STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265832	A. Building B. Wing	07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Senath South Health Care Center	300 East Hornbeck Street Senath, MO 63876

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 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. 36220 Based on observation and interview, the facility failed to treat residents with dignity and respect when staff provided plastic or styrofoam dinnerware and did not provide enough seating for the residents on the Women's Unit. This had the potential to affect all of the residents on the Women's Unit. The facility census was 139. Observations on 7/10/22 at 2:03 P.M., of the Women's unit dining room, showed: - All 22 residents received their lunch meal at 2:00 P.M., with the meal served on paper plates, styrofoam bowls, foam cups, and plastic utensils; - Dining room with six tables and 13 chairs for 22 residents at meal times. Observations on 7/11/22 at 9:38 A.M., of the Women's unit, showed: - Breakfast trays brought to the Women's Unit with two trays sitting on top of the warming cart; - Dining room with 13 chairs and six tables available to accommodate 22-24 residents on the unit; - Thirteen residents sat in dining chairs and with staff calling residents' names to come get their trays; - One resident stood in the hallway and used a bedside table to eat breakfast; - Six resident meals served on paper plates. Observations on 7/11/22 at 2:00 P.M., of the Women's Unit, showed: - Dining room with 12 chairs and six tables to accommodate the 22-24 residents on the unit; - Lunch trays brought to the unit at 2:08 P.M.; - Twelve residents sat in dining chairs with staff calling residents' names to come get their trays; (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	- Eight resident meals served on paper plates. Observation on 7/11/22 at 2:33 P.M. of main dining room showed: -Residents eating on paper plates and using plastic utensils. Observations on 7/12/22 at 12:51 P.M., of the Women's Unit, showed: - Dining room with 13 chairs and six tables to accommodate the 22-24 residents on the unit; - Administrator sat in one of the 13 resident chairs, talked with the residents, and talked on his/her phone during the lunch meal; - Twelve residents sat in the dining room chairs and the meals were served on styrofoam plates; - One resident sat in the floor and ate two sandwiches that lay on plastic baggies on the floor without a plate or tray for his/her food to lay on. Four residents left the dining room and walked within three inches of the resident's food that lay on the floor. The hall cart from the men's unit pushed through the dining room and came within five inches of the resident's food that lay on the floor. During an interview on 7/11/22 at 11:05 A.M., Resident #289 said there aren't enough tables and chairs in the dining room for the residents to eat their meals. It was a fight sometimes to get a chair to sit in to eat his/her meals. They did not eat in shifts, everyone ate their meals at the same time. During an interview on 7/11/22 at 11:32 A.M., Resident #81 said most of his/her meals were eaten in his/her room. There weren't enough tables and chairs in the dining room and it was hard to get a chair at most meals. Everyone on the unit eats their meals at the same time. He/she didn't like the hassle and didn't want to get into an argument with another resident over a chair. During an interview on 7/11/22 at 2:24 P.M., CNA O said he/she was not aware why paper plates and plastic ware were being used. CNA O said the facility had been using paper plates and plastic utensils for approximately a month. He/she doesn't know why there aren't enough tables or chairs in the dining room. The residents all eat their meals at the same time, not in shifts. The residents have to hurry to try to get a place to sit to eat. During an interview on 7/11/22 at 2:30 P.M., Dietary UU said the facility did not have enough plates or silverware so that was why paper plates, styrofoam bowls, and plastic utensils were given to the residents during their meals. During an interview on 7/14/22 at 7:45 P.M., the Director of Operations said she would expect residents be treated with respect and dignity. She would expect the dining rooms to have enough chairs and tables to accommodate all residents. She did not realize there weren't enough tables and chairs to accommodate all of the residents on the Women's Unit at meal times. She would not expect for the residents to be sitting on the ground and the residents should be served on appropriate dinnerware. The facility did not provide a resident rights policy.

