STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185435	A. Building B. Wing	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Village Nursing and Rehabilitation Center	1381 Campbell Lane Bowling Green, KY 42104

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27868 Based on observation, interview, record review, and review of facility documents and policy, it was determined the facility failed to ensure freedom from abuse for five (Resident #2, #3, #4, #6 and resident #7) of nine (9) sampled residents. Resident-to-resident abuse was substantiated in four instances with residents being hit, pushed, or slapped by other residents of the facility Findings include: Review of the facility policy titled Abuse Prohibition, revised 05/01/2022, revealed the Center would ensure staff would do all that was within their control to prevent occurrences of abuse. Further review of the document revealed if suspected abuse was resident to resident, the resident who had a history of disruptive or intrusive interactions would be removed from the setting or the situation and an investigation would be completed, with options for room changes being provided based on the situation. 1. Review of a Self-Reported Incident Form, dated 09/08/2022, revealed that the facility reported to the State Agency (SA) an allegation regarding a resident-to-resident incident. Per the form, on 09/08/2022, a Certified Nursing Assistant (CNA) witnessed two residents (Resident #3 and Resident #5) having an altercation with each other in their room. Review of an attachment (Part C) to the 5 Day Follow Up/Final Report submitted to the SA on 09/12/2022 revealed that, After a comprehensive investigation that included an interview, observation, and record review, this resident-to resident will be substantiated with no harm. Although the attachment noted that This was an isolated incident, as a precautionary measure, education and post-test regarding abuse prevention and accident and incidents in regard the resident to a resident were completed and was ongoing. Record review for the two residents, who were roommates at the time of this incident, included the following: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185435	A. Building B. Wing	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Village Nursing and Rehabilitation Center	1381 Campbell Lane Bowling Green, KY 42104

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Review of Resident #5's hard copy Admission Record revealed the resident was admitted to the facility on [DATE] with diagnosis which included dementia. The most recent assessment prior to the 09/08/2022 incident, a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/02/2022 in the electronic medical record (EMR), revealed the resident was severely cognitively impaired, based on a Brief Interview for Mental Status (BIMS) score of three (3) out of fifteen (15). Per this assessment, Resident #5 displayed no physical or verbal behaviors towards others in the seven-day assessment period. Review of Resident #5's current comprehensive care plan revealed that the potential for physical behaviors had been care planned since 03/14/2022 and the potential for verbal behaviors had been care planned since 03/25/2022. b. Review of Resident #3's hard copy Admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses including dementia, anxiety disorder, and malignant neoplasm (cancer). The most recent MDS conducted prior to the 09/08/2022 incident, a quarterly MDS with an ARD of 07/01/2022, revealed the facility was severely cognitively impaired, based on a BIMS score of three (3) out of fifteen (15). Per this MDS, the resident, who was independent in walking in the room at the time, displayed no physical or verbal behaviors during the seven-day assessment period. Review of Resident #3's current comprehensive care plan revealed that the potential for physical behaviors had been care planned since 06/15/2022 and the potential for verbal behaviors had been care planned since 06/17/2022. Review of a witness statement, dated 09/08/2022, revealed that CNA #4 documented that she heard a pound and grunting from Resident #3/Resident #5's room. CNA #4 noted that the door to the resident's room was closed. When I entered the room, Resident #5 was holding on to Resident #3's arm and using the other hand to punch him/her on the left side near rib cage. I did not witness Resident #3 hitting the other resident. Resident #5 said he/she did it because Resident #5 was trying to damage the blinds. When I entered in the room they were not broken. I immediately separated them and asked them what was going on. I took Resident #5 out of the room and I flagged down the nurse to come and assist. Review of a witness statement from the former interim Director of Nursing (DON) dated 09/08/2022, revealed that when he went to talk to and assess the residents, he asked Resident #5 if he had an altercation with his roommate and Resident #5 said he didn't know. Resident #3 could not tell me what had happened either. Review of a current staff list provided by the facility revealed the former interim DON was no longer employed by the facility and unavailable for interview. Observations on 10/11/2022 - 10/12/2022 and review of Resident #5 and Resident #3's EMR revealed that Resident #5 and Resident #3 were no longer roommates. Observations and interviews with the two residents included: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185435	A. Building B. Wing	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Village Nursing and Rehabilitation Center	1381 Campbell Lane Bowling Green, KY 42104

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Observation of Resident #5, on 10/11/2022 at 8:45 AM, revealed the resident was walking slowly but steadily in the day room/dining area. An interview with the resident at this time revealed the resident did not recall the 09/08/2022 incident. The resident was not oriented to time, stating that /she had lived in the facility all my life. Resident #5 stated that he/she had never had problems with anyone in the facility, had never been in a fight or altercation with anyone, and no one had ever been rough with Resident #5. The resident reported feeling safe, with no fear of other residents or staff. Observation on 10/11/2022 at 11:54 AM, revealed the resident was calmly sweeping in the day room. The resident was pleasant and did not remember the previous interview. Observation on 10/11/2022 at 1:39 PM revealed the resident was walking in the dining room, throwing away trash. The resident did not recall the incident with Resident #3, saying he/she had never been involved in any issues with anyone else, adding, They don't bother me, I don't bother them. On 10/11/2022 at 4:05 PM, Resident #5 was observed laying on his bed. No issues were observed between the resident and the current roommate, who was present in the other bed in the room. Throughout the observations on 10/11/2022, as well as additional observations on 10/12/2022 at 5:15 AM, 6:54 AM, 8:04 AM, 11:20 AM, and 12:35 PM, Resident #5 displayed no behaviors, and the resident was pleasant and calm at all times. During the observations of Resident #5 on 10/11/2022 at 4:05 PM and 10/12/22 at 5:15 AM, 6:54 AM, 11:20 AM, and 12:35 PM, it was noted that Resident #5 occupied the far bed in the room, next to the window which was covered by blinds. b. Observation of Resident #3, on 10/11/2022 at 8:51 AM, revealed the resident was sitting on the side of his bed. The resident was unable to answer basic screening questions and did not respond to his/her name. During the attempted interview, the resident made low, mumbling sounds that could not be identified as words. Observation on 10/11/2022 at 9:40 AM, 1:33 PM, 3:54 PM, and 10/12/2022 at 5:15 AM, 6:54 AM, 8:10 AM, 11:12 AM, and `12:20 PM revealed the resident was in bed during all observations. Multiple attempts to interview the resident during these observations revealed that the resident was not oriented to person, place, or time during basic screening questions. The resident mumbled with no discernable words when asked about the resident-to-resident altercation; however, during an attempt at an interview on 10/12/2022 at 8:10 AM, when asked if the resident felt safe, the words sure thing could be understood. Interview with CNA #4, on 09/19/2022 at 4:30 PM, revealed she witnessed the altercation between the two residents around a week or two ago. CNA #4 stated the incident occurred in the two residents' room. She revealed she was in the next room over and heard a thump and grunting. She went into their room and saw Resident #5 had Resident #3 by the arm and was punching Resident #3 in the ribs. CNA #4 stated she removed Resident #3 from the room and reported the incident to the nurse, An additional interview was conducted with CNA #4 on 10/12/2022 at 1:37 PM. She confirmed that, while working in another resident room, she heard like noises that shouldn't be. I immediately went over to Resident #3 and Resident #5's room. During this interview, CNA #4 noted that the door to the room had been closed because both residents were on isolation due to COVID-19. She confirmed that Resident #5 had Resident #3 by the arm and was punching the resident in the ribs. CNA #4 stated that she separated the residents and got a nurse who assessed the residents. Further interview with CNA #4 revealed that Resident #5 was very protective of his things and had gotten agitated because Resident #3 was touching his/her blinds. She stated that Resident #3 was not aggressive back to Resident #5, saying, the resident just stood there. CNA #4 reiterated that Resident #5 was Pretty particular about his/her things and that the incident had occurred when Resident #3 had come onto Resident #5's side of the room and was handling the window blinds. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185435	A. Building B. Wing	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Village Nursing and Rehabilitation Center	1381 Campbell Lane Bowling Green, KY 42104

