall. Observation, on 05/12/2021 at 9:44 AM, revealed Resident #75 ambulating to the employee lounge. No staff was present on the hall, Resident #75 opened the lounge door approximately three (3) inches where staff was visible in the gap of the door. Observation of Resident #75, on 05/12/2021 at 9:45 AM, revealed the resident at end of the odd side of the hall. He/she opened the break room door and looked inside of break room beside chapel. Observation of Resident #75, on 05/12/2021 at 9:50 AM, revealed Resident #75 turning the doorknob of the chapel. Observation of Resident #75, on 05/13/2021 at 3:28 PM, revealed the resident in the employee breakroom standing behind the door by the trashcan. Interview with Housekeeper #3 at the time of observation revealed Resident #75 will get into the trash sometimes. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Observation of Resident #75, on 05/19/2021 at 10:34 AM, revealed Resident #75 entered room [ROOM NUMBER], opened the bathroom door, stood at the bathroom vanity, touched and picked up linen on the sink counter. On 05/19/2021 at 10:42 AM, Resident #75 exited room [ROOM NUMBER]. No staff present to redirect Resident #75 at the time of observation. Interview with CNA #13, on 05/14/2021 at 10:56 AM, revealed she tried to redirect Resident #75 when he/she entered resident's room. Interview with LPN #17, on 05/14/2021 at 3:03 PM, revealed in report, she was not told of any interventions for residents that wandered. Interview with LPN #12, on 05/19/2021 at 3:05 PM, revealed she monitored wandering residents closer. She stated occasionally she saw Resident #75 in the staff bathroom or staff break room. Interview with Unit Manager (UM) #3 on 05/19/2021 at 3:16 PM, revealed falls were monitored by adding a care plan intervention anytime someone had a fall. She added each fall was individual and each had a different intervention. UM #3 also addressed wandering behaviors and stated each resident has the right to wander. She further stated it was hard to ensure Resident #75 did not go into other resident rooms. Review of Resident #75's Progress Notes, dated 05/07/2021 at 1:54 PM, revealed the IDT (Interdisciplinary Team) met and discussed residents' previous falls event. On 05/06/2021, Resident #75 ambulated with a staff member behind him/her and witnessed the fall. Further review revealed the resident's pants were too long

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 30898 Based on observation, interview, record review, and review of the Kentucky Board of Nursing (KBN kbn.ky.gov) website it was determined the facility failed to ensure competent staff for one (1) of one (1) Registered Nurse Applicant (RNA). The facility assigned an RNA to train with a Licensed Practical Nurse (LPN). However, the KBN required an RNA be supervised by a Registered Nurse (RN) or Advanced Registered Nurse Practitioner (ARNP). The findings include: Review of the facility's policy Nursing Services and Sufficient Staff, created 11/2017, revealed the facility provided sufficient staff with appropriate competencies and skill sets to assure resident safety. The facility would supply services by sufficient numbers of licensed nurses. The facility must ensure licensed nurses had the specific competencies and skill sets necessary for resident needs identified through the resident assessment and plan of care. The facility did not provide a policy on use of Registered Nurse Applicants (RNAs). Review of the Registered Nurse (RN) Job Description, not dated, revealed the RN provided direct nursing care to residents and supervised the day-to-day nursing activities performed by nursing assistants. The RN would ensure assigned personnel followed established infection control procedures when isolation precautions were necessary, including the procedure for use of personal protective equipment (PPE). He/she would follow isolation, PPE, and infection control precautions and procedures. The RN recommended to the nurse supervisor equipment and supply needs of the unit/shift, and ensured an adequate stock level of medications, medical supplies, and equipment was maintained at all times to meet the needs of the residents. The RN would ensure the CNAs (Certified Nurse Aides) were aware of residents' care plans. He/she reported and investigated all allegations of resident abuse and/or misappropriation of resident property. The RN must possess a current, unencumbered, active license to practice as an RN in the state. The facility did not provide a job description for an RNA. Review of the Online Validation Results from the KBN website for the Registered Nurse Applicant (RNA) revealed KBN issued a Registered Nurse (RN) Provisional License (PL) to the RNA, on 05/17/2021. The validation revealed the RNA must practice under the direct supervision of an Advanced Registered Nurse Practitioner or RN. Review of the KBN website, kbn.ky.gov, revealed practice based on a provisional license required direct supervision. Direct supervision meant the nurse responsible for the applicant should at all times be physically present in the facility and immediately available to the applicant during working hours while the applicant held a provisional license. Further review revealed a RNA required direct supervision by a RN or APRN. Nursing practice was the performance of direct patient care, which utilized critical thinking, knowledge, and skill. Additionally, a PL required use of the title RNA. Additionally, the RNA must practice under direct supervision until full licensure was issued. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the New Hire Notification Form revealed the RNA's date of hire was 06/22/2021, with the position of RN (Provisional) documented. Review of the General Orientation Checklist for the RNA, dated 06/22/2021, revealed the RNA's job title was documented as RN. Review of a blank RN/LPN Check List revealed multiple columns and included Skill or Procedure, that included admission and transfer of a resident, performance of a physical assessment, chart in the nurses' notes, transcribing physician's orders, document in the Medication Administration Record (MAR), fingerstick blood sugar documentation, wound care, medications, and vital signs. Review of the staffing schedule, dated 06/26/2021, revealed the RNA was scheduled to orient on the second floor. The two (2) nurses scheduled on the second floor for the same shift as the RNA, were Licensed Practical Nurse (LPN) #37 and LPN #43. Review of the staffing schedule, dated 07/01/2021, revealed the RNA scheduled for a twelve (12) hour shift with LPN #27 on the third floor. The second nurse assigned to the third floor was also an LPN. Interview, on 07/01/2021 at 3:41 PM with the Scheduler revealed she spoke to Human Resources (HR) about new employee schedules. She stated HR gave her days and times, and she (the Scheduler) placed the new employee on the schedule. The Scheduler stated she and HR decided which floor to orient new employees. She further revealed when a new nurse was hired, she tried to orient the nurse with a nurse who had been with the facility the longest. She stated orientation occurred with nurses with seniority. Continued interview revealed new hire nurses were provided a check list in orientation, which was turned in to HR, after their orientation was completed. She stated the nurse the orientee was training with, was responsible to mark off on the check list the skills completed. She also stated when a nurse was hired for a specific floor, she tried to keep the new nurse on that floor to orient. The Scheduler stated she was not provided any other direction for scheduling for the RNA, and all she needed to know was if the new employee was full time or part time. She stated she thought all nurses could train with all nurses, LPNS to RNS, and RNS to LPNs. Continued interview revealed the facility had one (1) RNA who was learning how to chart and learn treatments. On, 07/01/2021 at 4:26 PM, interview with HR revealed she and the scheduler made the schedule for new employees, nurses and aides to orient on the floor. She stated the length of time a nurse oriented on the floor was dependent on the nurse, but usually the orientation was three (3) days on the floor. She further stated a brand new nurse was given longer time to orient. HR stated the facility did not have a preceptor program to train staff how to be a preceptor to new staff. She stated they tried to schedule new staff on their floor with someone who had tenure at the facility. Continued interview revealed staff was responsible to keep up with their check off sheet, and the preceptor was to sign for each item, indicating the new hire understood it. The HR stated the completed check off list would be submitted to the Staff Development Coordinator (SDC) once completed. She stated the facility had one (1) RNA, who started the week before. She further stated she was unsure who the RNA trained with, or if there was anything the RNA could or could not do compared to other nurses. The HR stated she was unaware if the facility had a policy for using RNAs. She stated she conducted the KBN licensure verification prior to hire. Further interview revealed she was not aware a RNA had to work with an RN or APRN. She stated that she knew there was a difference between RNs and LPNs; however, she did not know what one type of nurse could do that the other could not. She stated she was not provided any instructions for the RNA's training. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/01/2021 at 4:56 PM, interview with the Assistant Director of Nursing (ADON) revealed she conducted new employee training, after HR. The ADON stated the training was related to infection control, resident rights, use of the mechanical lifts, and abuse. She stated on the second day of training she provided a check off list and informed new staff to take the sheet with them every day to the floor. The ADON stated the preceptor was responsible to sign the sheet with the orientee. She stated once the check list was completed, the employee turned it in to HR. She revealed the facility had one (1) RNA at the time, and the average orientation time for an RNA was about two (2) weeks. The ADON stated she could not recall if RNs had to train with RNs, or LPNs trained with LPNs, however the Scheduler and HR determined new staff orientation trainers. The ADON further stated an RN should be training an RNA as an LPN could not delegate to an RN or RNA. She revealed if an LPN trained an RNA, the RNA might not get the best training. The ADON stated that direct supervision meant one (1) to one (1) with the RN. She further stated she and the DON were responsible to share with the Scheduler and HR the supervision requirement, however she was unaware if the information was shared. Interview with the Director of Nursing (DON), on 07/01/2021 at 5:25 PM, revealed the facility did not have designated mentors or trainers for new employee orientation. She stated the trainers received their training through their own orientation and their own daily activities. The DON revealed orienting a new employee included the entire day's process, such as medication pass, charting, and any responsibilities they had throughout the day. She stated orientees had a check off list they were responsible to carry to their work environment every day, and once completed turned in to HR. The DON stated the facility had one (1) RNA at this time. She stated she would need to review the RNA job responsibilities to determine if there was anything the RNA could or could not do. She stated LPNs and RNs could team up for training. She revealed an RN would need to be in the building for an RNA, however she would need to review the RNA policy to check. She stated there were RNs in the building, and direct supervision referred to the nurse responsible for the RNA. The DON stated the KBN website referred to the direct supervision of an applicant must be in the present in the facility and immediately available to the applicant. She further revealed LPN #27, who was scheduled to train the RNA, could orient and train an RNA. The DON stated an LPN could train an RNA. She further stated the facility followed KBN state requirements for licensed personnel. On 07/02/2021 at 9:49 AM, interview with the Administrator revealed RNAs oriented like any other nurse. She stated an RNA was a nurse graduate waiting to take the registered nurse test. She further stated she was unsure what the A in RNA stood for. The Administrator revealed her expectation was the RNA worked as a nurse. She stated the ADON and DON determined who was a good nurse for the RNA to train with. She stated the new nurse had a check off sheet to guide them in their orientation, and it should be returned to HR once completed. The Administrator stated there was nothing any different and an RNA could or could not do. She further stated the facility did not have a policy for use of RNAs or LPNAs and they followed the job descriptions, however the facility did not have job descriptions for RNAs or LPNAs. The Administrator stated KBN's requirement of direct supervision meant someone to ask questions to and to make sure the RNA was doing the right things. On 07/02/2021 at 10:10 AM, continued interview with the Administrator revealed all nurses were directly supervised under the DON, as she was their supervisor. She stated the facility's RNs were trained how to work with an RNA who may need assistance, as their education provided that training. The Administrator further stated she was unaware how the facility RNs were informed they may need to be available to an RNA. The Administrator revealed there was nothing to say that a RNA could not orient with an LPN.