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 46521 Based on interview and record review, the facility failed to issue the Notice of Medicare Non-Coverage (NOMNC) forms with the required information, to document the resident's choice to have continuation of the Medicare covered services on the Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) forms, and to complete and notify in the proper time frame of at least two calendar days before services were to end for the NOMNC and the SNF ABN forms, for three of three sampled residents (Resident #33, #63, and #127). The facility census was 139. 1. Record review of Resident #33's medical record showed: - Skilled Medicare Services started on 1/21/22; - The resident remained in the facility after the skilled Medicare services ended on 1/26/22; - No NOMNC provided to the resident; - The incorrect Advanced Beneficiary Notice (ABN) form signed by the resident on 1/23/22 instead of the correct SNF ABN form; - The facility failed to provide the correct SNF ABN form to the resident. 2. Record review of Resident #63's medical record showed: - Skilled Medicare Services started on 3/21/22; - The resident remained in the facility after the skilled Medicare services ended on 3/27/22; - No NOMNC provided to the resident; - The incorrect ABN form signed by the resident on 3/25/22 instead of the correct SNF ABN form; - The facility failed to provide the correct SNF ABN form to the resident. 3. Record Review of Resident #127's medical record showed: - Skilled Medicare Services started on 1/10/22; - The resident remained in the facility after the skilled Medicare services ended on 1/26/21; - No NOMNC provided to the resident; - The incorrect ABN form signed by the resident on 1/23/22 instead of the correct SNF ABN form; - The facility failed to provide the correct SNF ABN form to the resident. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/14/22 at 4:20 P.M., the medical records staff said he/she was responsible for the SNF ABN forms. The medical records staff said he/she was not aware that providing an NOMNC form was necessary. He/she did not know the wrong (SNF ABN) form had been completed. During an interview on 7/14/22 at 7:45 P.M., the Director of Operations said she would expect the correct SNF ABN forms to be completed and the NOMNC to be provided to the residents and/or legal guardians. The facility did not provide a policy.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - 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** 31057 Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #1), with a history of unwelcome behaviors towards others, was free from abuse that resulted in Resident #1's death. On [DATE], two residents (Resident #1 and #2) had a physical altercation in their room. Facility staff noted blood and lacerations on Resident #1's head. Staff moved Resident #1 to a different room, but did not monitor or redirect him/her when Resident #1 later reentered the room with Resident #2. Facility staff entered Resident #1 and #2's room at 3:45 A.M., and found Resident #1 face down in the floor, unresponsive. Resident #1 was pronounced dead at the hospital and the cause of death listed as strangulation. The facility census was 139. The administrator was notified on [DATE] of an Immediate Jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE], as confirmed by surveyor onsite verification. Record review of the facility Abuse and Neglect policy, dated 2022, showed: - Physical abuse defined as purposefully beating, striking, wounding, and or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner; - This facility will be committed to protecting the residents from abuse by anyone, including but not limited to, the facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends, and or any other individuals; - Employees will be trained through orientation and ongoing training on issues related to abuse prohibition practices such as dealing with an aggressive resident, reporting allegations without fear of reprisal, recognizing signs of burn out, frustrations or stress that may lead to abuse and the definition that constitutes abuse, neglect and misappropriation of resident property; - The facility will identify and correct by providing interventions in which abuse, neglect, or misappropriation will more likely to occur by assessment of the physical environment, which may make abuse or neglect more likely to occur, such as more secluded area in the facility, the deployment of staff on each shift in sufficient numbers to meet the resident needs and that the staff will be knowledgeable of resident care needs; - Residents who allegedly mistreat another resident, will be removed from contact with the resident during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches and placement considering his or her safety, as well as the safety of other residents and employees in the facility. Record review of the Nursing Staff Sheet, dated [DATE], showed: - Cognitive unit staffing with one LPN (LPN TT), and one CNA (CNA DD) for the night shift. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Record review of Resident #1's Pre-Admission Screening/Resident Review (PASRR), dated [DATE], showed: - Met the federal definition of serious mental illness, but did not require specialized services; - Met the federal definition of intellectual disability/related condition (ID/RC), but did not require specialized services; - Diagnoses of bipolar, intermittent explosive disorder, depression, mild intellectual disability, and developmental delay and seizure disorder. Record review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by the facility staff, dated [DATE] showed: - Admission to the facility on [DATE]; - Diagnoses of schizophrenia (mental disorder of a type involving a breakdown in the relation between thought, emotion, and behavior, leading to faulty perception, inappropriate actions and feelings, withdrawal from reality and personal relationships into fantasy and delusion, and a sense of mental fragmentation), bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), depression, chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problem); - Cognition impaired; - Little interest or pleasure in doing things, ,d+[DATE] days out of the past 7 day period; - Feeling down, depressed, or hopeless, ,d+[DATE] days out of the past 7 day period; - Trouble concentrating on things, such as reading the newspaper or watching television, ,d+[DATE] days out of the past 7 day period; - Requires supervision of one staff member for exiting secure unit; - Independent with activities of daily