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Assistant Director of Nursing (ADON), on 09/20/2022 at 3:19 PM, confirmed Resident #5 was witnessed by the facility's staff holding Resident #3's arm and punching him in the left flank area. The ADON stated that Resident #5 physically abused Resident #3 and the facility investigated the allegation of abuse and reported to the State Office of Inspector General Office of Health Care on 09/08/2022. An additional interview with the ADON, on 10/12/2022 at 10:50 AM, confirmed that at the time of this incident, Resident #5 and Resident #3 were roommates. She said that, to her knowledge, there had never been any issues between the two residents prior to the 09/08/2022 incident. She stated that when CNA #4 told her what she saw, she went and assessed both residents and found that Resident #3 had redness that looked as if it was going to bruise, as well as a scratch to the elbow. In response, an x-ray was ordered. Review of a Radiology Results Report, dated 09/08/2022 and located in the facility's investigation file, revealed that there was no acute rib fracture notes and no significant soft tissue swelling. Further interview with the ADON revealed that Resident #5 was more cognitively aware than Resident #3, and therefore the decision was made to move Resident #3 to another room, which did not have any impact on the resident. The ADON stated that Resident #5 was provided a new roommate, who was non-ambulatory and could therefore not touch Resident #5's belongings, and no further instances had occurred. Interview with the Social Services Director (SSD), on 09/21/2022 at 2:00 PM, revealed the altercation between Resident #3 and Resident #5 was an isolated incident and no altercations between the two residents occurred prior to or after the incident. Interview with the Administrator, on 09/20/2022 at 5:40 PM, revealed facility staff witnessed the incident between Resident #5 and Resident #3. She further stated the facility investigated the incident as an abuse allegation and it was substantiated. An additional interview was conducted with the Administrator on 10/12/2022 at 10:56 AM. The Administrator stated that because both residents were on COVID precautions, they had to stay in their room with the door closed. She noted that, as had been observed on 10/11/2022 and 10/12/2022, Resident #5 was social, pleasant and did not like to stay in his room, as he was routinely out and about in the facility, particularly liking to help clean. She stated that the facility's investigation found that the incident occurred when Resident #3 went over to fiddle with and touch the blinds which were on Resident #5's side of the room. The Administrator described this as a on-off situation in which Resident #5 became agitated with the roommate. 2. Review of a Self-Reported Incident Form, dated 06/15/2022, revealed that the facility reported to the SA an allegation regarding a resident-to-resident incident. Per the form, on 06/15/2022, It was reported that a staff member witnessed Resident #3 make physical contact with Resident #4 in the activity room. Per the attachment to the 5-Day Follow up/Final Report submitted to the SA on 06/19/2022, the facility reported that, After a comprehensive investigation that included an interview, observation and record review this resident to resident will be substantiated with no harm. This was an isolated incident and after 15 minute checks daily for two (2) days, neither Resident #3 had any other altercations with Resident #4. There were no bruises on either resident. Resident #3 was also seen by the Geri-psych. Resident #3 has responded well to the new orders received. As a precautionary measure, education regarding abuse prevention in regard to the resident to a resident has been completed and is ongoing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185435	A. Building B. Wing	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Village Nursing and Rehabilitation Center	1381 Campbell Lane Bowling Green, KY 42104

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review for the two-resident involved included the following: a. Review of Resident #3's hard copy Admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses including Dementia, Anxiety Disorder, and Malignant Neoplasm (Cancer). Per the most recent MDS prior to the 06/15/2022 incident (an admission MDS with an ARD of 03/31/2022), Resident #3 had a BIMS of eleven (11) out of fifteen (15), indicating moderate cognitive impairment. The resident was ambulatory and wandered and displayed no physical or verbal behaviors during the seven-day assessment period. A review of Resident #3's current comprehensive care plan, initiated on 03/26/2022, revealed that the problem of behaviors was not care planned until 06/15/2022 (when this incident occurred), as there had been no previous issues. A review of all Progress Notes confirmed the resident did not display physical or verbal behaviors towards others prior to this incident. Review of Resident #3's Progress Notes revealed the resident was sent out to the hospital for evaluation after the 06/15/2022 incident, and returned the same day with no new orders, and was placed on fifteen (15) minute checks. Further review of physician orders under the Orders tab in the EMR revealed an order for hospice care and treatment effective 06/17/2022, as well as multiple orders for medication changes with concurrent medication regimen reviews. b. Review of Resident #4's hard copy Admission Record revealed the resident was admitted to the facility on [DATE] and had diagnoses including Dementia with Behavioral Disturbance Psychotic Disorder with Delusions, and Schizophrenia. Per the most recent MDS prior to the 06/15/2022 incident, (a quarterly MDS with an ARD of 05/06/2022), the resident was assessed by staff to have moderate cognitive impairment after the resident was not able to complete the BIMS test. Per the MDS, Resident #4 displayed physical and verbal behaviors towards orders one (1) to three (3) days of the assessment period. Review of the current comprehensive care plan revealed that the problem of potential for both physical and verbal behaviors had been care planned since 02/28/2022. Review of an undated witness statement completed by the Activities Director (AD), revealed that the 06/15/2022 incident occurred when, We were all sitting at the activity table, and we were watching virtual tour of a dairy farm. Resident #3 stood up and was looking straight at Resident #4 and pointing at the resident. I told Resident #3, Resident #4 was fine and wasn't bothering anyone. Resident #3 then voiced he/she was leaving and getting out. My back was cattycornered to Resident #4 and Resident #3 got up like he/she was leaving and instead quickly went over to Resident #4 and made physical contact with a closed fist on Resident #4's right cheek. Resident #4 grabbed his/her face and said oh. Resident #3 then took off running down the hall, I intervened and got a charge nurse to come and evaluate Resident #4. Observations on 10/11/2022 - 10/12/2022 revealed no evidence of behaviors by either Resident #3 or Resident #4. Observations and interviews with the two residents included: a. Observation of Resident #3 on 10/11/2022 at 8:51 AM, 9:40 AM, 1:33 PM, 3:54 PM, and 10/12/2022 at 5:15 AM, 6:54 AM, 8:10 AM, 11:12 AM, and 12:20 PM revealed the resident was in bed during all observations. Multiple attempts to interview the resident during these observations revealed that he was not oriented to person, place, or time during basic screening questions. The resident mumbled with no discernable words when asked about the resident-to-resident incident with Resident #4; however, during an attempt at an interview on 10/12/22 at 8:10 AM, when asked if the resident felt safe, the words sure thing could be understood. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185435	A. Building B. Wing	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Village Nursing and Rehabilitation Center	1381 Campbell Lane Bowling Green, KY 42104