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30898 Based on observation, interview, and record review it was determined the facility failed to ensure two (2) of one hundred thirteen (113) residents received medically related social services related to assessment for a resident's capacity to consent to sexual contact with others. On 03/19/2021, Resident #47 and Resident #161 engaged in sexual contact with each other. At the time of the incident, the facility did not have a full time Social Worker to ensure Resident #47 and Resident #161 were assessed to determine his/her capacity to consent. The facility utilized a contracted social worker approximately one (1) day per week. Additionally, the facility failed to inform the contracted social worker of the sexual contact that occurred between Resident #47 and Resident #161. Immediate Jeopardy was identified on 05/17/2021 and determined to exist on 03/19/2021 in the areas of 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation, F600 Free From Abuse and Neglect at S/S of J and F607 Develop/Implement Abuse/Neglect, etc. Policies at S/S of J, 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F657 Care Plan Timing and Revision at S/S of J, 42 CFR 483.40 Behavioral Health, F745 Provision of Medically Related Social Services at S/S of J, and 42 CFR 483.70, Administration, F835 Administration at S/S of J. Substandard Quality of Care (SQC) was identified at 42 CFR 483.12, F600 Free from Abuse and Neglect, F607 Develop/Implement Abuse/Neglect, etc. Policies, and 42 CFR 483.40, F745 Provision of Medically Related Social Services. The facility was notified of the Immediate Jeopardy on 05/17/2021. The facility failed to ensure residents were free from abuse. On 03/19/2021 Resident #47 and Resident #161 were in the dining room/dayroom common area without staff in the room and the lights off. Certified Nurse Aide (CNA) #36 entered the room and found Resident #16'w hand on Resident #47's exposed genitalia. The facility failed to assess the residents for capacity to consent to sexual contact. An Extended Survey and AoC validation Survey were conducted 06/30/2021 through 07/03/2021 and determined the facility implemented the AoC as alleged by 06/27/2021, prior to exit on 07/03/2021, with remaining non-compliance in the areas of 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation, F600 Free from Abuse and Neglect at S/S of D, F607 Develop/Implement Abuse/ neglect, etc. Policies at S/S of D, 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F657 Care Plan Timing and Revision at S/S of D, 42 CFR 483.40 Behavioral Health, F745 Provision of Medically Related Social Services, F745 at S/S of D, and 42 CFR 483.70 Administration, F835 Administration at S/S of D, while the facility developed and implemented a Plan of Correction and monitored the effectiveness of the systemic changes. The findings include: Review of Social Services Aide job description, not dated, revealed the Aide reported to the Director of Social Services and assisted in planning, developing, organizing, implementing, evaluating, and directing social service programs. The Aide must assure medically related emotional and social needs of the resident were met/maintained on an individual basis. Additionally, the Aide safeguarded the health, safety, and welfare of all residents of the facility. The Aide was delegated responsibility to carry out assigned duties and responsibilities in accordance with current existing federal and state regulations and established company policies and procedures. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Consulting Services Agreement, effective 01/01/2021, revealed the contracted group provided assistance, consultation, and training. Consultation services were provided onsite, remotely, via telephone, fax, and email to the facility. Consultants were qualified by education, experience, training, professional licensure and/or certification. Services included Social Service Consultation and Social Service Interim. Review of the Assessments policy, dated 08/2017, revealed assessments were completed when an event occurred that required an assessment by a qualified medical professional. An example of an assessment based on the event included Post Behavior. Nurses and other qualified health professionals would perform appropriate assessments of the resident. The facility did not provide a policy related to resident consent for sexual contact with others. 1. Review of the clinical record for Resident #161 revealed the facility readmitted the resident on 10/09/2017. The resident's diagnoses included Vascular Dementia with Behavioral Disturbance, Cognitive Communication Deficit, and Cerebral Infarction. Review of the Durable Power of Attorney (POA), dated 10/04/2021, for Resident #161 revealed the resident authorized his/her POA to take charge of the resident in case of sickness or disability. Review of a facility investigation revealed Resident #161 engaged in sexual contact with another resident, on 04/05/2019, in a common area. Resident #161's Brief Interview Mental Status (BIMS) of three (3), and the resident severely cognitively impaired. Review of Resident #161's care plan revealed the facility initiated a care plan for reaching out for others, on 04/06/2019, with an intervention to intervene as necessary to protect the rights and safety of others, and discuss the resident's behavior. Review of a Geriatric Visit note revealed the Nurse Practitioner saw Resident #161, on 01/20/2021. The NP note revealed the resident had memory loss and chronic confusion, oriented to person only, and had advanced dementia. Review of a Psychology Progress note for Resident #161, dated 01/26/2021, revealed the resident was moderately impaired for comprehension, executive function, insight, and judgement. The resident had impairment to memory, orientation, and rarely made decisions for him/herself. A Psychology Progress note, dated 03/09/2021, revealed Resident #161 had memory deficits immediate, recent, and remote. The resident was moderately impaired in comprehension, executive function, insight, and judgement. Review of a quarterly Minimum Data Set (MDS) for Resident #161, dated 03/16/2021, revealed the facility assessed the resident with a BIMS of eleven (11), and moderately impaired. Review of the facility incident report revealed Resident #47 stood by Resident #16, with his/her genitalia exposed. Resident #161 was unable to verbalize if anything occurred. Review of the care plan for Resident #161 revealed, on 03/19/2021, an intervention added not to leave the resident alone in the dayroom. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Psychology Progress note, dated 03/23/2021, revealed Resident #161 was moderately impaired for comprehension, executive function, insight, and judgement. The resident did not endorse memory of the recent behavior and, due to dementia, the resident did not have capacity to make major decisions, including consent for relationships with other residents. Observation, on 05/06/2021 at 2:23 PM, revealed Resident #161 in a geri-chair at the nurse's station on the fourth floor. Attempted interview, on 05/06/2021 at 2:23 PM, revealed Resident #161 did not respond to the State Survey Agency (SSA) surveyor. 2. Review of the clinical record for Resident #47 revealed the facility admitted the resident on 06/11/2020. The Resident diagnosed with Personal history of Transient Ischemic Attack (TIA), Cerebral Infarction without residual effects, and Dementia with Behavioral Disturbance. Review of the care plan, dated 08/03/2020, for Resident #47 revealed the resident had episodes of verbal aggression toward another resident. Interventions, dated 08/03/2020, included assess resident understanding of the situation, and psychiatric consult as indicted. Additional intervention added, on 02/10/2021, included redirect as needed. Review of the quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed Resident #47 with a Brief Interview Mental Status (BIMS) of seven (7), and severely cognitively impaired. The resident required supervision for transfers, and one (1) person assistance for locomotion on the unit. Review of a Psychiatry Progress note, dated 03/19/2021, revealed the resident had Dementia, was confused, and insight was impaired. The note documented the resident was oriented to person, place, and situation this day. The resident was severely impaired in executive function, insight, and judgement. Resident #47 had a memory deficit recent, and memory deficit remote. Review of a facility incident report, dated 03/19/2021 at 10:03 PM, revealed Resident #47 was seen with his/her exposed genitalia, standing in front of Resident #161. Resident #161 was unable to verbalize what occurred. Resident #47 stated he/she came from the bathroom and forgot to zip his/her pants. The facility immediately placed Resident #47 on one to one (1:1) supervision with staff. Review of the Psychology Report, dated 03/22/2021, revealed Resident #47 had a diagnosis of Vascular Dementia and recent cognitive impairment. Facility staff requested follow up, and reported the resident was recently discovered to have his/her private area out in front of another resident in the common room. The resident was moved to another floor. Resident #47 stated nothing occurred in the common room with the other resident. The note further revealed the resident's comprehension, executive function, insight, and judgement were noted Severe Impairment. The note documented the resident has memory deficit, both recent and remote. The resident did not endorse he/she made any advances toward the other resident. Further review of Resident #47's care plan revealed an intervention added, on 03/24/2021 and discontinued on 06/11/2021, for the resident to remain on one (1) hour safety checks. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation of Resident #47, on 04/28/2021 at 2:04 PM, revealed the resident sat in a chair with a cell phone in his/her doorway on the third floor. Interview with Resident #47, on 04/28/2021 at 2:04 PM, revealed no other residents had touched him/her inappropriately. Interview, on 04/30/2021 at 1:00 PM, with Social Service Designee #1 revealed she interviewed other residents as part of the facility investigation of the sexual contact between Resident #47 and Resident #161. She stated she asked residents if they felt safe, if anyone tried to hurt him/her or see anyone get hurt, and if the resident knew who to go to if he/she was hurt by someone. She stated the facility completed three (3) day follow up with residents involved in the reportable incident to see how the resident was doing. She revealed she completed the three (3) day follow up visits with Resident #47, who did not say much to her. Additionally, the Designee stated she completed the three (3) day follow up visits with Resident #161. Designee #1 revealed she was unaware of what happened between Resident #47 and Resident #161. She further revealed Resident #161 could do better on his/her BIMS score on one (1) day but not as well on another day. She stated Resident #161 had some impairment. On 04/30/2021 at 2:06 PM, interview with the Assistant Director of Nursing (ADON) revealed Resident #47 told her nothing happened, and Resident #161 said Resident #47 tied his/her show. The ADON stated both residents were cognitively impaired. She revealed social services department interviewed other residents, and followed up with Resident #47 and Resident #161 daily to determine if the resident had any emotional needs or psychological issues. Interview with the Physician, on 06/03/2021 at 9:17 AM, revealed Resident #47 and Resident #161 were both cognitively challenged. He stated Resident #47 had cognitive impairment, and Resident #161 had Dementia. He revealed neither resident was able to make decisions to engage on sexual behavior with another. Continued interview with the ADON, on 06/03/2021 at 9:44 AM, revealed if a resident's BIMS was high enough or the responsible party was okay with it, a resident could have sexual relations with another person. She stated Resident #47 and Resident #161 both had higher BIMS, and was high enough to consent to sexual contact. The ADON revealed she was unsure if Resident #161's POA gave permission for the resident to engage in a sexual relationship. She stated Resident #161 had fluctuated periods of confusion. Interview, on 06/03/2021 at 1:30 PM, with Resident #161's POA revealed functioned in the capacity of POA since 2011. She stated Resident #161 was not able to say he/she wanted to be in a relationship and was not able to make his/her own decisions. The POA further stated she did not think Resident #161 would remember what happened. On 06/04/2021 at 2:12 PM, interview with Social Service Designee #2 revealed the assessment used to determine if a resident was capable to give consent was the BIMS. She stated she completed the BIMS for Resident #47 and Resident #161 after the incident. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Administrator, on 06/04/2021 at 4:52 PM, revealed no one assessed if Resident #161 wanted to be in a sexual relationship or have sexual contact. She stated the facility did not ask residents if they had a need or urge for sex. The Administrator revealed A BIMS between eight (8) and twelve (12) was moderately impaired. She further revealed a resident with a BIMS between eight (8) and twelve (12) may not know the month, or year, however the resident was still capable to make decisions. She stated the facility did not have a resource of what moderately impaired meant. She also stated the residents were able to make decisions based off their BIMS scores. Continued interview with Social Service Designee #2, on 06/08/2021 at 9:16 AM, revealed she asked the psych provider to see Resident #47 and Resident #161 after the incident. She stated she could not recall his report to her about the residents. Designee #2 further stated psych emailed her their reports, she printed and read them, and gave them to the Unit Managers to read and file in the chart. She revealed she did not believe the psych report for Resident #161, dated 03/23/2021, that the resident did not have capacity to give consent. Designee #2 stated if Resident #161's BIMS was below eight (8) theny would know he/she was impaired. Interview with the Psychologist, on 06/08/2021 at 3:21 PM, revealed he saw Resident #47 and Resident #161 after the incident. He stated Resident #161 was moderately cognitively impaired and not able to make decisions. He revealed he believed he shared with the facility social services department that Resident #161 was not able to consent in a sexual relationship. Interview, on 06/11/2021 at 8:34 AM, with the Administrator revealed the facility used a consultant company at the time of the incident between Resident #47 and Resident #161 to fulfill the duties of the social services director. She stated the consulting company was unaware of the incident. On 06/11/2021 at 9:13 AM, interview with Social Services Consultant #1 revealed her organization provided consultant services to the facility for social services in the role of the interim Social Services Director. She stated the Social Services Designees with the facility we able to provide all social services duties and there was nothing Designee #2 could not do as long as her agency provided oversight. Consultant #1 revealed her agency assisted the facility when the facility was without a social services director. She further revealed her agency helped with care plan meetings, behavior management meetings, and BIMS assessments. Additional interview with Social Service Designee #2, on 06/11/2021 at 9:55 AM and 10:15 AM, revealed when there was not a social service director, she completed the duties of the office. She stated the social services consultant was in the building once a week and available by phone. Designee #2 revealed she informed the Social Services Consultant #2 about the incident between Resident #47 and Resident #161, however she could not recall when she informed the consultant. She stated the consultant did not provide any direction regarding the two (2) residents, and no one asked her to determine if either resident gave consent. She further stated she did not assess if Resident #161 was aware of or had knowledge of risks and benefits of sexual contact with others. Designee #2 stated she took direction from Consultant #2. Interview with the ADON, on 06/11/2021 at 10:21 AM, revealed she did not ask Resident #161 if he/she was aware of the risks and benefits of sexual contact with others and did not know who would be responsible. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/11/2021 at 11:31 AM, interview with the DON revealed she based on Resident #47 and Resident #161 cognitive levels they should know the risks and benefits of sexual contact, and their cognitive levels let them decide if they want to engage or not. She revealed each state may have differences how to assess if a resident was aware of the risks and benefits of sexual activity, and was unsure of Kentucky's requirement. She stated the facility used the CMS guidelines and the court was responsible to determine capacity to consent as his/her rights as a human being were still in full effect. Interview, on 06/11/2021 at 11:45 AM, with the Administrator revealed there was no risk or benefit to sexual touching as Resident #47 and Resident #161 were both able to make his/her own decisions based on their BIMS scores. Interview with Social Services Consultant #2, on 06/15/2021 at 8:48 AM, revealed she was a social service consultant to the facility and was the main contact when the facility needed help. She revealed she usually delegated to the facility designees anything they could do. Consultant #2 stated the facility did not inform her what happened between Resident #47 and Resident #161. She revealed the facility informed her it was investigated and there was nothing to share. Consultant #2 stated a resident was determined for capacity to consent through the BIMS score, then if unsure refer the resident to psych for a third party evaluation of how the resident thought things through, his/her mental status, and if there may have been any medical issues that could have affected the resident's cognition. The facility took the following actions: 1. A licensed social worker reviewed Resident #47 and Resident #161's medical records, on 06/17/2021, and on 06/23/2021 when the social worker also visited with the residents [NAME]-to-face. Review of medical records included assessments for capacity to consent to sexual contact with another consenting adult. 2. Social services reviewed all resident medical records, by 06/24/2021 for all social service related assessments were reviewed and new assessments completed if indicated. Resident care plans and CNA assignment sheets were revised and updated. 3. New admission and re-admissions would have social service related assessments completed within fourteen (14) days, with care plans completed based on results of assessments. CNA assignment sheets would be updated as indicated. If further assessments was needed by another outside provider, the need would be reflected on the care plan and the resident seen. 4. The DON/ADON/Designee monitored ten (10) resident medical records five (5) days a week for three (3) months, then weekly for six (6) months, on a rotating basis and included new admissions and re-admissions to ensure assessments and care plans were completed by social services. 5. At the CQI meeting progress notes reviewed that prompted a social services assessment would be listed. Social services would complete the assessment and care plan and report back to the IDT. 6. Beginning 06/21/2021, all staff were trained by the DON, ADON, or designee on the abuse policy, resident rights, the role of the social services designee, when to refer a resident/family member, or visitor to social services, and how staff could assist the designee to meet resident needs. A post-test required 100% for passing grade. The RDO trained the trainers, on 06/17/2021. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Per Resident #87's care plan, last reviewed on 09/01/2021, the interventions listed for the resident's wandering behavior included: allowing the resident to make choices about treatment; providing a sense of control (Initiated 07/10/2019, no revisions); and giving clear explanation of all care activities (Initiated 07/10/2019, no revisions). If Resident #87 refused Activities of Daily Living (ADLs) staff was to reassure the resident, leave and return in five (5) to ten (10) minutes, and try again (Initiated 07/10/2019, no revisions). Additionally, staff was to check on the resident frequently and meet needs in a timely manner, (with an initiation date 04/02/2021). Resident #87's care plan also revealed staff was to offer immediate education and redirection of possible outcomes for not complying with treatment or care as needed and staff were to the provide the resident with opportunities to make choices during care (Initiated 07/10/2019). On 12/27/2019, another intervention for wandering was added; redirect resident as needed. Interview with Certified Nursing Assistant (CNA) # 1 on 09/29/2021 at 4:00 PM, revealed Resident #87 wandered all of the time and got into bed with other resident's and if the other resident's did not know any better, they did not say anything and do not care. CNA #1 revealed she has told management on several occasions this facility may not be the best fit for this resident. Interview with CNA #58 on 10/03/2021 at 2:53 PM, revealed she had physically witnessed Resident #87 in bed with male and female residents all the time. She revealed she always reported this information to the nurse on duty, but everybody knows he/she gets in everybody's bed. Interview with Certified Medication Technician (CMT) #5 on 10/03/2021 at 9:26 AM, revealed she had physically found Resident #87 in bed with both male and female residents and resident would just be asleep. She also revealed she always let the floor supervisor know about these events. CMT #5 revealed she referred to Resident #87 as a team project. She revealed she told the staff who worked with her, Resident #87 had to be watched at all times, checked and changed frequently. Interview with Licensed Practical Nurse (LPN) #2 on 09/30/2021 at 2:05 PM, revealed she had worked at the facility for three (3) months. She revealed Resident #87 liked to wander and that he/she liked to cuddle with anybody in bed. LPN #2 revealed on this day she had taken Resident #87 to his/her bed and went back fifteen (15) minutes later to give resident medication and resident was not there. LPN #2 went to look for resident and found him/her in room [ROOM NUMBER], in an unoccupied bed with his/her eyes closed. The resident in room [ROOM NUMBER] was in his/her bed as[TRUNCATED]

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 28733 Based on observation, interviews, and facility policy review, it was determined the facility failed to ensure discontinued controlled substances were disposed of in a timely manner. Observation, on 05/14/2021 at 9:51 AM, revealed one thousand four hundred and forty-nine and one-half (1449.5) controlled medication pills stored in the Director of Nursing's office. In addition, there were controlled liquid medications stored in the same location. The findings include: The facility did not provide a policy regarding disposal of medications. Review of Drug Enforcement Administration (DEA) 21 CFR 1317.80, dated 09/09/14, revealed a long-term care facility may dispose of controlled substances in Schedules II, III, IV, and V on behalf of an ultimate user who resided, or had resided, at such long-term care facility by transferring those controlled substances into an authorized collection receptacle located at the long-term care facility. When disposing of such controlled substances by transferring those substances into a collection receptacle, such disposal shall occur immediately, but no longer than three (3) business days after the discontinuation of use by the ultimate user. Discontinuation of use included a permanent discontinuation as directed by the physician as the result of the resident's transfer from the long-term care facility, or in the result of death. Observation of the controlled medications, on 05/14/2021 at 9:51 AM, with the Director of Nursing (DON) revealed a five (5) drawer file cabinet, with one (1) drawer of narcotics. The oldest documented medication had a last dose date of 11/18/2020. Continued observation, on 05/14/2021 at 9:51 AM, revealed one thousand four hundred and forty-nine and one-half (1449.5) controlled medication pills stored in the Director of Nursing's office. In addition, there were controlled liquid medications, 2.0 milliliters (ml) of Hydrocodone; 52.5 ml of Morphine; 52.5 ml of Lorazepam, 295 ml of Oxycodone; and 117.25 ml of Morphine, stored in the same location On 05/14/2021 at 9:51 AM, interview with the DON during the observation of the controlled medications stored in the DON's office revealed she began employment at the facility on 04/09/2021. The DON stated the controlled substances/narcotics that were to be wasted were stored in her office. She stated the drawer of narcotics was there when she started as the DON, and she had added more controlled medications (meds) to the drawer. She revealed the Unit Manager (UM) brought the controlled meds to her office as needed and they verified that the count was correct. The DON stated there was not a log to document the when other controlled medications were added. She stated she had not yet used the solution to dissolve the meds as she did not know the process. She further stated she and the Assistant Director of Nursing (ADON) had to destroy the meds together. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation, on 05/14/2021 at 11:44 AM, of the controlled meds that needed to be waste revealed the DON locked the file cabinet lock and the padlock on the file cabinet. The file cabinet was affixed to the wall. Interview, on 05/14/2021 at 1:18 PM, with the DON revealed she was unaware of the process for destruction of the controlled meds. She stated she was unaware if there was a timeframe for the medications to be brought to the DON's office for destruction, as long as staff continued to count the medication. Additionally, the DON was unaware of a timeframe for the meds destruction once they were brought to her office. She stated she had not reviewed a policy regarding controlled med storage. The DON stated when a medication was brought to her office for destruction, she counted the medication to ensure accuracy compared to the physician's order. She revealed the purpose of sign out sheets for the meds was to ensure there was no diversion of the medications. She also stated she could not find the key to the file cabinet for a while when she started, however there was no appropriate number of meds to store in the cabinet. The DON stated she was first aware of the meds in the cabinet about a week after she started; however, she just didn't destroy the medications. The DON further revealed if the meds were left stored, someone could break into the office to take them. She stated she had not taken anything related to the storage and destruction of controlled medications to the Quality Assurance (QA) Committee. Interview with Administrator (Admin), on 05/27/2021 on 2:21 PM revealed the stored medication were not identified as a concern, or brought to her attention. She stated the Director of Nursing oversaw storage of the medications. Continued interview revealed the Unit Managers audited medication carts. In addition, the Administrator stated she was not a micro-manager; however, she addressed issues identified.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28733 Based on observation, interview, and facility policy review, it was determined the facility failed to ensure medications and biologicals were labeled and stored for four (4) of six (6) medication carts and three (3) of three (3) medication rooms. Observation revealed medication carts and treatment carts were unlocked, unattended and out of staff 's view. Observation revealed food items in the medication carts. Staff left medication unsecured at the fourth (4th) floor nurse's station. Additionally, three (3) of three (3) sampled emergency crash carts were not documented as checked for all needed supplies or had expired supplies. The medication refrigerator temperatures were not documented as checked, and glucometer controls were not documented as completed. The findings include: Review of the facility's policy, Medication Storage in the Facility, undated, revealed medications and biologicals were stored safely, securely, and properly following the manufacturer's or supplier's recommendations. The policy revealed the medication supply was accessible only to licensed nursing personnel, or staff members lawfully authorized to administer medications. The policy revealed medication rooms, carts, and medication supplies were locked or attended by a person with authorized access: Licensed Nurses, Consultant Pharmacist, Pharmacist Technician, individuals lawfully authorized to administer drugs, and Consultant Nurses. Further review revealed drugs for internal use were kept separate from externally used medications. External medications including ointments for skin irritations and medication for application to wounds should be kept in a treatment cart, or in a separate drawer in the medication cart, which was labeled as such. Outdated, contaminated, or deteriorated drugs and those in containers, which were cracked, soiled or without secure closures would be immediately withdrawn from stock. Review of the policy revealed medications requiring refrigeration or temperatures between 36 degrees Fahrenheit and 46 degrees Fahrenheit were kept in a refrigerator. Medications requiring storage 'in a cool place' were refrigerated unless otherwise directed on the label. The policy stated refrigerator medications to be used should be stored in a manner separating internal and external medications, and separate from fruit juices, applesauce, and other foods used in administering medications. Other foods (e.g. employee lunches, activity department refreshments) should not be stored in the refrigerator. The facility did not provide a policy for the Code Blue Supply Cart. Review of the facility's policy, Blood Glucose Quality Control, not dated, revealed the glucose control solutions contained an amount of glucose that reacted with test strips. Comparing the control solution test results to the expected range printed on the test strip vial label determined if the meter and the test strips worked together as a system, and the test was performed correctly. Routine checks of the meter and test strips should be conducted daily. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Evencare G2 Glucose Control Solutions manufacturer's insert revealed the purpose of the control solution test was to validate the performance of the Evencare G2 Blood Glucose Monitoring System using a testing solution with a known range of glucose. The insert revealed a control test that fell within the acceptable range indicated the user's technique was appropriate and the test strip and meter were functioning properly. Further review revealed control solutions should be used in the following instances: before testing with the Blood Glucose System for the first time; every time a new bottle of test strips was opened; whenever it was suspected that the meter or test strips were not working properly; when blood glucose results did not reflect how the resident felt; if the meter was dropped; and if the reading appeared to be abnormally high or low. In addition, review of the Storage and Handling policy revealed the control solution should not be used after the expiration date and any unused control solution should be discarded 90 days after first opening or after the expiration date. 1. Observation of the fifth (5th) floor, on 05/08/2021 at 6:21 AM, revealed the Odd Side-Medication Cart was unlocked without staff in attendance of the medication cart, or within direct visualization of the cart. Continued observation revealed the Treatment Cart was unlocked on the even side. Continued observation of the fifth (5th) floor Odd Side Medication Cart and the Even Side Treatment Cart, on 05/08/2021 at 6:31 AM revealed both carts remained unlocked without staff in attendance of the medication cart, or direct visual of the carts. Interview with Licensed Practical Nurse (LPN) #29 while approaching the Odd-Side Medication Cart, on 05/08/2021 at 6:31 AM revealed she was the only nurse on the unit. LPN #29 stated the medication carts should be kept locked for security of the medications. She stated locked medication carts prevented staff or residents from removing the medicines. LPN #29 stated it would be a problem for a resident to take a different person's medications, as the resident could possibly be allergic to the medication, or result in an overdose. Observation of the seventh (7th) floor medication room with Unit Manager #1, on 05/12/2021 at 9:12 AM, revealed an unsecured narcotic locked box located in the medication refrigerator. Continued observation of the medication refrigerator revealed one (1) of one (1) vial of Purified Protein Derivative (PPD) solution (skin test for Tuberculosis) opened and not dated with the opening date or initialed. Continued observation of the medication room revealed seven (7) intravenous (IV) start kits with Chloraprep, expiration date of 03/31/2021, and available for use. An opened box of Tempa Dots-B (single use disposable thermometers), was noted with an expiration date of October 2018. Interview with Unit Manager #1, on 05/12/2021 at 9:12 AM revealed the unsecured narcotic lock box should be secured in the refrigerator. She stated a secured narcotic box prevented staff with access from walking off with the box and any narcotics stored in the box. Continued interview revealed the box should be secured to the refrigerator with a chain and it was not secured. The Unit Manager stated the opened vial of Purified Protein Derivative (PPD) solution (skin test for Tuberculosis) lacked the date and initials. She stated the opened medications should be dated and initials written on the side of the vial. Unit Manager #1 stated an opened vial of medication lasted for thirty (30) days related to concerns of contamination and it should be trashed after the 30 days or if it had expired. She stated she was responsible for checking expiration dates in the medication room. 34116 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation, on 05/08/2021 at 6:20 AM, revealed an unlocked medication cart was unattended outside room [ROOM NUMBER]. Further observation, on 05/08/2021 at 6:24 AM, revealed Licensed Practical Nurse (LPN) #36 exited the room to the unlocked cart. Interview with the LPN at the time of the observation revealed the cart was supposed to be locked; however, he forgot to lock it when he went in the room. Observation, on 05/10/2021 at 10:57 AM, revealed an unlocked treatment cart in the hallway located across from room [ROOM NUMBER]. Continued observation revealed seven (7) staff walked past the unlocked cart. Interview with LPN #27, on 05/10/2021 at 11:11 AM, revealed topical medications were stored in the treatment cart. The LPN stated the cart should remain locked when unattended because a resident with dementia could get in the cart and eat the medication or get it in their eyes. Interview with Unit Manager (UM) #7, on 05/18/2021 at 10:39 AM, revealed he was not aware of any issues related to unsecured medication carts. He stated staff intermittently forgot to lock the cart, but it did not occur on a regular basis. Interview with the Director of Nursing (DON), on 05/14/2021 at 1:18 PM, revealed medication and treatment carts should be locked when unattended to ensure security of the medication and prevent resident access. 3. Observation of the 4th floor medication room, on 05/12/2021 at 8:37 AM, with the Unit Manager (UM) revealed the facility failed to monitor the temperature of the medication refrigerator for March, April, and May 2021. In addition, there were eight (8) missing entries for February 2021. Interview with the UM during the observation revealed she had to search for the logs. The facility did not provide temperature monitoring logs for the refrigerator for March, April, and May 2021. Observation of the 4th floor medication refrigerator, on 05/12/2021 at 3:30 PM, with Licensed Practical Nurse (LPN) #30 revealed two (2) 30 milliliter bottles of Ativan labeled Store at 36 - 46 degrees Fahrenheit; 2 vials of Humulin N insulin; two (2) vials of Humulin R insulin; eight (8) Levemir Flextouch insulin pens; and three (3) Lantus Solostar insulin pens. Interview with LPN #30 during observation revealed the emergency stock medications were stored in the refrigerator. LPN #30 stated the 3rd shift nurse was responsible for checking the temperatures. She stated it was important to monitor the temperature of the refrigerator to ensure it functioned correctly and to prevent medications from spoiling. Interview with LPN #34, on 05/20/2021 at 10:14 AM, revealed the temperature of the medication refrigerator should be checked daily on night shift to ensure the correct temperature and prevent medications from going bad. He stated sometimes he could not find the temperature log and replaced it with a new one. Interview with LPN #24, on 05/21/2021 at 9:37 AM, revealed the night shift nurse was responsible for checking refrigerator temperatures nightly to ensure medications were stored at the recommended temperature. She stated medications stored at the improper temperature could potentially affect the effectiveness of the medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the UM, on 05/12/2021 at 8:37 AM, revealed the temperature log should be kept on the refrigerator. The UM stated the night shift nurse was supposed to check the temperature daily. She stated she was responsible for ensuring the temperature was monitored; however, she forgot about it. She stated medications should be stored at proper temperatures to ensure they were effective. Interview with House Supervisor #1, on 05/20/2021 at 10:36 AM, revealed all nurses were responsible for monitoring refrigerator temperatures. She stated she rounded during the shift and checked to ensure refrigerator temperatures were done; however, sometimes she was assigned to a medication cart and could not check them. The LPN stated she had noticed issues with temperatures not being recorded. She stated she reminded the nurses whenever she noticed a missing entry and reported it to the oncoming House Supervisor as needed. She stated the previous Director of Nursing (DON) was aware of the issue with refrigerator temperatures; however, she had not reported the issue to the current DON. Interview was attempted with House Supervisor #2, on 05/21/2021 at 9:34 AM; however, she did not return the call. Interview with the Director of Nursing (DON), on 05/14/2021 at 1:18 PM, revealed the night shift nurse was responsible for checking refrigerator temperatures and the UM was responsible for monitoring to ensure it was done. She stated she was aware of issues with missing entries on refrigerator temperature logs. The DON stated the refrigerator temperature should be monitored daily to ensure the effectiveness of the medication was not altered. Interview with the Administrator, on 05/28/2021 at 4:13 PM, revealed she monitored the interdisciplinary team during walking rounds, daily stand-up/stand-down meetings, and through complaints. The Administrator revealed she was not aware of any issues related to medication refrigerator temperatures. 