living; - Continent of bowel and bladder; - Received antipsychotic (used to treat certain types of mental health problem whose symptoms include psychotic experiences), antidepressant (medications used to treat depression), and anticoagulation (used to prevent blood clots) medications seven days a week on a routine basis; - Guardian (a person appointed by a court to have the care and custody of a minor or of an adult person legally determined to be incapacitated) in place. Record review of the resident's [DATE] Physician Order Sheet (POS) showed: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Diagnoses of chronic obstructive pulmonary disease, acute embolism and thrombosis of deep vein of lower extremity (blood clot), bipolar disorder, major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily living), intermittent explosive disorder (repeated, sudden episodes of impulsive, aggressive, violent behavior or angry verbal outbursts in which a person reacts grossly out of proportion to the situation), epilepsy (seizure), intellectual disability (term used when there are limits to a person's ability to learn at an expected level and function in daily life); - Monitor behaviors every shift; - May have psych evaluation and treatment as needed; - Full code (emergency lifesaving procedure performed when the heart stops beating, cardiopulmonary resuscitation (CPR)). Record review of the resident's care plan, revised on [DATE], showed: - Behavioral problems of verbal and physical aggression related to schizoaffective disorder and with interventions to intervene as necessary to protect the rights and safety of others, approach and speak in a calm manner, divert attention and remove from the situation and take alternate location if needed; - Monitor behavioral episodes and attempt to determine underlying cause, consider location, time of day, person involved and situation, document behavior and potential causes; - If reasonable, discuss the resident behavior and explain/reinforce why the behavior considered inappropriate and/or unacceptable to the resident; - Praise any indication of the resident progress/improvement in behavior; - The resident triggered for negative behaviors so not allowed to call family via the phone. Record review of the resident's progress notes showed staff documented: - On [DATE] at 1:35 A.M., the resident became involved in a verbal altercation with his/her roommate. A PRN medication administered per the resident's request. The resident with a small laceration noted to the his/her forehead with minimal bleeding, but the resident denied being hit. This nurse cleansed the area with Dakin's Wound Cleanser (DWC) (a wound cleanser solution) and then the resident asked the nurse to leave him/her alone. The resident appeared calm at that time. The resident moved to another room for the night and he/she agreed; -Further review of the resident's progress notes showed staff did not document any further interventions or increased monitoring done after this incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- On [DATE] at 3:45 A.M., CNA B called the nurse to come to the resident's assigned room. Upon entering the resident's room, Resident #1 lay face down on the floor, unresponsive. The nurse detected no pulse and no visual rise or fall of the resident's chest, the nurse called a code blue (a code used to signal others to a person with no heartbeat) and initiated CPR at 3:47 A.M. Notification of the physician and orders received to send the resident to the emergency room . Notified the ambulance at 3:48 A.M., and at the facility at 3:53 A. M. The ambulance left in route for the hospital at 4:05 A.M. The DON and the Administrator notified. The nurse called the guardian three times with no success with a message left to return the call at their earliest convenience. The nurse called report to the Registered Nurse (RN) at the hospital. 2. Record review of Resident #2's PASRR, dated [DATE], showed: - Met the federal definition of serious mental illness, but did not require specialized services; - Met the federal definition of intellectual disability/related condition (ID/RC), but did not require specialized services; - Diagnoses of behaviors, schizophrenia, and dementia, mild mental retardation (a below-average intelligence or mental ability), borderline intellectual function. Record review of the resident's care plan, revised on [DATE], showed: - Little or no activity involvement related to his/her wishes not to participate; - Manifestation of behaviors related to his/her mental illness that may create disturbances that affect others, behaviors including being verbal and physically aggressive; - Monitor for elopement attempts and with history of schizophrenia and a history of self harm. Record review of the resident's quarterly MDS, dated [DATE], showed: - Cognition intact; - Admission to facility on [DATE]; - Diagnoses of schizophrenia, hypertension (high blood pressure), and diabetes (a chronic health condition that affects how your body turns food into energy); - Required supervision of one staff member for exiting secure unit; - Independent with activities of daily living; - Continent of bowel and bladder; - Received antipsychotic and insulin medications seven days a week on a routine basis; - No guardian in place. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the resident's [DATE] POS showed: - Diagnoses of hypertension, schizophrenia, and diabetes; - Monitor behaviors every shift; - May have psych evaluation and treatment as needed; - Full code status. Record review of the resident's progress notes showed: - On [DATE] at 1:40 A.M., the resident involved in a verbal altercation with another resident. As needed medication administered without incident. The resident calmed and sat in the hallway. - No other behaviors documented on this date; - No other interventions put in place at this time. During an interview on [DATE] at 1:25 P.M., Resident #2 said Resident #1 hit him/her in the balls while he/she was asleep last night. Resident #2 said he/she hit Resident #1 in the jaw one time and pushed him/her down. Resident #1 came at Resident #2 again, and Resident #2 called for help but no one came. CNA DD said to go back to his/her room and to be quiet and took Resident #1 to another room. Resident #1 came back later and fell on the other side of the bed. Resident #2 said a spirit may have pushed Resident #1. Resident #2 said the first time he/she hit Resident #1, his/her nose was bleeding, the second time Resident #1 didn't move. Resident #2 said someone pulled Resident #1 out of the corner and did CPR. During