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Observation of Resident #4 on 10/11/2022 at 8:51 AM, 9:40 AM. 11:59 AM, 1:33 PM, 3:54 PM, and 10/12/2022 at 5:15 AM, 6:54 AM, 8:07 AM, 11:15 AM, 12:20 PM, revealed the resident was in bed during all observations. No evidence of bruising or other injuries were noted to the resident's face. Multiple attempts to interview the resident were made during these observations; however, the resident did not answer any basic screening questions, including his/her name. Interview with CNA #10, who was present and feeding the resident during the observation on 10/11/2022 at 11:59 AM revealed that the resident is pretty calm and currently has no behaviors. Interview with the AD on 09/20/2022 at 4:09 PM, revealed she witnessed Resident #3's closed fist physically contact Resident #4's cheek. The AD also confirmed physical assault was considered abuse. An additional interview was conducted with the AD on 10/12/2022 at 8:36 AM. The AD showed where she had been sitting in the activity room, noting that Resident #3 was sitting at the table with her. She stated that Resident #3 stood up, began mumbling, and pointed at Resident #4, who was sitting in a chair, catty-cornered behind her. She said that she asked Resident #3 to sit back down, but he/she did not, and began walking away like he/she was leaving the activity room. The AD stated, Before I could get to the resident, Resident #3 hit Resident#4 in the face. She stated that this was the first resident-to-resident behavior she had ever seen Resident #3 display, and to her knowledge, was the first time the resident had been physical to another resident. She said that although I didn't see the punch coming, she did see Resident #3 make contact with Resident #4, adding that although she was less than three feet away, I just couldn't get to Resident #3 in time. It was unprovoked. She said she immediately checked Resident #4 and hollered down the hall for the nurse. The AD stated that when Resident #3 first hit Resident #4, the resident grabbed his/her face; however, within three minutes Resident #4 had forgotten it. The AD stated that she thought the resident's face was red but there was no bruising. The AD described the incident as unexpected, stating that it could not be predicted that as Resident #3 walked by Resident #4, the resident would just reach out and punch Resident #4. Interview with the Skin Health Lead (SHL) on 10/12/2022 at 9:31 AM revealed she was previously the DON. She stated she was called in after the incident and all residents, including Resident #4, had a skin assessment and no issues were identified Interview with the ADON, on 09/20/2022 at 3:44 PM, revealed the facility confirmed Resident #3's fist made physical contact with Resident #4's face, and substantiated abuse of Resident #4 by Resident #3. Interview with the Administrator on 10/12/2022 at 9:49 AM revealed that in response to the incident, the facility dove deeper to try and determine the root cause of Resident #3's behavior on 06/15/2022, noting that this incident was the first incidence of physical abuse that the resident had displayed. In addition to reaching out to the family to understand the resident's past history and its possible impact on his/her behavior, the facility brought in hospice to assess if pain from the resident's cancer, which was spreading, was an issue in the resident's behavior. She stated that based on the resident's past history, the facility had begun looking for a different placement that would better suit the residents' needs; however, a transfer had become unnecessary as the resident had gone downhill as the cancer spread and the resident no longer displayed any behaviors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185435	A. Building B. Wing	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Village Nursing and Rehabilitation Center	1381 Campbell Lane Bowling Green, KY 42104

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of a Self-Reported Incident Form, dated 05/15/2022, revealed that the facility reported to the SA an allegation regarding a resident-to-resident incident. Per the form, on 05/15/2022, Resident #6 swatted at Resident #7. Per the attachment to the 05/19/2022 5 Day Follow Up/Final Report, the investigation found that Resident #6 was in Resident #7's room. When staff noticed the resident in there, they went to remove/redirect him/her. As staff removed Resident #6 from Resident#7's room, Resident #7, proceeded to tell Resident #6 to stay out of his/her room. Resident #6 then slapped Resident #7 on the inside of her forearm. Staff quickly separated and removed both residents from the area. Resident #7 was placed on a 15-minute watch, while Resident #6 was transferred to the hospital for evaluation due to the behavior. Review of the attachment for the final report revealed that the facility found that After a comprehensive investigation that included an interview, observation and record review this resident to resident will be substantiated with no harm. This was an isolated incident and after the 15-minute checks daily for 3 days neither Resident #7 nor Resident #6 had any other altercations. There were no bruises [sic] on either resident. Resident #6 did receive orders for new medication while he/she was at the hospital and will be seen by Geri-psych. In addition, the attachment noted that a stop sign was ordered and would go across Resident #7's room, upon delivery and, As a precautionary measure, education regarding abuse prevention in regard to resident to a resident has been completed and is ongoing. Record review for the two residents involved included the following: a. Review of Resident #6's hard copy Admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease with late onset, Dementia with Behavioral Disturbance, Anxiety Disorder, and Cerebral Infarction. Review of an 05/09/2022 Nursing Documentation Note under the Notes tab in the EMR revealed that the resident was admitted from an assisted living facility, and was alert to self only, confused to place and time. Per this note, the resident is currently pacing halls and going to doors, redirected and other activities offered but is refusing at this time .wandering occurs daily or almost daily and poses significant risk and/or is intruding on others. Review of Resident #6's admission MDS, with an ARD of 05/16/2022 (one day after the 05/15/2022 resident-to-resident abuse) revealed that the resident was severely cognitively impaired, based on a BIMS score of three (3) of fifteen (15). Per this MDS, the resident wandered one (1) to three (3) days of the seven-day assessment period, and required supervision for transfers, walking in the room and the corridor, and locomotion on and off the unit. Review of Resident #6's comprehensive care plan, initiated on 05/09/2022, revealed the resident was care planned for the potential wandering behaviors and exit seeking from admission on 05/09/2022. The problem of physical behaviors was added to the care plan on 05/15/2022, the day of the resident-to-resident incident. Further review of Resident #6's closed medical record revealed the resident was no longer in the facility and had been transferred to the hospital on 07/23/2022 and never returned. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185435	A. Building B. Wing	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Village Nursing and Rehabilitation Center	1381 Campbell Lane Bowling Green, KY 42104