4. Review of the Code Blue Supply Cart Weekly Checklist for the 4th floor, dated 05/09/2021, revealed a nurse verified the cart was stocked with a full oxygen cylinder (set-up with a regulator attached) and intravenous (IV) fluids. According to the checklist, the cart should be checked monthly by the Charge Nurse/Assistant UM. Further review of the checklist revealed there was no check-off to verify function of the Automatic External Defibrillator. Observation of the Code Blue Supply Cart, on 05/12/2021 at 9:01 AM, with the UM revealed there was no regulator on the oxygen tank on the cart. In addition, there were no IV fluids or supplies. Interview with the UM during the observation revealed a regulator should be attached to the oxygen cylinder in the event of an emergency. She stated the missing regulator could result in a delay of supplemental oxygen for Cardiopulmonary Resuscitation (CPR). The UM stated there was supposed to be IV supplies and fluids stored on the cart; however, she could not find an IV kit and did not know what type of fluids should be on the cart. She stated extra IV fluids were locked up and required a code from pharmacy to access them. Interview with LPN #30, on 05/12/2021 at 3:30 PM, revealed she did not know who was responsible for checking the Code Blue Cart or how often it should be checked. She stated it was important to check the cart to ensure the oxygen tank was full and all supplies were readily available. According to LPN #30, a resident could potentially die if there was a delay in CPR. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with LPN #24, on 05/21/2021 at 9:37 AM, revealed she did not know who was responsible for checking supplies on the Code Blue Cart. Interview with House Supervisor #1, on 05/20/2021 at 10:36 AM, revealed the night shift supervisor was responsible for checking the Code Blue Cart to ensure all supplies were stocked and not expired. The Supervisor stated the former DON provided the supervisors with a checklist to ensure the cart checks were not missed; however, she had not seen one since the DON left. According to the Supervisor, staff sometimes removed supplies from the emergency cart instead of going to find them elsewhere. Interview with House Supervisor #2 was attempted on 05/21/2021 at 9:34 AM; however, she did not return the call. Interview with the Assistant Director of Nursing (ADON), on 05/27/2021 at 9:50 AM, revealed UM's were responsible for checking the Code Blue Cart weekly to ensure the cart was stocked with required supplies. She stated she was not aware of any issues with checks of the cart or availability of emergency supplies. Interview with the Director of Nursing (DON), on 05/14/2021 at 9:20 AM, revealed the night shift nurse and the UM were responsible for ensuring the Code Blue Cart was checked weekly to ensure supplies were available according to the checklist. She stated missing or expired supplies could alter the outcome of a CPR event. However, she did not monitor the carts. The DON stated she was not aware of any issues. Interview with the Administrator, on 05/27/2021 at 2:21 PM, revealed the DON was responsible for oversight of the Code Blue Cart, She stated she was not aware of any issues related to the carts or supplies. 5. Observation of the medication cart, on 05/09/2021 at 10:05 AM, for the 6th floor even rooms revealed a chocolate snack cake stored in the bottom drawer of the cart. Interview with Certified Medication Technician (CMT) #1, during the observation, revealed food should not be stored in the medication cart because of the potential for contamination and bugs. Observation of the medication cart, on 05/12/2021 at 10:10 AM, for the 4th floor even rooms revealed one (1) bottle of Betadine solution, one (1) 3 oz. tube of Bio-freeze gel, and one (1) 3 oz. bottle of Microguard anti-fungal powder were stored with oral medications. Further observation revealed an opened bottle of potassium chloride, one (1) bottle of milk of magnesia, one (1) bottle of Gavilax that were not labeled with an open date. In addition, one (1) bottle of Eucerin cream, one (1) bottle of Pure Gentle enema, two (2) bottles of Glucerna Carb Steady 1.0 with an expiration date of 05/02/2021, and one (1) 4 oz. tube of lubricating jelly with an expiration date of 08/2019 were stored in the cart. Interview with CMT #3, during the observation, revealed topical medications should not be stored in the medication cart to prevent a potential mix up with oral medications. She stated she was responsible for ensuring the topicals and orals were stored separately; however, she had not noticed the items in the cart. The CMT stated she was not sure of the policy for labeling opened medications. She stated she was not sure who was responsible for checking the cart to ensure expired medications were removed from the cart and not available for use. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the medication cart, on 05/12/2021 at 10:39 AM, for the 4th floor odd rooms revealed two (2) snack size packages of shortbread cookies and fig bars were stored in the bottom drawer. Further observation revealed one (1) bottle of Colace liquid and one (1) 8oz. bottle of multivitamins that were not labeled with an open date. Interview with Registered Nurse (RN) #5, during the observation, revealed food items should be stored in the kitchen to prevent potential contamination with germs. She further revealed open medications should be labeled with an opened date to ensure the medication was not administered past the recommended use by date. She stated staff were responsible for monitoring the cart daily to ensure medications were labeled/dated and expired medications were removed. According to RN #5, expired medications could potentially make the resident sick or not be as effective. She stated she was not aware of any facility audits of medication administration or the carts. Interview with Licensed Practical Nurse (LPN) #30, on 05/12/2021 at 3:30 PM, revealed food should not be stored on the medication cart because of the potential for cross contamination. She revealed nurses were responsible for labeling medication with the date and their initials when opening a new bottle to ensure it was used within the recommended timeframe and not expired. The LPN stated topical medication should be stored on the treatment cart. She stated she removed items when she noticed an issue; however, she was not sure who was responsible for monitoring to ensure medications were stored properly. Interview with UM #4, on 05/12/2021 at 11:07 AM, revealed all nurses were responsible for labeling open medication, removing expired medication, ensuring opened medications were labeled with a date, and ensuring the cart was clean. She stated she thought night shift nursing staff was responsible for auditing medication carts nightly. However, there was no documentation of the audits. The UM revealed she audited the medication carts; however, she had not audited them recently and she was not sure how often it was supposed to be done. She further revealed she did not document the findings of the audits. According to the UM, the pharmacy consultant audited the carts once or twice a month. Interview with the Director of Nursing (DON), on 05/14/2021 at 1:18 PM, revealed treatment supplies (i.e. Betadine, antifungal powder, lotions, and enemas) should be stored on the treatment cart. She stated it was not okay to store snack food on the medication cart due to infection control issues. She stated every nurse that assumed the medication cart was responsible for ensuring it was clean and in good order. The DON revealed there was no audit process in place to ensure the medication/treatment carts were maintained according to policy. She stated pharmacy audited the carts; however, they did not provide her with the findings of those audits. Interview with the Administrator, on 05/28/2021 at 4:13 PM, revealed the DON was responsible for oversight of the medication carts and storage. She stated the facility had not identified any concerns with storage of medications. 6. Review of the Blood Glucose Monitor Quality Control Records for the 4th floor with LPN #30 revealed the facility failed to perform quality controls checks of glucometers in March and April 2021. Further review revealed one (1) control check was performed on 05/05/2021. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Licensed Practical Nurse (LPN) #30, on 05/12/2021 at 3:30 PM, revealed each resident was assigned their own glucometer and the night shift nurse was responsible for checking controls nightly to ensure they were functioning correctly. The LPN stated a resident could receive the wrong dose of insulin as the result of an inaccurate glucometer reading. Observation of the Evencare G2 glucose control solution (for even hall glucometers), on 05/12/2021 at 3:35 PM, revealed the high and low control solutions were not labeled with an open date. Further observation of the control solution (for odd hall glucometers) revealed the box was labeled with an open date of 12/23/2020 (50 days past the discard date). In addition, there was no open date labeled on the bottles. Interview with the UM during the observation revealed the glucose control solution should be labeled with an open date and initialed to ensure expired solution was not used to test the glucometer. She stated it was important that controls were not expired to ensure glucometers functioned properly. Continued interview with the UM, on 05/12/2021 at 4:53 PM, revealed she did not monitor the Quality Control Records to ensure staff performed glucometer controls. However, she was learning she should do them now. Review of the Facility's Matrix, dated 05/03/2021, revealed there were seven (7) diabetic residents prescribed insulin residing on the 4th floor. Interview with LPN #24, on 05/21/2021 at 9:37 AM, revealed the night shift nurse was responsible for monitoring glucose controls daily for every residents' glucometer. However, she had not worked the 4th floor for a long time. She stated it was important to check quality controls daily to ensure the glucometer was working properly. Interview with LPN #34, on 05/20/2021 at 10:14 AM, revealed he was assigned to work different floors. He stated the night shift nurse was responsible for checking glucometer controls daily. However, he did not know where to find the supplies. He stated the purpose of the quality controls was to make sure the glucometer was accurate. According to LPN #34, he trained on day shift and most of what he knew he picked up while working. Interview with House Supervisor #1, on 05/20/2021 at 10:36 AM, revealed the night shift nurse was responsible for glucometer controls. She stated the UM was responsible for monitoring to ensure the controls were done. Interview with House Supervisor #2 was attempted, on 05/21/2021 at 9:34 AM; however, she did not return the call. Interview with the Director of Nursing (DON), on 05/14/2021 at 1:18 PM, revealed glucometer controls should be done by the Certified Medication Technician (CMT) or nurse on night shift. The DON revealed the UM was responsible for monitoring to ensure they were completed; however, the majority of the UM's were new to the position and not aware they were supposed to monitor. She further revealed there was no process in place to ensure agency staff were aware of the process for glucometer controls. The DON stated it was important to perform quality controls of the glucometers due to the potential for inaccurate readings. She revealed inaccurate readings could lead to a negative outcome for the resident, such as hypoglycemia or hyperglycemia. The DON revealed she was not aware of any issues with glucometer controls or records prior to the survey. (continued on next page)

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	185122	A. Building B. Wing	07/03/2021