an interview on [DATE] at 5:30 P.M., CNA DD said he/she worked the night shift on [DATE] to [DATE]. CNA DD said he/she is routinely the only staff on the hall. There is an LPN assigned to the hall, but he/she is at the nurse's station on the other side of the unit's closed doors. CNA DD said on [DATE], Residents #1 and #2 were arguing with each other at about 12:30 A.M. At around 1:00 A.M., Resident #1 walked out of the room and was bleeding from the back and side of the head with blood on the floor. CNA DD called LPN TT twice using his/her cell phone due to being the only CNA on the hall to report the incident to LPN TT. The nurse came to the unit and took Resident #1 to the nurses' station while Resident #2 sat in his/her room and did not say what happened at that point. LPN TT told CNA DD to move Resident #1 to another room for the night and to leave Resident #2 in his/her room. The residents settled down and went to sleep. No other interventions were put in place at that time. At about 3:00 A.M., he/she heard a noise, saw Resident #1 go back to his/her room, but he/she had to complete bed checks on the other residents, as she was the only staff on the hall, and was unable to go directly to Residents #1 & 2's room. At approximately 3:30 A.M., CNA DD saw Residents #1 and 2's call light was on and went to assist. CNA DD found Resident #1's privacy curtain partially closed. When he/she pulled the curtain open, Resident #1 lay across the chair facing towards the wall, head was down and lay over the chair like he/she was trying to use the call light. He/she was unresponsive at that time. CNA DD called LPN TT. Both the CNA and LPN moved Resident #1's body to the floor and started CPR. Resident #2 calmly remained in the room and said he/she hit Resident #1 three times and was not sorry for it. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 9:30 A.M., LPN TT said CNA DD called him/her at approximately 1:00 A.M., to report Resident #1 and Resident #2 had been into a verbal and physical altercation. LPN TT went to the hall and upon entering standing in the door was both residents and CNA DD. LPN TT ask what was going on and CNA DD said they got into it. LPN TT then noticed Resident #1 had a small scratch on his/her forehead so he/she took him/her to the nurse's station and cleaned the area which was only a small scratch like a fingernail mark. LPN TT asked Resident #1 if he/she was ok and he/she said yes, denied being hit and asked for a prn medication. LPN TT also administered a PRN to Resident #2. He/she then had CNA DD to put Resident #1 in another resident room and allow Resident #2 to go back to his/her room and instructed the CNA to keep the two separated for the night. LPN TT gave no further instructions to the CNA to follow regarding the two residents. CNA DD at this time did not report any physical altercation between the two residents. At approximately 3:45 A.M., CNA DD called and stated Resident #1 would not answer him/her and was not breathing. Upon entering the room he/she saw Resident #1 laying on the floor on his/her stomach with his/her head in a laundry basket with both call lights draped across his/her left shoulder. LPN TT observed for respirations, found none, rolled the resident over and noted a bloody nose, no pulse, and immediately started CPR. After Resident #1 was transferred and towards the end of the shift CNA DD stated to LPN TT Resident #2 hit Resident #1 with the bedside table earlier in the night. He/she then asked CNA DD why he/she did not report this to him/her when it happened and CNA DD said he/she thought he/she did. LPN TT told CNA DD if he/she had reported the resident hitting he/she would have begun neuro checks (brief, serial bedside exams performed by nursing to evaluate for changes in clinical status or neurological function) and sent both resident to the hospital per facility policy. During a telephone interview on [DATE] at 5:15 P.M., the county Coroner said earlier this date, he/she had been contacted by the hospital (where Resident #1 had been sent) to report a suspicious death by strangulation. Hospital staff informed the Coroner Resident #1 appeared as if he/she had been beaten up with bruising around the neck which appeared as if he/she had been strangled. The Coroner said he/she contacted the nursing home and was informed the resident had an altercation with another resident. The Coroner viewed Resident #1's body which showed bruising marks around the neck, swelling of the eyes, and a pump knot (raised area of bruising) with bleeding on the forehead. He/She then requested an autopsy to be performed by the Forensic Examiner for the exact cause of death. Observaton and interview on [DATE] at 2:10 P.M., the State Highway Patrol officer (HP) and the County Sheriff (CS) officer arrived back onsite and announced the official cause of death had been determined to be strangulation by the Forensic Examiner. Observations on [DATE] at 1:30 P.M., of the cognitive unit, where Resident #1 and Resident #2 resided, showed a long hallway located behind locked double doors. Entry to the cognitive unit door must be made by using a key pad with an assigned code. The nurse's station was an enclosed glass desk area which was locked from the inside and was located outside the locked doorway with staff being unable to see down the cognitive hall and or hall next to the unit sitting at the nurses station. On [DATE] there were 30 residents that resided on the unit with one CNA and one LPN scheduled. The CNA was the only staff member on the hall as the LPN was stationed at the enclosed nurse's station on the outside of the shut doors. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Note: At the time of the complaint survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview, and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s). Complaint #MO203509

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	265832	A. Building B. Wing	07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Senath South Health Care Center	300 East Hornbeck Street Senath, MO 63876