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Review of Resident #7's hard copy Admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses including Dementia with Behavioral Disturbance, Major Depressive Disorder, and Anxiety Disorder. Review of the resident's most recent MDS prior to the 05/15/22 incident revealed a quarterly MDS with an ARD of 04/08/2022. This assessment showed that the resident was cognitively intact, based on a BIMS of thirteen (13) out of fifteen (15), and displayed no behaviors during the seven-day assessment period. Review of Resident #7's comprehensive care plan, initiated 02/08/2022, revealed that there was no care plan for behaviors prior to 05/15/2022, as the resident did not display any and this problem area was not triggered. Further review of Resident #7's medical record revealed the resident was not currently in the facility and was being treated in the hospital. Review of an undated witness statement from CNA #6 revealed that, it was after lunch, I heard Resident #7 yelling so I went into the room to help him/her. Resident #6 was in her room beside the bed, digging through Resident #7's items. Licensed Practical Nurse (LPN) # 2, was there trying to tell Resident #6 that it wasn't her room and that we needed to leave because she was in the wrong room. And we got Resident #6] out of the room shortly after that. Can't remember what Resident #7 said to Resident #6, but I know she was upset. So Resident #6 slapped Resident #7 on the arm. Then we separated the two (2) and tried to calm them both down. Review of a witness statement dated 05/15/2022 by LPN #2 revealed the same description of Resident #6 rummaging through Resident #7's things., Per this statement, Resident #7 became upset and started screaming at Resident #6. I explained to Resident #7 that yelling will not help the situation as Resident #6 does not understand what she is doing .Resident #6 became resistant to leaving the room, CNA #6 and I were able to remove the resident after a few minutes. As we were passing Resident #7 in the hallway. She began yelling at Resident #6 again. Resident #6 was able to open hand slap Resident #7 on the inside of the forearm. Per the statement, as Resident #7 began swinging back at Resident #6, the CNA moved Resident #6 away while the LPN stood in front of Resident #7. LPN #2's statement noted that when she assessed Resident #7, the resident was not injured and there were no visible marks from the altercation on the residents arm. Review of facility staffing records revealed that LPN#2 was no longer employed by the facility. Attempts were made to contact LPN #2 by telephone on 10/11/2022 at 1:09 PM and 4:35 PM; however, she did not answer the telephone or return a call-in response and was unavailable for interview. Review of an undated statement from the Social Services Director revealed that she spoke with Resident #7 on 05/16/2022 to discuss the incident that took place over the weekend, Per this note, Resident #7 was content and friendly, and stated that she was not too upset, knowing Resident #6 does not know what she is doing. The note from the Social Services Director noted that Resident #7 was asked if any resident had ever physically abused her in the facility and she said, 'no'. As both residents were out to the hospital at the time of the investigation, no observations or interviews could be conducted. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185435	A. Building B. Wing	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Village Nursing and Rehabilitation Center	1381 Campbell Lane Bowling Green, KY 42104

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with CNA #6 on 10/12/2022 at 3:21 PM revealed that Resident #6 would often wander into other resident's rooms, and she described the resident as always roaming and so quick. She stated on the day of the incident, She went into Resident #7's room. Resident #7 was mad at her and yelling at her. CNA #6 stated that Resident #6, who had severe dementia, did not intend to upset other residents, and thought he/she was helping by going into closets and drawers and arranging things. However, Resident #7 was angry that Resident #6 was in her room. CNA #6 confirmed that she saw Resident #6 hit Resident #7 on her arm after Resident #7 yelled at her. Per the CNA, Resident #6 struck out at Resident #7 before she and the nurse had a chance to do anything. CNA #6 stated that after this incident, Resident #6 was sent out to the hospital and the facility ordered a stop sign for Resident #7's door which was in place and used until Resident #7 was recently transferred to the hospital. Interview with the ADON, on 09/20/2022 at 5:25 PM, revealed Resident #7 was not free from abuse. She confirmed two facility staff -LPN #2 and CNA #6 witnessed Resident #6 open handed slap Resident #7 on the arm and therefore, the facility substantiated physical abuse of Resident #7. Interview with the Administrator, on 09/20/2022 at 5:40 PM, also confirmed that the facility substantiated resident-to-resident abuse, based on staff witnessing Resident #6 slap Resident #7 on the arm. The Administrator stated that although abuse was substantiated, Resident #7 was not injured by the physical abuse. 4. Review of a Self-Reported Incident Form, dated 06/13/2022, revealed that the facility reported to the SA an allegation regarding a resident-to-resident incident. Per the form, on 06/13/2022, staff witnessed Resident #6 being pushed up against the wall by Resident #2. As staff intervened, Resident #2 then informed the staff member that Resident #6 hit her. Per the attachment to the 5 Day Follow Up/Final Report noted that, After a comprehensive investigation that included an interview, observation and record review this resident to resident will be substantiated with no harm. This was an isolated incident and after fifteen (15) minute checks daily for two (2) days Resident #6 nor Resident #2 had any other altercations with each other .There were no bruises on either resident. Per the report, Resident #6 was sent out to the medical center on 06/13/2022 and returned the same day, with a new diagnosis of urinary tract infection (UTI) and receipt of an antibiotic injection. In addition, Resident #6 was seen by Geri-psych and has responded well to the new orders received. A stop sign was placed across the doorway to Resident #2's room. In addition, as a precautionary measure, education regarding abuse prevention in regard to the resident to resident has been completed and ongoing. Record review for the two residents involved included the following: a. Review of Resident #2's hard copy Admission Record revealed the resident was admitted on [DATE] with diagnoses including Dementia with Behavioral Disturbance and Anxiety Disorder. Review of the most recent MDS prior to the 06/13/2022 incident revealed a quarterly MDS with an ARD of 04/05/2022. Per this MDS, Resident #2 was severely cognitively impaired, based on a BIMS score of three (3) out of fifteen (15), and had no behaviors or wandering during the seven-day assessment period. Review of Resident #2's comprehensive care plan revealed that a plan for behaviors was in place since 04/03/2021, with an additional plan related to verbal behaviors initiated on 02/02/2022, Further review of Resident #2's medical records revealed that in response to Resident #2's allegation that he/she was hit, the facility obtained medical imaging. Review of the Radiology Report, dated 06/13/2022 revealed that there was no pelvic or hip fracture. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185435	A. Building B. Wing	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Village Nursing and Rehabilitation Center	1381 Campbell Lane Bowling Green, KY 42104