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Administrator, on 05/28/2021 at 4:13 PM, revealed the facility had not identified any issues related to glucometers or quality controls.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 43328 Based on observation, interview, record review and review of the facility's policy it was determined the facility failed to ensure dietary staff were knowledgeable of procedures related to functions of the food nutrition service. Interviews revealed dietary staff were unaware of the procedures to clean carts; and how to clean and sanitize dishware and meal carts. The findings include: Review of the facility's policy, Cleaning and Sanitation dated 09/02/2020, revealed the Dietary Director (DD) developed, implemented, and monitored the completion of a cleaning schedule including all areas of the kitchen and equipment. Food service employees were trained on how to properly use, clean, and maintain all equipment. The DD posted cleaning schedules identifying tasks and responsibilities in an accessible area. Review of the facility's document, Cleaning Responsibilities: Daily, Weekly, Monthly, undated, revealed, dietary staff cleaned the grill area daily, disinfected preparation surfaces and wiped down the fryer, oven and steamer daily. Additional daily tasks included washing the can opener, meat slicer and beverage station. Furthermore, plate warmers and delivery carts were wiped down every day. Staff were responsible for mopping the kitchen floor daily. Continued review revealed the walk-in freezer and refrigerator were washed and sanitized weekly. Weekly tasks included de-liming the dish machine, cleaning the ovens and polishing the plate warmers. Staff cleaned the coffee machine, washed vent hoods, and the dry storage room monthly. Review of the facility's document, Dietary Aide Job Skills Training and Proficiency Checklist, undated, revealed staff were educated on the proper use and maintenance of all kitchen equipment assigned for use appropriate to the position. Observation at 3:00 PM on 05/11/2021, revealed dried spatters and crumbs on the prep table edge and back splash while staff prepared salads. Further observation revealed a salad bowl that touched the dirty back splash. Interview with Dietary Aide (DA) #3, on 05/11/2021 at 3:00 PM, revealed staff were responsible for cleaning their assigned area daily. DA #3 reported she wiped the surface of the preparatory (prep) table prior to preparing the salads. However, she did not wipe down and sanitize the back of the prep table or the edge of the table. DA #3 stated she was not aware of a cleaning schedule for the kitchen, or procedures for operating the dishwasher. Observation, on 05/11/2021 at 3:30 PM, revealed visible spatters and dried food on the inside and outside surfaces of the meal delivery carts. In addition, dried food spatters and a sticky substance were observed in the cart door crevices and around the door hinges. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with Dietary Aide (DA) #1, on 05/11/2021 at 3:15 PM, revealed she was not sure how much bleach to mix with the soap for cleaning the delivery carts. She just mixed the two together. In addition, she reported staff cleaned the tray delivery carts after every meal. DA #1 stated she was not aware of a cleaning schedule for the kitchen. Observation, on 05/11/2021 at 3:45 PM, revealed DA #2 placed clean dishes into a plate warmer. Further observation of the plate warmer revealed spatters, dried food and crumbs inside. Interview with DA #2, on 05/11/2021 at 3:35 PM, revealed she did not know how often the plate warmer was cleaned. DA #2 stated she was not aware of a cleaning schedule for the kitchen or the procedure to record dishwasher temperatures. Interview with the DD on 05/14/2021 at 9:15 AM revealed he could not educate staff quickly enough before they were gone. Further interview with the DD revealed he was having an issue with staff cleaning the plate warmer, and was planning an in-service on the matter. Continued interview revealed the current staffing was a problem and training new staff was difficult due to his responsibilities. The DD continued to explain that staff not practicing cleaning procedures could cause food borne illness. Interview with the Administrator, on 05/28/2021 at 11:14 AM, revealed she was not aware of performance or training issues related to the dietary staff.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43328 Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to ensure food was stored and prepared in a sanitary manner. Observations during the survey revealed meat thawing over eggs, soiled preparation surfaces and walls and food items in the refrigerator not labeled or dated. Additionally, canned goods were stored directly on the floor, expired food items were present, and improper dishwasher temperatures. Further observations revealed the facility failed to ensure kitchen equipment was clean; staff transported drinks not covered; food carts remained open during tray delivery; and, improper or no hand hygiene during tray delivery. Additionally, the facility failed to ensure the nourishment refrigerator temperatures were monitored and clean for two (2) nourishment refrigerators. The findings include: Review of the facility's policy, Nutritional Services Cleaning and Sanitation, dated [DATE], revealed the Director of Food and Nutrition Services developed, implemented, and monitored schedules for cleaning, sanitizing, and maintenance. Documentation was kept on record for one year. In addition, the policy stated to ensure the Food Service Department was maintained according to State and federal regulations as well as a clean, sanitary, and safe environment. Review of the facility's, document titled,Cleaning Responsibilities, Daily, Weekly, Monthly undated, revealed daily, weekly, and monthly tasks for work areas, equipment and cleanliness of the kitchen. Review of the facility's document titled, Daily Cleaning Log, AM, dated January through [DATE] revealed the daily cleaning schedule with staff's initials for sanitation, equipment, and kitchen environment. The facility did not provide documentation of weekly and monthly cleaning responsibilities. Review of a document titled,Recording Temperatures (Wash- Rinse) for [NAME] CL44en Dish Machine revealed the machine read temperatures of ,d+[DATE] degrees Fahrenheit (F) for the wash and ,d+[DATE] degrees F for the rinse once you initiated the wash cycle. In addition, the document stated after the first three (3) racks were sent through, then send the fourth (4th); record the wash and rinse temperatures at this time. This was the operation wash and rinse temperatures to record. Wash should range from ,d+[DATE] degrees F and the rinse between ,d+[DATE] degrees F. Review of the document titled, High Temperature Dish Machine Sanitation Log, dated April and [DATE], revealed wash temperatures were logged at 158 to 161 degrees F. Further review revealed the rinse temperatures were logged at 168 to 174 degrees F. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's policy titled, Food Brought into the Facility by Friends/Family/Other (Outside Sources) for Residents, dated [DATE], revealed cooked or prepared foods brought in for residents was stored in the resident's personal refrigerator or in the facility's appropriate pantry or refrigerator. The food items were appropriately labeled and dated when accepted for storage and discarded after forty-eight (48) hours. In addition, Nursing Staff monitored residents' rooms, resident personal refrigerators, unit pantries, as well as facility refrigerators and freezers for food and beverage disposal needed for safety. All refrigerators in use in the facility had an internal thermometer to monitor temperatures and had their internal temperatures recorded daily. The facility did not provide policies requested for labeling and dating food and food storage. The Facility did not provide policies on cleaning and sanitation of food prep surfaces. Interview with Certified Nursing Assistant (CNA) #26, on [DATE] at 2:30 PM, revealed the food was terrible and the residents complained constantly. In addition, the CNA stated the food appeared unpresentable and the portions were small. CNA #26 stated that last week she called dietary because the bacon was raw and the juice pitcher had little black bugs in it. She further stated the dietary department replaced the juice and bacon. CNA #26 continued and explained the CNAs were responsible for assisting residents with setting up their food trays. Dining observation, on [DATE] at 5:00 PM, revealed CNA #58 failed to wash her hands between delivering trays to three (3) residents. The CNA was observed touching food with her bare hands, while assisting three (3) residents with tray set up. Observation at 3:00 PM on [DATE], revealed dried spatters and crumbs on the preparation (prep) table edge and back splash, while staff prepared the salads. Further observation revealed the salad bowl touched the dirty back splash. Interview with Dietary Aid (DA) #3, on [DATE] at 3:00 PM, revealed staff were responsible for cleaning the area assigned for the day. DA #3 stated she wiped the surface of the preparatory (prep) table prior to preparing salads; however, she did not wipe down and sanitize the back of the prep table or the edge of the table. DA #3 stated she was not aware of a cleaning schedule for the kitchen. Observation, on [DATE] at 3:15 PM, revealed the delivery carts had visible spatters and dried food on the inside and outside surface. Continued observation revealed the dried food spatters and sticky substance in the cart door crevices and around the door hinges. Observation of the second floor dining, on [DATE] at 5:15 PM, revealed the door to the dining cart was left open while staff delivered dinner trays. Interview with Dietary Aid, (DA) #1, on [DATE] at 3:15 PM, revealed the DA was unaware how much bleach to mix with the soap for cleaning the delivery cart. She stated she just mixed bleach and dish soap together in water. In addition, DA #1 stated staff cleaned the carts after every meal. DA #1 stated she was not aware of a cleaning schedule for the kitchen. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on [DATE] at 3:20 PM, revealed two (2) staff members operating/loading a dishwashing machine. One (1) staff member placed clean dishes into a plate warmer. Continued observation revealed the plate warmer had spatters, dried food and crumbs inside. Multiple finger prints and smudges were noted on the outside of the plate warmer. Interview with DA #2, on [DATE] at 3:20 PM, revealed she did not know how often staff cleaned the plate warmer. She stated she was not aware of a cleaning schedule for the kitchen or procedure to record dishwasher temperatures. Interview with Unit Manager, (UM) #4, on [DATE] at 8:30 AM, revealed staff last checked the temperatures on the nourishment refrigerator over the weekend, but she did not notice there was not a temperature log. UM #4 stated the night shift nurse recorded the nourishment refrigerator temperatures on the log. During continued interview, UM #4 explained that staff monitored the refrigerator temperatures to make sure medications were good and that food did not spoil, but she was not sure about a cleaning schedule for refrigerators. UM #4 stated the Unit Manager was responsible for making sure the temperature logs were completed and she had forgotten about them. Observation of the fourth (4th) floor nourishment refrigerator, on [DATE] at 830 AM, revealed two (2) ice cream cartons that were opened but, not dated. Continued observation revealed: coffee creamer, one (1) open, not dated; and, there was no temperature log for the nourishment refrigerator present. A small black refrigerator in the medication storage room was present with no temperature log present. Interview with UM #1, on [DATE] at 9:15 AM, revealed a nurse checked the refrigerator temperatures and cleaned the snack refrigerator weekly. UM #1 could not locate a temperature log for the snack refrigerator. Observation on [DATE] at 9:05 AM, of the seventh (7th) floor snack refrigerator revealed a dried red substance spillage on the bottom shelf tray was noted where the liquid supplements were stored for residents. Continued observation revealed a dried brown and red substance on each shelf insert and no temperature log was noted. Observation of the kitchen, on [DATE] at 3:00 PM, revealed crumbs, debris and splatters on the rolling carts used for holding baking trays. Additionally, the walls were soiled with splatters; and, dried food was observed throughout the food prep area. Observation of the walk-in cooler, on [DATE] at 9:45 AM revealed three (3) open jars of jelly not dated. One (1) jar of pickles was opened and not dated. One (1) package of meat was thawing over liquid eggs. One (1) bottle of liquid smoke was opened, not dated It had an expiration date of 2019. Continued observation of the dry goods storage area revealed boxes of cans stored directly on the floor in the middle of the room. Juice machine boxes were stored on the floor outside of the dish area. Dining observation on [DATE] at 5:15 PM, revealed the second (2nd) floor meal cart door was opened during tray delivery for the evening meal. Additional observation revealed twenty- two (22) plastic cups filled with orange liquid/ice on top of the cart, uncovered. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dining observation on [DATE] at 11:50 AM, revealed the second (2nd) floor meal cart was moved to room [ROOM NUMBER] with uncovered drinks on top, and the cart door was left open during the tray delivery. Continued observation revealed the cart door remained open while the trays were delivered to rooms #216, #218, #220, and # 224. Interview with the Dietary Director (DD), on [DATE] at 9:15 AM, revealed the kitchen used a dual temperature dishwasher and he used a form he found online to record the dishwasher temperatures. The DD stated staff notified him directly if there were issues with the dishwasher. In addition, he stated there was an alarm if it did not get to the proper temperature. Interview, on [DATE] at 11:00 AM, with the DD revealed he was recording the wrong temperatures on the dishwasher temperature log. He explained that the procedure called for reading temperatures after putting four (4) racks through the machine, and then record the temperature. He stated that he had been recording the temperature as soon as the dishwasher started. Further interview with the DD, on [DATE] at 9:15 AM, revealed the plate warmer needed cleaning, and it was an issue. The DD stated there were ongoing issues with training and staff performance and if a kitchen was not clean, it could cause food borne illness. Continued interview revealed he did not assign specific cleaning projects to staff. The DD stated that food not labeled could have bacterial growth. He stated cups and beverages should be delivered to the floor covered to prevent debris from getting into the cups. He explained during tray delivery the cart doors should remain closed at all times to maintain food temperature. Interview with the Administrator, on [DATE] at 11:14 AM, revealed residents did not like the food so an All Day Menu with additional items was added to honor resident food preferences. Continued interview revealed a concern about portion sizes was brought to her attention by the residents and she discovered dietary was using the wrong scoop size. The Administrator stated she was not aware of issues with food storage and preparation.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 28733 30898 Based on interview, record review, review of the facility's policy, and review of repeated deficient practice citations, it was determined the facility failed to have effective administration responsible for establishing and implementing policies regarding the management and operation of the facility. This was evidenced by the facility being cited on 12/06/2019 for F584, F600, F656, F657, F689, F761, and F880; on 11/08/2020 for F656, and F689; and current citations including F584, F600, F656, F657, F689, F761, and F880. Record review and interview revealed the facility failed to ensure residents were free from abuse and ensure resident behaviors were addressed; failed to ensure residents' care plans were developed, revised and implemented; failed to ensure the facility was safe, comfortable, and supervised for residents, and medications were labeled and stored accordingly. The facility's failure to provide an effective administration responsible for establishing and implementing policies regarding the management and operation of the facility has caused or is likely to cause serious injury, harm, impairment, or death to residents. Immediate Jeopardy (IJ) was identified at 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation, F600 and F607, at a scope and severity of a J; 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F657, at a scope and severity of a J; 42 CFR 483.40 Behavioral health Services, F745, at a scope and severity of J; 42 CFR 483.70 Administration, F835, at a scope and severity of a J; and, 42 CFR 483.75 Quality Assurance and Performance Improvement, F867, at a scope and severity of a J. The Immediate Jeopardy was determined to exist on 03/17/2021 and the facility was notified of the Immediate Jeopardy on 06/17/2021. Substandard Quality of Care (SQC) was identified in the area of 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation (F600 and F607) and 42 CFR 483.40 Behavioral Health Services, (F745). The facility provided an IJ Removal Plan on 06/27/2021, alleging removal of the Immediate Jeopardy on 06/27/2021. The State Survey Agency determined the Immediate Jeopardy was removed on 06/27/2021, as alleged, prior to exit on 07/03/2021, with remaining non-compliance at a Scope and Severity of a G while the facility developed and implemented a Plan of Correction and the facility's Quality Assurance (QA) monitored to ensure compliance with systemic changes. Additional repeat deficiencies, from the 12/06/2019 recertification survey, were identified in the areas of 42 CFR 483.10 Resident Rights, (F584); 42 CFR 483.45 Pharmacy Services (F761); and 42 CFR 483.80 Infection Control (F880). The findings include: (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Administrator Job Description, not dated, revealed the Administrator led and directed the overall operation of the facility in accordance with resident needs, federal and state government regulations and company policies/procedures to maintain quality care for residents. The Administrator worked with facility management staff and consultants in planning all aspects of facility operations. The Administrator monitored each department's activities, evaluated performance, and monitored operations of all departments, cleanliness and appearance of the facility. He/she ensured the facility appropriately utilized consultants and other support resources, and maintained a working knowledge and ensured compliance with all governmental regulations. The Administrator ensured adequate staffing through appropriate orientation, training, and staff education. Furthermore, the Administrator ensured maintenance of the building and grounds and equipment, and that work areas were clean, safe, and orderly. The Administrator ensured infection control, isolation, and sanitation practices and procedures were followed. Review of the Director of Nursing (DON) Job Description, not dated, revealed under the direction of the Administrator the DON had authority, responsibility, and accountability for the functions, activities, and training of nursing services staff. The DON demonstrated knowledge and skills necessary to care for residents with needs for dementia, infectious disease, and therapeutic needs. The DON conducted periodic review to ensure the environment was clean. He/she conducted periodic reviews of care plans to ensure they were interdisciplinary and updated by the charge nurse daily as changes occurred. He/she ensured all nursing personnel followed established hand-washing procedures and possessed strong knowledge of state, federal, and local regulations as they pertain to long-term care. Interview with Administrator, on 06/17/2021 at 3:32 PM, revealed she reported to the Regional Director of Operations (RDO). She further revealed the RDO interviewed and hired her into the role as the administrator. The RDO was whom she reported to and who provided the Administrator the onboarding process for the facility. She further stated she has been in long-term care; she was responsible for the functioning of the facility. Continued interview with the Administrator, revealed the purpose for the plan of correction (POC) was to correct deficient practice and not continue with repeat allegations of the same deficient practices. She revealed if an identified area of concern occurred, then the facility developed a new plan, or perhaps put an old plan back in place. She further revealed difficulty with staffing to meet the needs of the residents and sure, things have fell through the cracks. She revealed the prior sitting administrator identified all of the deficiencies as cleared; therefore, she stated she did not review the prior plan of correction. Telephonic interview with the Regional Director of Operation, on 07/01/2021 at 3:28 PM, revealed the facility was a Limited Liability Company (LLC) with the administrator responsible for the facility. Interview with the Center Nurse Executive (CNE), on 05/11/2021 at 11:25 PM, revealed she worked at the facility since 10/13/2020. Per interview, she stated she was aware of the repeated deficiencies of F600, F656, F657, and F740. The CNE further stated she did not discuss the outcomes of the audits as per the POC; she was aware staff did not complete the rounds frequently on the Memory care unit and facility staffing was discussed; however, there were no concerns identified. The facility took the following actions: (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. The administrator and Interdisciplinary Team (IDT) would ensure its resources were used, including operating budget, staff, supplies, or other services necessary to provide care to residents. 2. A regional team member would review the available resources with the Administrator, and included outside providers such as the Regional Director of Operations (RDO), Regional Nurse Consultant, and Social Services Consultant. MDS Consultant, and any other ancillary staff who could assist in maintaining services and/or assist that required assessments were completed, care plans completed. 3. The RDO monitored weekly for three (3) months, then at least bi-weekly, to ensure the Administrator had all needed ancillary or support staff available to ensure residents were successfully cared for and needs met. 4. The RDO in-serviced the Administrator and IDT, on 06/17/2021, to the facility's resources, including CMS guidelines, policies and procedures, administrator reference manual, various consultants, and risk management. Also included resident capacity to consent and care plan updates. 5. The RDO's monitoring that the facility had all needed resources would be presented to the COO monthly. 6. An Ad-hoc QAPI meeting was conducted, on 06/18/2021, with the Administrator and IDT to review and implement the AOC. A full QAPI meeting was held on 06/24/2021. Education began 06/18/2021. The State Survey Agency (SSA) validated the facility took the following actions: 1. Interview with the Administrator and Director of Nursing (DON), on 07/02/2021 at 2:35 PM, revealed the Administrator and Interdisciplinary Team (IDT) would ensure the facility's resources were used. 2. Review of Audit Tool #6 revealed, on 07/01/2021, the RDO educated the Administrator on outside resources available, policies and procedures, all ancillary support available with assigned nurse consultant out and coverage maintained by other RNC, resident needs were met and no issues identified. On 07/02/2021 at 2:35 PM, interview with the Administrator and DON revealed the Administrator and IDT were educated to ensure the facility's resources were used. Interview with the Regional Director of Operations (RDO), on 07/03/2021 at 6:20 PM, revealed she reviewed the budget, the available resources to include the Regional Nurse Consultant, the MDS Consultant, Social Services Consultant, and Risk Management, and agency or contracted support, and the Administrator's Reference Manual. 3. Interview with the Administrator and DON, on 07/02/2021 at 2:35 PM, revealed the RDO completed audits the facility used its resources. Interview, on 07/03/2021 at 6:20 PM, with the RDO revealed she monitored weekly followed by bi-weekly audits to ensure the facility resources were available. (continued on next page)

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Landmark of Louisville Rehabilitation and Nursing	1155 Eastern Parkway Louisville, KY 40217

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Review of a QAPI Committee Meeting Minutes and sign in sheet, dated 06/17/2021, revealed the Regional Director of Operations (RDO) in-serviced by phone the Assistant Director of Nursing (ADON), the Director of Nursing (DON) and the Administrator regarding resources of the CMS guidelines, consultants, administrator reference manual, risk management, policies and procedures, and care plans. Interview with the Administrator and the Director of Nursing (DON), on 07/02/2021 at 2:35 PM, revealed the RDO reviewed the budget, available consulting services, such as the Regional Nurse Consultant, the MDS Consultant, Social Services Consultant, and Risk Management, and agency or contracted support. On 07/03/2021 at 6:20 PM, interview with the RDO revealed she reviewed with the Administrator, DON, and SSD on the facility's available resources and any staff who failed to comply with the in-service information provided would be further educated or progressively disciplined. 5. Review of Audit #4 revealed on 07/01/2021 the RDO reviewed all audits and noted review of resources, to determine consent, with psych and physicians completed, education completed, and policies, procedures, and audits were updated. Interview, on 07/03/2021 at 6:20 PM, with the RDO revealed she submitted her monitoring data to the COO monthly. 6. Review of a sign in sheet for the combined form for Morning Meeting Stand-Up and Afternoon Meeting Stand Down, revealed an Ad-hoc QAPI at stand down, dated 06/18/2021, noted IJ in-services related to consent, develop practices for sexual consent, and what tools to use. Review of QAPI Committee Meeting Minutes sign in sheet, dated 06/24/2021, revealed noted corrective action audits, education and post-test, sexual consent, resident rights, and resources. The RDO participated by phone, and the Medical Director participated. Interview, on 07/02/2021 at 2:35 PM, with the Administrator and DON, revealed an Ad-hoc QAPI meeting met on 06/18/2021, and QAPI also met on 06/24/2021, to review development and progress, and included the RDO by phone on 06/18/2021. Interview with the RDO, on 07/03/2021 at 6:20 PM, reviewed an Ad-hoc QAPI meeting was conducted on 06/17/2021, and met on 06/24/2021, and discussed abuse, resident rights, and education.