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46521 Based on record review and interview, the facility failed to provide a Preadmission Screening and Resident Review (PASRR) (a federally mandated preliminary assessment to determine whether a resident may have a mental illness or an intellectual disorder, to determine the level of care needed) for one resident (Resident #30) out of three sampled residents. The facility census was 139. Review of the facility's PASARR Assessments Policy and Procedure, dated 7/9/21, showed: - Upon the resident's admission to the facility and upon the facility receiving the PASARR, the Customer Service Consultant will make a copy of the PASARR with the clinical history of previous behaviors and services provided. The Customer Service Consultant will give a copy of the PASARR to the Director of Nursing, MDS/Care Plan Coordinator and Social Services Director; - The plan of care will holistically address the resident's needs to assist in the resident reaching and maintaining their highest level of mental and psychosocial functioning; - The PASARR will be utilized as an instrument to assist the facility in maintaining as much as possible, previous treatment modalities effective in the resident's life prior to placement at this facility; - The PASARR will be a guide in developing an assessment that will assist in the continuity of care and services in the best interest of the resident. 1. Record review of Resident #30's medical record showed: - An admitted [DATE]; - Diagnoses of depression (loss of pleasure or interest in life); - No level I PASRR. Record review of the quarterly Minimum Data Set (MDS), a federally mandated assessment, required to be completed by the facility), dated 4/4/22, showed: - Moderately impaired cognition; - No level one PASRR documented. During an interview on 07/14/22 at 9:35 A.M., the medical records staff said Resident #30 may not have needed a level one PASRR since he/she did not require a Level II. He/she was responsible for making sure the Level I and Level II's were completed. During an interview on 7/14/22 at 7:45 P.M., the Director of Operations, said she would expect there to be a Level I PASRR for all residents.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26904 Based on interview and record review, the facility failed to provide an ongoing program of activities to meet the interests and physical, mental, and psychosocial well-being of each resident for 17 residents (Resident #16, #25, #28, #29, #41, #46, #67, #71, #72, #74, #81, #91, #93, #95, #130, #289 and #440) out of 28 sampled residents. The facility's census was 139. Record review of the facility's Activities policy, revised 2/16/21, showed: - The Life Enhancement Director coordinates the activities section of the comprehensive assessment and ensures that activities will be designed to promote and enhance the emotional health, self esteem, pleasure, comfort, education, creativity, success and independence for all residents, based on interview and assessing the resident's likes and dislikes; - If the resident requires more intensive interventions for activities, 1:1 programming relevant to the resident's specific needs, interests, culture, and history/background, then an individualized activities plan will be developed to enhance their psychosocial well being; - To ensure that an ongoing program of activities will be designed, The Life Enhancement Director will monitor large and small groups activities, 1:1 programming and self directed activities. The Life Enhancement Director will modify the care plan interventions to resident-centered approaches to promote self expression; - The activities section of the Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility, will be reviewed on all residents to ensure that the facility identifies resident's interests and needs and has a plan in place for individual 1:1 and self-directed activities; - Under the direction of the Life Enhancement Director/Activities Director, documentation will be completed on each resident's activity within the facility daily. Documentation will note participation in activities and specific resident-centered individualized programming that will include but not limited to; the emotional health, physical, cognition, promotion of self esteem, pleasure, comfort, education, creativity, success and independence. Observations on 7/10/22 at 9:23 A.M., showed: - The June 2022 Activities Calendars posted on all halls of the facility; - There were no July 2022 Activities Calendars posted. Observations on 7/10/22 through 7/14/22 showed: - No general activities provided for groups or gatherings. 1. Record review of Resident #16's medical record showed: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- An admitted [DATE]; - Age of [AGE] years; - Diagnoses included bipolar disorder (a disorder with episodes of mood swing ranging from depressive lows to manic highs) and borderline personality disorder (a mental disorder in which you have a rigid and unhealthy pattern of thinking, functioning and behaving). Record review of the resident's annual MDS, dated [DATE], showed: - Cognition intact; - Somewhat important activities included reading, music, group activities, outdoor activities, and religious activities. During an interview on 7/14/22 at 10:46 A.M., the resident said it would be nice to have outside activities or just general activities. A social hour with other halls would be great. Resident #16 said he/she understands those things would need to be supervised, but it is like a jail when they only get to go outside just to smoke. 2. Record review of Resident #25's medical record showed: - admitted on [DATE]; - Age of [AGE] years; - Diagnoses included bipolar disorder and psychotic disorder with delusions (unshakeable belief in something implausible, bizarre or obviously untrue). Record review of the resident's annual MDS, dated [DATE], showed: - Moderately cognitively impaired; - Very important activities included favorite activities; - Somewhat important activities included music, outdoor activities, and group activities. During an interview on 7/11/22 at 9:19 A.M., the resident said he/she likes activities, but was only offered the same old movies, and once in a while they got to play bingo and board games. 