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Review of Resident #6's hard copy Admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease with Late Onset, Dementia with Behavioral Disturbance, Anxiety Disorder, and Cerebral Infarction. Review of Resident #6's most recent MDS prior to the 06/13/2022 incident, revealed an admission MDS with an ARD of 05/16/2022. Per this MDS, the resident was severely cognitively impaired, based on a BIMS score of three (3), wandered one (1) to three (3) days of the seven (7) day assessment period, and required supervision for transfers, walking in the room and the corridor, and locomotion on and off the unit. Review of Resident #6's comprehensive care plan, initiated on 05/09/2022, revealed the resident was care planned for the potential wandering behaviors, as well as exit seeking from admission on 05/09/2022. In addition, the problem of physical behaviors was added to the care plan on 05/15/2022, the day that Resident #6 slapped Resident #7. (See finding #3.) Further review of Resident #6's closed medical record revealed the res [TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185435	A. Building B. Wing	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Village Nursing and Rehabilitation Center	1381 Campbell Lane Bowling Green, KY 42104

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 27868 Based on observation, interview, record review, and review of facility documents and policy, the facility failed to assure that one resident, (Resident #6) out of nine (9) sampled residents received the necessary supervision and/or assistance device to prevent accidents (elopement.) On 07/23/2022, staff did not initially hear and immediately respond to the alarm which sounded when Resident #6 overrode the magnetic lock system and exited through the front door from the residential unit without first entering the required code. Resident #6, who was assessed with severe cognitive deficit and a history of exit seeking, left the building without staff supervision at approximately 2:00 AM and was ultimately found by facility staff at an unoccupied building across a major (five-lane) highway from the facility. This failure placed the resident at the likelihood of death or serious injury. On 10/12/2022, a past-noncompliance immediate jeopardy (IJ) situation was determined to exist related to the facility's failure to provide supervision and/or an effective assistance device to prevent accidents. The IJ was determined to exist on 07/23/2022, when Resident #6 eloped from the facility and staff did not initially hear the alarm designed to sound when the door was opened without first entering a code. On 10/12/2022 at 12:00 PM, the Administrator was notified of the past noncompliance IJ situation, which also constituted Substandard Quality of Care (SQC). On 10/12/2022 at 12:08 PM, the Administrator was provided a copy of the CMS-IJ Template. Based on the facility's implementation of corrective actions, the State Agency (SA) determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed, with substantial compliance achieved, prior to the initiation of the complaint investigation on 09/19/2022. The Findings include: Review of the facility's policy titled, Elopement of Patient, dated 05/01/2022 revealed an elopement occurred when a patient leaves the premises or safe area without prior authorization. Review of Resident #6's hard copy Admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease with Late Onset, Dementia with Behavioral Disturbance, Anxiety Disorder, and Cerebral Infarction. Review of an 05/09/2022 Nursing Documentation Note under the Notes tab in the electronic medical record (EMR) revealed that the resident was admitted from an assisted living facility, and was alert to self only, confused to place and time. Per this note, the resident is currently pacing halls and going to doors, redirected and other activities offered but is refusing at this time .wandering occurs daily or almost daily and poses significant risk and/or is intruding on others. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185435	A. Building B. Wing	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Village Nursing and Rehabilitation Center	1381 Campbell Lane Bowling Green, KY 42104

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of an Elopement Evaluation completed on 05/09/2022 and located in the Assessment tab of the EMR, also identified that Resident #6 was at risk for elopement. The resident, who was able to ambulate, had risk factors including diagnosis (Dementia), a history of wandering, expressing the desire to leave, the inability to locate significant landmarks without assistance, and attempts to maintain a daily routine/leisure interests that were not consistent with their new environment which could lead to exit-seeking behaviors. The Elopement Evaluation noted that the resident's behaviors included hovering near exits, as well as hyperactivity, frustration, and restlessness and/or agitation. Review of the admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/16/2022 and located under the MDS tab of the EMR, revealed that the resident was severely cognitively impaired, based on a Brief Interview for Mental Status (BIMS) score of three (3). Per this MDS, the resident wandered one (1) to three (3) days of the seven-day assessment period, and required supervision for transfers, walking in the room and the corridor, and locomotion on and off the unit. Review of Resident #6's comprehensive care plan, initiated on 05/09/2022, revealed the resident was care planned to prevent elopements from the day of admission. The goal of will not attempt to leave the facility without an escort was to be met through multiple interventions, including: Observe risk factors/[NAME] for exit seeking behavior and adjust care delivery. Provide increased supervision as appropriate when resident is verbalizing or exhibiting desire to leave the facility .As appropriate, redirect resident/patient if near exits or doorways. Review of Resident #6's Progress Notes revealed that, in addition to wandering through the facility on a routine basis, the resident displayed exit seeking behaviors on 05/09/2022, 05/10/2022, 05/15/2022, 05/19/2022, 05/22/2022, 05/25/2022, 07/07/2022, 07/08/2022, 07/14/2022, and 07/22/2022. Review of the Progress Notes for these days revealed that the resident's exit-seeking behaviors occurred at least once on all three (3) shifts but were more common on the second (afternoon/evening) and third (night) shifts. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185435	A. Building B. Wing	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Village Nursing and Rehabilitation Center	1381 Campbell Lane Bowling Green, KY 42104