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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 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 28733 Based on interview, record review, and review of the facility's policy, it was determined the facility failed to have an effective governing body that was responsible for establishing and implementing policies regarding the management and operation of the facility. This was evidenced by the facility's failure to maintain substantial compliance, since the 12/06/2019 recertification survey, in the areas of 42 CFR 482.10 Resident Rights (F584); 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation (F600); 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F656 and F657); 42 CFR 483.25 Quality of Care (F689); 42 CFR 483.45 Pharmacy Services (F761); and, 42 CFR 483.80 Infection Control (F880). The facility's failure to provide an effective governing body responsible for establishing and implementing policies regarding the management and operation of the facility has caused or is likely to cause serious injury, harm, impairment, or death to residents. Immediate Jeopardy (IJ) was identified at 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation, F600 and F607, at a scope and severity of a J; 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F657, at a scope and severity of a J; 42 CFR 483.40 Behavioral health Services, F745, at a scope and severity of J; 42 CFR 483.70 Administration, F835, at a scope and severity of a J; and, 42 CFR 483.75 Quality Assurance and Performance Improvement, F867, at a scope and severity of a J. The Immediate Jeopardy was determined to exist on 03/17/2021 and the facility was notified of the Immediate Jeopardy on 06/17/2021. Substandard Quality of Care (SQC) was identified in the area of 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation (F600 and F607) and 42 CFR 483.40 Behavioral Health Services, (F745). The facility provided an IJ Removal Plan on 06/27/2021, alleging removal of the Immediate Jeopardy on 06/27/2021. The State Survey Agency determined the Immediate Jeopardy was removed on 06/27/2021, as alleged, prior to exit on 07/03/2021, with remaining non-compliance at a Scope and Severity of an G while the facility developed and implemented a Plan of Correction and the facility's Quality Assurance (QA) monitored to ensure compliance with systemic changes. Additional repeat deficiencies, from the 12/06/2019 recertification survey, were identified in the areas of 42 CFR 483.10 Resident Rights, F584 at a scope and severity of a E; 42 CFR 483.45 Pharmacy Services (F761); and 42 CFR 483.80 Infection Control (F880). The findings include: Record review revealed the facility failed to ensure residents were free from abuse and ensure residents' behaviors were addressed; failed to ensure residents' care plans were developed, revised and implemented; and, failed to ensure the facility was managed with an effective quality assurance program to maintain substantial compliance. (Refer to F600, F656, F657, F689, F761, and F880). (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with the Administrator, on 06/17/2021 at 3:32 PM, revealed the facility did not have a Governing Body. She stated the RDO interviewed and hired her into the role as the administrator. Further interview revealed the RDO was whom she reported to and who had provided her the onboarding process for the facility. She stated the facility was a limited liability company (LLC) and she was responsible for the functioning of the facility. Telephonic interview with the Regional Director of Operation, on 07/01/2021 at 3:28 PM, revealed the facility was a Limited Liability Company (LLC) with the administrator responsible for the facility. She further stated there was no governing body as the facility was ran by the administrator. However, consulting services were provided through a different LLC, with whom the RDO was employed. She stated her LLC provided consulting services for the facility's budget. Additional services included nurse consultant, Minimum Data Set (MDS) Consultant, Human Resource Consultant, and Accounts Payable/Receivable Consultant provided to the facility. In addition, she stated her responsibilities included the training and annual evaluation of the administrator.

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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 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 28733 Based on observation, interview, record review, and facility policy review, it was determined the facility failed to have an effective system to address systerm failures through regular scheduled Quality Assurance Performance Improvement (QAPI) meetings. The facility failed to identify quality of care deficiencies, and failed to take actions aimed at performance improvement to ensure improvements were realized and sustained. This is evidenced by repeated deficient practice cited at 42 CFR 482.10 Resident Rights (F584); 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation (F600); 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F656 and F657); 42 CFR 483.25 Quality of Care (F689); 42 CFR 483.45 Pharmacy Services (F761); and 42 CFR 483.80 Infection Control (F880). These deficiences were cited during the 12/06/2019 recertification survey. Record review revealed the facility failed to ensure residents were free from abuse and failed to ensure residents' behaviors were addressed; failed to ensure residents' care plans were developed, revised and implemented; and, failed to ensure the facility was effectively managed with an effective quality assurance program to maintain substantial compliance. (Refer to F600, F656, F657, F689, F761, and F880). The facility's failure to provide an effective Quality Assurance Performance Improvement (QAPI) Program responsible planning, developing, implementing, amd maintaining an effective, comprehensive, and data driven program in accordance with Federal Guidelines focused on indications of outcomes in the facility has caused or is likely to cause serious injury, harm, impairment, or death to residents. Immediate Jeopardy (IJ) was identified at 42 CFR 483.12 Freedom from Abuse, Neglect and Exploitation, F600 and F607, at a scope and severity of a J; 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F657, at a scope and severity of a J; 42 CFR 483.40 Behavioral health Services, F745, at a scope and severity of J; 42 CFR 483.70 Administration, F835, at a scope and severity of a J; and, 42 CFR 483.75 Quality Assurance and Performance Improvement, F867, at a scope and severity of a J. The Immediate Jeopardy was determined to exist on 03/17/2021 and the facility was notified of the Immediate Jeopardy on 06/17/2021. Substandard Quality of Care (SQC) was identified in the area of 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation (F600 and F607) and 42 CFR 483.40 Behavioral Health Services, (F745). The facility provided an IJ Removal Plan on 06/27/2021, alleging removal of the Immediate Jeopardy on 06/27/2021. The State Survey Agency determined the Immediate Jeopardy was removed on 06/27/2021, as alleged, prior to exit on 07/03/2021, with remaining non-compliance at a Scope and Severity of an G while the facility developed and implemented a Plan of Correction and the facility's Quality Assurance (QA) monitored to ensure compliance with systemic changes. Additional repeat deficiencies, from the 12/06/2019 recertification survey, were identified in the areas of 42 CFR 483.10 Resident Rights, F584 at a scope and severity of a E; 42 CFR 483.45 Pharmacy Services (F761) at a s/s of E; and 42 CFR 483.80 Infection Control (F880), at a s/s of E. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The findings include: Review of the facility's Quality Assurance and Performance Improvement (QAPI) Program and Plan, version dated 2017, revealed the mission of the QAPI plan was to develop, implement, and maintain an effective, comprehensive, and data driven QAPI Program in accordance with Federal Guidelines focused on indicators of outcomes of quality of care (QOC) and quality of life (QOL) for the residents. The comprehensive and ongoing program addresses the full range of care and services provided by the facility including all systems of care and management practices, clinical care, QOL and resident choices. Utilization of the best available evidence defining and measuring indicator of quality and facility goals reflecting the processes of care and facility operations predictive of the desired outcomes. In addition, the program reflects the complexities, the unique care and services provided by the facility. The plan describes the processes, systems and reports guiding the facility's efforts to ensure care and services maintained at acceptable levels of performance and ongoing improvement. Review of the QAPI Committee Meeting, dated 02/25/2021 at 8:30 AM revealed the committee discussion consisted of dietary tray cards and diets, falls, and weight loss listed as POC; however, the follow-up date was not identified. Additionally, no documented evidence the facilty was auditing and/or monitoring previous defeciences cited. Review of the QAPI Committee Meeting, dated 03/25/2021 and not timed revealed the committee discussion were continued food and laundry; however, the follow-up date was identified for the next QAPI meeting, dated 04/29/2021. Additionally, no documented evidence the facilty was auditing and/or monitoring previous defeciences cited. Review of the QAPI Committee Meeting, dated 04/29/2021 and not timed revealed the committee discussion identified QAPI Plan of food and laundry with the follow-up date listed as the next meeting, dated 05/27/2021. Additionally, no documented evidence the facilty was auditing and/or monitoring previous defeciences cited. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Director of Housekeeping and Laundry, on 06/17/2021 at 11:56 AM revealed he attends the Quality Assurance Performance Improvement meeting; however, was not aware this was a committee. He revealed employment began in December 2019 at the end of the survey. He stated the plan of correction was not his plan of correction, but provided to him by a prior administrator. He stated the adminitrator provided him with three of four clip boards for housekeeping and the laundry with the to do audits. Resident interviews with two (2) residents any locations of the facility pertaining to laundry and housekeeping were initiated. Another clipboard for tracking residents personal laundry. He revealed tracking the laundry as idendified when pulled from the floor and again when the laudry was returned. However, if the laundry was late, then the resident was to be notified when the laundry was late and why it was late. Also, a random audit of one room, per floor, per day. He stated the POC audits were stopped in June or July, 2020 as the interim administrator decided audits had occured long enough and had sufficient results to stop. He stated he was not providing any follow up with the residents for any laundry exceeding the time frame identified in the prior POC, nor collecting any data for the QAPI with late laundry not returned. He stated there were not any audits, documentation, or logs kept tracking the resident's laundry or clothing. He stated he makes observation of the clothing in the facility's laundry. He stated the current administertor was focused on the facility's linens earlier in 2021, not the resident's personal laundry. He further stated he did audits identifying the retention and availability of the facility's linens. He stated there was a mountain of unidentified clothing in the laundry. He stated the facility has a Clothes Closet as there were so many unidentified clothing. In addition, in revealed being unsure if the resident's laundry was being processed and returned within the forty-eight (48) hour time frame identified during the plan of correction. Interview with Unit Manager (UM) #1, on 07/02/2021 revealed data was collected for the QAPI meetings. She revealed data collection was related to pressure ulcers, and staging, pain management information. She revealed the information was presented to the Director of Nurses (DON) for QAPI. Interview with Unit Manager (UM) #7, on 07/02/2021 at 11:20 AM revealed ongoing data collection for the QAPI meetings included data on wounds, indwelling catheters, respiratory care, pain management and anticoagulants. Continued interview revealed no memory recall of data collection or discussion of any information related to previous deficiencies. Interview with Administrator, on 06/17/2021 at 3:32 PM revealed the Quality Assurance Performance Improvement (QAPI) process were included in her responsibilities. She stated the purpose for the plan of correction (POC) were to correct deficient practice and not continue with repeat allegations of the same deficient practices. She revealed if an identified area of concerns occurred, then a new plan placed, or an old plan back in place. She further revealed moving residents around in the building, and difficulty with staffing meeting the needs of the residents. Per interview with the Administrator, she revealed things have fallen through the cracks. She revealed the facility has the Guardian Angel Program. The Guardian Angel program does not utilize any tracking tool, nor any data collected on the findings identified. Continued interview revealed she claimed not being a micromanager, and she has a Director of Nursing (DON) to address the clinical concerns. Continued interview revealed the prior sitting administrator identified all of the deficiencies were cleared; therefore, she did not review the prior plan of correction, but should have. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Telephonic interview with the Regional Director of Operation (RDO), on 07/01/2021 at 3:28 PM, revealed the purpose of the plan of correction (POC) were to correct actions and deficient practice. The POC goal were to correct and maintain compliance. She stated the Quality Assurance Performance Improvement (QAPI) process for the POC was to ensure compliance; however, once compliance was determined she was not sure how the compliance was maintained. She revealed repeat citations should not occur following a plan of correction. The RDO revealed she does not attend the regular QAPI meeting. She revealed the tours of the facility were completed individually without any of the department directors. Continued interview revealed the facility self reported incident lead to an event call to the facility. The purpose of the event call was to review ideas, solutions, and areas for review when identifying a root cause and analysis of the reportable incident.