3. Record review of Resident #28's medical record showed: - An admitted [DATE]; - Age of [AGE] years; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Diagnoses of schizophrenia (a disorder that affects a person's ability to think, feel and behave correctly), major depressive disorder (a severe mood disorder with persistent or extended periods of depressed mood), bipolar disorder, intermittent explosive disorder (a disorder involving repeated episodes of impulsive, aggressive, violent behavior or angry outbursts in which you react grossly out of proportion to the situation), post-traumatic stress disorder (a disorder causing difficulty recovering after experiencing or witnessing a terrifying event). Record review of the resident's admission MDS, dated [DATE], showed: - Mild cognitive impairment; - Very important activities included outdoor activities; - Somewhat important activities included music. During an interview on 7/10/22 at 3:49 P.M., the resident said he/she didn't care for bingo and board games, but there wasn't much anything offered that he/she was interested in. 4. Record review of Resident #29's medical record showed: - An admitted [DATE]; - Age of [AGE] years; - Diagnoses of schizoaffective disorder (a condition including schizophrenia and other mood disorder). Record review of the resident's admission MDS, dated [DATE], showed: - Cognition intact; - Very important activities included music, reading, group activities, outside activities, animals/pets, and favorite activities. During an interview on 7/11/22 at 2:44 P.M., the resident said all that was offered was the same old movies, bingo and some board games. It would be nice to have some good movies and some other things to do. 5. Record review of Resident #41's medical record showed: - admitted on [DATE]; - Age of [AGE] years; - Diagnoses of traumatic brain injury (TBI) (an injury that affects how the brain works), schizoaffective disorder, bipolar disorder, anxiety (feeling nervous, restless, or tense), and major depressive disorder; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident attended activities with interests of cards and bingo per a quarterly activity assessment, dated 4/7/22. Record review of the resident's annual MDS, dated [DATE], showed: - Moderately impaired cognitive status; - Snacks between meals as activity preference. Record review of the resident's care plan, dated 4/28/22, did not address activities with interventions. Observations of the resident, showed: - On 7/10/22 at 3:22 P.M., the resident lay quietly in bed and watched television (TV); - On 7/11/22 at 12:55 P.M., the resident lay quietly in bed, watched TV, and chewed on the bed sheet that covered him/her; - On 7/11/22 at 3:47 P.M., the resident lay in bed and watched TV; - On 7/12/22 at 9:20 A.M., the resident lay quietly in bed with his/her eyes closed; - On 7/13/22 at 9:46 A.M., the resident lay quietly in bed with his/her eyes closed; - On 7/14/22 at 9:37 A.M., the resident lay quietly in bed with his/her eyes closed. During an interview on 7/11/22 at 10:05 A.M., the resident said he/she doesn't attend activities because he/she doesn't like the activities provided. 6. Record review of Resident #46's medical record showed: - admitted on [DATE]; - Age of [AGE] years; - Diagnoses of schizophrenia, and bipolar disorder. Record review of the resident's annual MDS, dated [DATE], showed: - Moderately cognitive impairment; - Very important activities included music, group activities, outside activities, and favorite activities. During an interview on 7/11/22 at 10:40 A.M., the resident said the facility only had the television in the dining room for residents to watch. He/she said there were hardly any activities offered. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Record review of Resident #67's medical record showed: - An admitted [DATE]; - Age of [AGE] years; - Diagnoses of bipolar disorder, borderline personality disorder, hyperactivity disorder (chronic condition including attention difficulty, hyperactivity and impulsiveness), obsessive-compulsive disorder (characterized by unreasonable thoughts and fears that lead to compulsive behaviors), anxiety, and oppositional defiant disorder (disobedient behavior to authority figures). Record review of the resident's annual MDS, dated [DATE], showed: - Moderate cognitive impairment; - Very important activities included music, group activities, outside activities, and favorite activities. During an interview on 7/14/22 at 9:43 A.M., the resident said he/she would like to have activities like water balloons and water guns outside, but they never got to do that anymore. He/she said they really had not had activities in a while. He/she would really love it if there were church services and feels that helps him/her. 8. Record review of Resident #71's medical record showed: - An admitted [DATE]; - Age of [AGE] years; - Diagnoses of schizoaffective disorder. Record review of the resident's annual MDS, dated [DATE], showed: - Cognition intact; - Very important activities included reading, music, animals/pets, group activities, outdoor activities, and religious activities. During an interview on 7/12/22 at 10:30 A.M., the resident said the only activities offered were bingo and he/she got too confused trying to play that, but he/she would like to try some different things. 9. Record review of Resident #72's medical record showed: - An admitted [DATE]; - Age of [AGE] years; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Diagnosis of anxiety. Record review of the resident's admission MDS, dated [DATE], showed: - Cognition intact; - Very important activities included music and favorite activities; - Somewhat important activities included reading and the news. During an interview on 7/10/22 at 12:37 P.M., the resident said he/she would like to have more activities than playing cards. 10. Record review of Resident #74's medical record showed: - An admitted [DATE]; - Age of [AGE] years; - Diagnosis of schizophrenia. Record review of the resident's admission MDS, dated [DATE], showed: - Cognition intact; - Activities somewhat important included reading and the news; - Activities very important included music and favorite activities. During an interview on 7/14/22 at 10:56 A.M., the resident said it would be nice to have activities that were age appropriate. The resident said they are treated like little kids with the constant coloring, but it would be nice to be treated like adults. He/she would like activities that aid their mental health since that was why they were here. Painting fingernails was not going to help them. It would be nice to have some exercises/yoga/meditation or coping skills. He/she does not usually participate in activities because they were pointless. 