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a facility document titled, Self-Reported Incident Form, dated 07/23/2022, revealed that Resident #6 eloped from the facility on 07/23/2022. Per this document, It was reported that Resident #6 had exited the facility unsupervised and was located off facility property. Review of an attachment to a five-day follow-up report to the SA, dated 07/27/2022, revealed that staff reported on 07/23/2022 around 2:00 AM they heard the front door alarms sounding and began to do a head count and realized Resident #6 was unable to be located. Procedures related to a missing resident were initiated and followed. During the facility search, staff were able to locate fifty-eight (58) of fifty-nine (59) residents. When the resident was identified the charge nurse sent two (2) employees on foot to search the perimeters of the facility and sent two (2) staff to search near the entrance of the facility. Two (2) Certified Nursing Assistants (CNA) quickly saw Resident #6 attempting to enter a place of business that was not in operation due to the time of hours. The CNA's quickly approached the resident and redirected him/her back into the facility. Review of Progress Notes for 07/23/22 revealed that after the elopement, Resident #6 was placed on one to one (1:1) care until further notice related to the elopement risk, was assessed for injuries with none found, and the physician was notified. Although Resident #6's Progress Notes and facility investigation revealed the resident sustained no injury from the elopement, a note on 07/23/2022 at 12:30 PM revealed the resident was transferred to the hospital for worsening dementia, including physical aggression/combativeness with an inability to redirect. Review of MDS tracking data revealed that, as of the date of the survey, Resident #6 had not returned to the facility and was unavailable for observation or interview. Per an attachment to the 07/27/2022 five-day follow-up report to the SA, as part of the investigation into the elopement, the Maintenance Director assessed all doors to ensure that all doors were working properly. The Maintenance Director would continue to audit doors as a precautionary measure. Review of written statements, interviews with staff, and observation revealed that although the doors were working properly, as noted in the attachment to the 07/27/2022 report to the SA, the alarm on the door through which Resident #6 exited the residential unit did not sound loudly enough to alert staff at the time that the resident was able to get off the secured unit: a. Review of an undated witness statement from CNA #1 revealed that, We went to do rounds around 2:00 AM in the morning. I heard the front door alarm going off. I looked around for anyone and when I didn't see Resident #6 as he/she was last seen at the nurse's station, I started to look for him/her. All CNA's started to search for her in the rooms, bathrooms, closets, and courtyard. When she couldn't find the resident in the building we went outside and walked the sidewalk. CNA #5 and I spotted her across the street at a building trying to get in the door. We got Resident #6 and walked back to Magnolia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185435	A. Building B. Wing	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Village Nursing and Rehabilitation Center	1381 Campbell Lane Bowling Green, KY 42104

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with CNA #1 on 10/12/2022 at 5:30 AM revealed she was working on the one-hundred (100) hall where Resident #6 resided on the night that the resident eloped. She stated she was doing rounds, and I came out to the hall to throw away trash and heard the alarm. CNA #1 stated, I didn't hear the alarm when I was in the room providing care to another resident, but as soon as I came out of the room, after opening the door and going into the hall to discard the resident's soiled brief, I heard it. CNA #1 confirmed that she was unable to hear the alarm while working in the resident's room, which she stated was at the end of hall. CNA #1 verified she was unaware that the alarm was sounding until she opened the door and went out into the hallway. CNA #1 stated she then came up to the nurses' station and found that the front (locked/coded) door off the unit was closed; however, both the panel at the nurses' station and the annunciator by the door were showing that the locked door from the unit (which went into the lobby and lead to three (3) unsecured exits from the building had been opened. Further interview with CNA #1 revealed that Resident #6 had been up by the doors earlier that night, but she had not attempted to push the exit bar, which set off the alarm, prior to the elopement. CNA #1 stated that several days earlier, Resident #6 had figured out that if he/she pressed the door long enough, it would unlock. CNA #1 estimated that it had been no more than five (5) minutes since she had last seen the resident, prior to going into another resident's room to provide care. She stated that while she was checking the panel, two (2) additional staff were coming down the hall to check as they could now hear the alarm sounding. b. Review of a witness statement from CNA #5, dated 07/23/2022, revealed that, Around 1:00 AM I was doing my round. We had to keep redirecting Resident #6 from the door. I needed to get my residents changed and begin my round. Around 2:00 AM I was assisting a resident and I heard the alarm go off, so I stopped what I was doing to go attend to it. I was in the first room on the right-hand side of one-hundred (100), I went out into the main lobby, and I walked all the way to end of the road and I notice the resident standing in front of the CED building. She was trying to get in the building. The resident had on a black and white dress. I proceeded to go across the road and lead the resident back to the building. There was no traffic or cars. When I approached the resident, there was a box of gloves in his/her hand. I escorted the resident back to the facility with CNA #1 and he/she came willingly. The nurse then took over to do her assessment. Interview with CNA #5 by telephone on 10/11/2022 at 12:09 PM revealed she was an agency staff who was not currently working at the facility. She stated she was familiar with Resident #6 who she described as always trying to get out. She stated that on the night of Resident #6's elopement, she was working on the one-hundred (100) Hall (where Resident #6 resided) and had been in a room providing care to another resident. CNA #5 stated that when she exited the room and went out into the hall, I could hear the alarm, but it was very faint. CNA #5 stated that I have hearing problems and confirmed that, I couldn't hear the alarm when I was in the room with door closed. She stated she was unaware of when the alarm first began to sound and did not know that a resident had managed to get out off the secured unit until she came out in the hall and heard the alarm sounding. She stated at this time, she and the other staff began a count of the residents and searched for Resident #6, whom they identified as the missing resident. CNA #5 confirmed that she and CNA #1 were the staff who located Resident #6 and returned her to the facility. Although CNA #5 stated she did not know when the alarm first sounded and the resident eloped, she estimated that the resident was gone for approximately eight minutes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185435	A. Building B. Wing	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Village Nursing and Rehabilitation Center	1381 Campbell Lane Bowling Green, KY 42104

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. Review of an undated witness statement from CNA #3 revealed, I last saw Resident #6 around 1:55 AM. CNA#2 and I were on the three-hundred (300) wing back in Resident #10's room, we did not hear the alarms sound over the TV, curtain was pulled, door was shut, and we were all talking. Once we came out of the room, we heard the alarm and CNA #1 informed us Resident #6 was gone. Per this statement, We did a head count, and checked all rooms, bathrooms, closets, dining room, and courtyard. After we could not find her in the building all four (4) of us CNA's went outside to search. CNA #1 and CNA #5 found Resident #6 at the building across the street. d. Review of an undated witness statement from CNA #2 revealed that at 1:55 AM, Resident #6 was last seen at the nurses' station. The resident had been exit seeking and rummaging all night, redirection was applied. CNA #3 and I went into Resident #10's room down three-hundred (300) hall to finish our round we had the door closed, TV on, curtain pulled and CNA #3 and I were talking to Resident #10. Once we left the room, we heard the front door alarm going off. Once we figured out Resident #6 was missing we done a head count and searched the building. Once we could not find the resident inside the building we went outside to search. CNA #1 told us Resident #6 was found across the street and had been missing for around 15 minutes. e. Review of an undated witness statement from Licensed Practical Nurse (LPN) #2, the nurse on duty, revealed that she was on break at the time Resident #6 eloped. She wrote the resident was last seen at the nurse's station around 1:50 AM. She stated that While I was on my fifteen (15) minute break, staff began their rounds and, When I came back to the floor, CNA #2 was looking around in the dining room and told me that they had been in Resident #10's room doing round and when they came out the front door alarm was sounding. They both stated they were not able to hear it from inside the room. LPN #2 wrote in her statement that when Resident #6 could not be found in the building, all four (4) CNAs went outside to look for the resident. Per the statement, Within a few minutes I received a call from CNA #1 that the resident was at the office building across the street. The resident was returned to the facility and LPN#2 assessed her with no injuries noted. f. Review of a statement dated 07/23/2022 and signed by the Administrator, Maintenance Director, and Admission Director, revealed that in response to the elopement, they did a simulation test based off the statements that were given. The test was done in Resident #10's room off three-hundred (300) hall. CED [Administrator] and the admission director both shut the door, ensured the tv was on, and the resident concentrator was on, and we also had a small conversation with the resident with the privacy curtain pulled. The maintenance director was at the main door to set the alarm off. He set the alarm off and the CED and AD both did not hear the alarm go off. After a period of time the MD [Maintenance Director] had to come in the room to tell us that the alarm was going off. g. Observation during a tour of the facility on 10/11/2022 at 8:41 AM revealed that the secure residential unit included three wings with resident rooms (100, 200, and 300 Halls), a day area, dining room, kitchen, and a central nursing station. The residential unit had five (5) exits accessible to residents and staff - four (4) of which led to locked courtyards. The fifth (5th) door, in front of the central nurses' station, led into the front lobby of the building, which had three (3) unlocked doors which lead the facility parking lot and drive. Each of the five exits had an alarm pad on an adjacent wall, on which a code had to be entered to release the magnetic lock to open the door. (Observation on 10/11/2022 at 9:45 AM also revealed an additional door to the outside from inside the kitchen; however, per observation and interview with the Dietary Manager who was present during the observation, this door was not accessible to residents.) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185435	A. Building B. Wing	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Village Nursing and Rehabilitation Center	1381 Campbell Lane Bowling Green, KY 42104

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation during an additional tour of the facility on 10/11/2022 at 9:54 AM revealed that each of the four (4) doors which led to the secured courtyards bore a sign that stated Push until alarm sounds. Door can be opened in fifteen (15) seconds. The front door by the nurses' station did not include such a sign. However, observation during a tour of the facility with the Maintenance Director on 10/11/2022 at 10:36 AM confirmed that by pushing on the exit bar on the front door near the nurses' station, as well as on the panic bar on each of the four doors which led to the secured courtyard, the magnetic lock holding the door closed would release and the door would open within approximately fifteen (15) seconds. During the tour on 10/11/2022 at 10:36 AM, observation also revealed that, when pushing on the release bar of each of the five (5) doors listed above, an alarm began to sound. Five (5) seconds later, a screeching siren noise began to sound and continued to [NAME] until the magnetic lock on the door released. The siren, as well as a strobe light near to the door, continued to operate until a code was entered to silence the alarm. During an interview with the Maintenance Director, on 09/21/2022 at 10:10 AM, he stated he assessed the facility's doors to ensure proper working conditions on 07/23/2022 after Resident #6's elopement incident. He confirmed that on 07/23/2022 he determined all the doors exiting the facility were in proper working condition. The Maintenance Director stated his conclusion was the door alarms were not loud enough for staff to hear while they were in resident's rooms. An additional interview with the Maintenance Director, on 10/11/2022 at 10:36 AM, revealed that the facility's investigation determined that Resident #6 could have only eloped off of the secure residential unit by going out the front door by the nurse's station, as each of the other doors that were accessible to residents lead into secured courtyards. Further interview with the Maintenance Director revealed that the siren that was heard during the test and the strobe light system that were observed during the tour on 10/11/2022, were not in place when Resident #6 eloped on 07/23/2022. He stated that when he tested the system on 07/23/2022, he found that the doors were operating as designed and the alarm that was in place on 07/23/2022 sounded when the resident pressed on the exit bar for 15 seconds, and thus overrode the magnetic lock to exit off the unit. However, he confirmed, during tests conducted as part of the investigation, he found that the alarm was not loud enough to be heard when staff were in resident rooms with the door closed. In response, he explained, the facility had installed the additional siren and strobe light system. The Maintenance Director stated that the volume of the alarm that was in place at the time of the 07/23/2022 elopement was the sound that was first heard (during the test of the system observed on 10/11/2022) when the bar was pushed, prior to the onset of the additional siren, five seconds later. A test of the alarm system's original volume was conducted on 10/11/2022 at 11:06 AM. Observation in a resident room at the far end of the three-hundred (300) Hall (which was further down the hall than the room where staff were working on the night of the elopement and which was used for the test conducted by the Administrator, Admission Director, and Maintenance Director), revealed that the alarm that was initially in place could not be heard in the resident's room when the door was closed. Further observation revealed that the new siren system which had been installed after the elopement was sufficiently loud to be heard when the door was closed, even with a radio playing in the room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185435	A. Building B. Wing	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Village Nursing and Rehabilitation Center	1381 Campbell Lane Bowling Green, KY 42104