11. Record review of Resident #81's medical record showed: - admitted on [DATE]; - Age of [AGE] years; - Diagnosis of schizoaffective disorder; - No documentation of an activity assessment. Record review of the resident's admission MDS, dated [DATE], showed: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Cognition intact; - Very important activities of music and outdoors; - Somewhat important activities of reading and favorite activities. Review of the resident's care plan, dated 5/27/22, showed staff did not address activities with interventions. Record review of the resident's Preadmission Screening and Resident Review (PASRR), a federally mandated preliminary assessment to determine whether a resident may have a mental illness or an intellectual disorder and to determine the level of care needed, dated 5/2/22, showed: - Resident with serious mental illness; - Resident required an activities program for socialization and crisis intervention. During an interview on 7/10/22 at 3:04 P.M., the resident said they have no activities on their locked unit. He/she would like to have items to do hair, nails, and makeup. If the residents had something to do, then that might keep the other residents from arguing and fighting. He/she stays in his/her room with their roommate so they don't get disturbed by other residents. Observation of the resident, showed: - On 7/10/22 at 11:45 A.M., the resident lay quietly in bed; - On 7/11/22 at 9:25 A.M., the resident lay quietly in bed; - On 7/11/22 at 3:39 P.M., the resident lay quietly in bed; - On 7/12/22 at 9:16 A.M., the resident sat outside and smoked a cigarette in the smoking area while supervised by staff; - On 7/13/22 at 9:55 A.M., the resident lay quietly in bed. 12. Record review of Resident #91's medical record showed: - An admitted [DATE]; - Age of [AGE] years; - Diagnoses of personality disorder, major depressive disorder, bipolar disorder and anxiety. Record review of the resident's annual MDS, dated [DATE], showed: - Cognition intact; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Very important activities included music, animals/pets, group activities, favorite activities, and outside activities. During an interview on 7/10/22 at 2:19 P.M., the resident said all he/she did for activities was play games on his/her cell phone. There were no activities, except sometimes movies, and would love to have some kind of gaming system for them to enjoy. The resident said there was another resident here in the facility that had one in his/her room, however, staff now will not let anyone else go into his/her room to play the games. He/she said would love to have holidays and celebrating parties. 13. Record review of Resident #93's medical record showed: - An admitted [DATE]; - Age of [AGE] years; - Diagnoses of paranoid schizophrenia, (a severe mental health condition that can involves delusions and paranoia). Record review of the resident's annual MDS, dated [DATE], showed: - Cognition intact; - Somewhat important activities included music, reading, group activities, outside activities, religious activities, and favorite activities. During an interview on 7/12/22 at 11:42 A.M., the resident said the facility didn't really offer any activities he/she would be interested in. 14. Record review of Resident #95's medical record showed: - admitted on [DATE]; - Age of [AGE] years; - Diagnoses of schizoaffective disorder, bipolar disorder, borderline personality disorder, major depressive disorder, and anxiety; - Resident participated in groups and activities with interests of cards, bingo and listening to music per a quarterly/annual participation review, dated 4/25/22. Record review of the resident's annual MDS, dated [DATE], showed: - Cognition intact; - Very important activities of reading, music, animals/pets, news, groups, favorite activities, outdoors, religious services. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the resident's care plan, dated 4/25/22, showed staff did not address activities with interventions. Observations of the resident showed: - On 7/10/22 at 3:22 P.M., the resident sat out in the dining room quietly and visited with other residents; - On 7/11/22 at 12:50 P.M., the resident sat out in the dining room quietly and visited with other residents while waiting to smoke; - On 7/11/22 at 3:45 P.M., the resident stood quietly in the dining room and visited with other residents; - On 7/12/22 at 9:16 A.M., the resident stood at the medicine cart and quietly spoke with staff; - On 7/13/22 at 9:55 A.M., the resident sat out in the dining room quietly and visited with other residents; - On 7/14/22 at 9:00 A.M., the resident sat out in the dining room quietly and visited with other residents. 15. Record review of Resident #130's medical record showed: - An admitted [DATE]; - Age of [AGE] years; - Diagnosis of schizophrenia. Record review of the resident's quarterly MDS, dated [DATE], showed: - Mild cognitive impairment; - Activities somewhat important included painting, drawing, coloring, movies and TV. During an interview on 7/10/22 at 12:27 P.M., the resident said he/she would like to have more activities instead of board games. 16. Record review of Resident #289's medical record showed: - admitted on [DATE]; - Diagnoses of schizoaffective disorder, bipolar disorder, anxiety, and social phobia (a chronic mental health condition in which social interactions cause irrational anxiety); - Very important activities of music, groups, favorite activities, and outdoors per the resident's Activity interview for daily activity and preferences, dated 6/29/22. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the resident's admission MDS, dated [DATE], showed: - Cognition intact; - Very important activities of reading, music, news, groups, favorite activities, outdoors, and religious services. During an interview on 7/10/22 at 12:55 P.M., the resident said the residents had no activities and were bored. If they had activities to keep them busy, it might keep some of the residents from arguing and fighting with each other. Observations of the resident, showed: - On 7/10/22 at 10:55 A.M., the resident sat quietly on the side of the bed; - On 7/11/22 at 9:20 A.M., the resident stood quietly at the exit doors of the unit; - On 7/11/22 at 3:38 P.M., the resident stood quietly in the dining room and visited with other residents; - On 7/12/22 at 9:16 A.M., the resident sat outside and smoked a cigarette in the smoking area while supervised by the staff; - On 7/13/22 at 10:05 A.M., the resident sat quietly in the dining room and visited with other residents; - On 7/14/22 at 9:07 A.M., the resident sat quietly in the dining room and ate his/her breakfast. Record review of the resident's care plan, revised on 7/13/22, showed: - The resident with little or no activity involvement related to the resident's wishes not to participate; - The resident needed encouragement from the staff to participate in activities. 