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During the tour with the Maintenance Director on 10/11/2022 at 11:10 AM, he pointed out the building where Resident #6 was found by staff. Observation revealed that to reach this building, Resident #6 had to traverse the facility property and cross US Highway 231, a five-lane road with a posted speed limit of forty-five (45 miles) per hour. Interview with the Assistant Director of Nursing (ADON), on 09/20/2022 at 2:50 PM, confirmed Resident #6 had eloped from the facility around 1:55 AM on 07/23/2022. The ADON stated the resident was found by facility staff off the facility's property, across the five-lane highway, at a place of business per the witness statements. The ADON confirmed the facility's investigation revealed the alarm system on the doors through which the resident exited were not loud enough for staff to hear. Interview with the Director of Nursing (DON), on 09/21/2022 at 9:52 AM, revealed Resident #6 eloped from the facility around 1:55 AM on 07/23/2022, and was found off the facility property across the five-lane highway, at a closed place of business by the facility's staff. She stated the facility failed to ensure the resident did not elope from the facility on 07/23/2022 as the alarm system on the doors (used to exit) was not loud enough for staff to hear. Interview with the Administrator, on 09/20/2022 at 5:40 PM, confirmed Resident #6 had eloped from the facility around 1:55 AM on 07/23/2022. The Administrator stated she conducted Resident #6's elopement investigation. She revealed the resident was found off the facility property across the five-lane highway at a closed place of business by the facility's staff. The Administrator confirmed the facility's investigation revealed the alarm system on the doors (used to exit) were not loud enough for staff to hear. Additional interviews with the Administrator on 10/11/2022 at 9:24 AM, 11:45 AM, 2:35 PM, and 5:00 PM revealed the facility reported the elopement to the State Agency in a timely manner (07/23/2022) and conducted a thorough investigation to determine the root cause of the incident. Witness statements were taken from staff, and all persons with possible knowledge of the incident were interviewed. The facility tested its alarm system. Per the Administrator, the facility took all the findings from the investigation through the QAPI system and provided a list of actions taken to correct the incident. Resident #6 was immediately placed on one-to-one (1:1) supervision after being returned to the facility and remained under constant supervision until she was sent out to the hospital later that day, due to non-elopement related behaviors. In response to the findings that the alarm system in place could not be heard by staff when they were working in resident rooms, the facility purchased a new system, with siren and strobe lights. The Administrator stated that during the time that facility was awaiting the new equipment, a dedicated staff was assigned to be at the nurses' station adjacent to the door was always visible and the alarm could be heard. In-services for all staff were conducted on 07/23/2022, and then again on 08/17/2022 when the new equipment was installed. All residents were re-evaluated for elopement risk, with 35 of 59 residents being identified at risk. Each of these resident's care plans was reviewed to assure that elopement risk was care planned, and the care plans were revised as needed. In addition to the in-services, the facility-initiated elopement drills that are still being conducted weekly. All findings were reported to the QA committee, with dated sign in sheets verifying all members attendance. Interview with the Administrator revealed that there had been no further elopements since each of the facility's actions had been implemented. The deficient practice was determined to be past noncompliance related to the facility identifying the IJ and implementing interventions to prevent recurrence of the situation. The facility's actions included the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185435	A. Building B. Wing	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Village Nursing and Rehabilitation Center	1381 Campbell Lane Bowling Green, KY 42104

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. The elopement incident and corrective action plans to prevent further incidents were reviewed through the facility's QAPI (Quality Assurance and Performance Improvement) program, with multiple meetings involving an interdisciplinary team. (Dates and attendees of this meeting were verified through record review.) 2. The facility conducted a root cause analysis. The facility investigated and determined that the elopement occurred because staff were unable to hear the alarm sound at the time the resident exited through the coded door which was used to secure the residential unit. (Verified through interview and review of the facility's investigation.) 3. In response to the root cause analysis, the facility purchased additional equipment, including a new annunciator system with a siren that can be heard through the entire facility. This system also includes a flashing strobe to alert staff when an attempt to exit through a coded door without first entering the code occurs. (The functioning of this system was verified through observation on 10/11/2022.) During the period the facility was awaiting installation of the new equipment, a dedicated staff was assigned to be the door monitor and assure that no residents left without staff knowledge (Verified through record review and interview.) 4. All staff were immediately provided in-services on the facility's elopement policy on 07/23/2022. Additional in-service was provided 08/17/2022 when the new equipment was installed. (These in-services were verified through record review and interview with staff on 10/11/2022 - 10/12/2022). 5. The facility began conducting elopement drills on a daily basis from 07/23/2022 through 08/06/2022. At this point, they are still conducted on a weekly basis. (The drills were verified through record review and interview with staff on 10/11/2022 - 10/12/2022.) 6. The facility began conducting door audits on a daily basis from 07/23/2022 through 08/05/2022. At this point they were still conducted on a weekly basis. (The audits were verified through record review and interview.) 7. On 07/23/2022, all residents were assessed for elopement risk. Thirty-five (35) of the 59 residents were identified at risk, based on ambulatory/locomotion status combined with other risk factors. (Verified through interview and a review of the assessments.) Those residents at risk for elopement had care plans for elopement reviewed and added/revised as needed. (Verified through interview and review of a sample of five residents to assure that, if identified at risk, the resident's care plan included the risk of elopement and interventions in response.) 8. Facility has conducted continuous audits of actions taken to assure ongoing compliance, with data from the audits reported back to QAPI committee. (Verified through record review and interview.) **The facility implemented the following actions to remove Immediate Jeopardy: 1. Dates and attendees of the Quality Assurance Performance Improvement were verified through record review. 2. The Root Cause Analysis was verified by interview and the review of the facility investigation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185435	A. Building B. Wing	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Village Nursing and Rehabilitation Center	1381 Campbell Lane Bowling Green, KY 42104

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. In response to the root cause analysis, the facility purchased additional equipment, including a new annunciator system with a siren that could be heard through the entire facility. The system also included a flashing strobe to alert staff when an attempt to exit through a coded door without first entering the code occurs. The functioning of this system was verified through observation on 10/22/2022. While facility was awaiting the installation of the new equipment, a dedicated staff was assigned to be the door monitor and assure that no residents left without staff knowledge. This was verified through record review and interview. 4. Staff were educated on the facility's elopement policy on 07/23/2022. Additional inservice training was done on 08/17/2022 when the new equipment was installed. These in-services were verified through record review and interview with staff on 10/11/2022 - 10/12/2022. 5. The facility initiated daily elopement drills on 07/23/2022 - 08/06/2022. After 08/06/2022, the elopement drills were done on a weekly basis. The drills were verified through record review and interview with staff on 10/11/2022 - 10/12/2022. 6. The facility began conducting door audits on a daily basis from 07/23/2022 through 08/05/2022. At this point they were still conducted on a weekly basis. Audits were verified through record review and staff interview. 7. On 07/23/2022, all residents were assessed for elopement risk. Thirty-five (35) of the fifty-nine (59) residents were identified at risk, based on ambulatory/locomotion status combined with other risk factors. These were verified through interview and a review of the assessments. The residents at risk for elopement had care plans for elopement reviewed and added/revised as needed. This was verified through interview and review of a sample of five (5) residents to assure that, if identified at risk, the resident's care plan included the risk of elopement and interventions in response. 8. The facility has conducted continuous audits of actions taken to assure ongoing compliance, with data from the audits reported back to QAPI committee. This was verified through record review and interview. 40417