17. Record review of Resident #440's medical record showed: - An admitted [DATE]; - Age of [AGE] years; - Diagnoses of schizoaffective disorder, personality disorder, anxiety disorder, and bipolar disorder. Record review of the resident's admission MDS, dated [DATE], showed: - Cognition intact; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Very important activities included music, favorite activities and outdoor activities; - Somewhat important activities included groups of people. During an interview on 7/14/22 at 11:00 A.M., the resident said there were no activities to help them cope and address their problems. They were all there for the same reasons. The resident said social groups to help them cope and discuss their anxiety/depression and how not to fight and support each other would be awesome. Observations of the 300 Hall (Cognitive Unit) showed: - On 7/10/22, 7/11/22, 7/12/22, and 7/13/22, no activities observed; - On 7/12/22 at 10:12 A.M., the activity staff member brought a wagon with a bingo game and bingo cards; - The wagon with the bingo game and bingo cards sat in the dining room of the 300 Hall and no activity done. Observations of the Women's Unit showed: - On 7/10/22, 7/12/22, 7/13/22, and 7/14/22, no activities observed; - On 7/11/22 at 8:33 A.M., the residents painted fingernails. During an interview on 7/11/22 at 1:38 P.M., the Hall Monitor (HM) RR said activities only come on the Men's Unit once or twice a month. During an interview on 7/14/22 at 7:48 P.M., the Director of Operations said she would expect activities to be ongoing, age appropriate and meet the needs of each individual resident. During a phone interview on 7/28/22 at 3:55 P.M., the Activity Director (AD) said the facility does have activities, and staff was doing them. Staff does have trouble getting the residents to participate. For example, the residents won't play bingo unless the prizes were snacks. The AD was out of snacks, so the residents were not interested in playing. The residents go outside to play basketball, the hoop on the men's unit hadn't been repaired yet, but staff can take them outside from the step down unit. Staff was supposed to be doing group concerns, but had just been doing individual concerns lately with the plan being to get back to group concerns. The June calendars were still out because the facility had a rodent problem and the rodents chewed up the paper for the July calendars. The large calendar in the men's unit did not get hung up because the residents tore the board down. Residents do get an activity calendar at the beginning of each month. 36220 37575 42699 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	45872

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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 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** 31057 Based on observation, interview, and record review, the facility failed to provide adequate supervision for two residents to prevent an altercation which included a head injury (Resident #1 and #2). Facility staff failed to assess or provide appropriate interventions after a first altercation. Facility staff failed to inform the licensed nurse of a potential head injury. The facility failed to keep the two residents from interacting with one another after a previous resident to resident incident, which resulted in Resident #1's death. The facility census was 139. Record review of the facility's Abuse and Neglect policy, dated 2022, showed: - Physical abuse defined as purposefully beating, striking, wounding, and/or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner; - This facility committed to protecting the residents from abuse by anyone including but not limited to facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends, and or any other individuals; - Employees will be trained through orientation and ongoing training on issues related to abuse prohibition practices such as dealing with an aggressive resident, reporting allegations without fear of reprisal, recognizing signs of burn out, frustrations or stress that may lead to abuse and the definition that constitutes abuse, neglect and misappropriation of resident property; - The facility will identify and correct by providing interventions in which abuse, neglect, or misappropriation would be more likely to occur by assessment of physical environment, which may make abuse or neglect more likely to occur, such as more secluded area in the facility, the deployment of staff on each shift in sufficient numbers to meet the resident needs and that the staff will be knowledgeable of resident care needs; - Residents who allegedly mistreat another resident will be removed from contact with the resident during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches and placement considering his or her safety, as well as the safety of other residents and employees in the facility. Record review of Resident Roster, dated [DATE], showed: - Resident #1 and #2 listed as roommates on the Cognitive Unit; - Thirty (30) male and female residents with mental illness diagnoses occupied the Cognitive Unit; - The [DATE] Staffing sheet indicated LPN TT and CNA DD worked the 11:00 P.M. through 7:00 A.M. shift on the cognitive unit. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 10:30 A.M., the Director of Nursing (DON) said it had been reported to her by Licensed Practical Nurse (LPN) TT at 1:00 A.M. on this date, there had been an altercation between roommates Residents #1 and #2 which resulted in Resident #1 requiring minor first aid. The residents were separated by moving Resident #1 to another room. Around 3:30 A.M., Certified Nurse Aide (CNA) DD found Resident #1 in the floor and alerted LPN TT, who could find no pulse and began CPR. Resident #1 was pronounced dead at the emergency department. The DON said she had just heard about the incident herself and was investigating. Observations on [DATE] at 11:30 A.M., of the Cognitive Unit showed a long hallway located behind locked double doors. Entry to the cognitive unit door must be made by using a key pad with an assigned code. When staff sat at the nurse's station, the staff would be unable to see down the Cognitive Unit and/or the hall next to this unit due to the desk being in an enclosed glass area locked from the inside and located outside the locked doorway. 1. Record review of resident #1's Pre-Admission Screening and Resident Review (PASRR), dated [DATE], showed: - Met the federal definition of serious mental illness, but did not require specialized services; - Met the federal definition of intellectual disability/related condition (ID/RC), but did not require specialized services; - Diagnoses of bipolar, intermittent explosive disorder, depression, mild intellectual disability, and developmental delay and seizure disorder. Record review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by the facility staff, dated [DATE] showed: - Admission to the facility on [DATE]; - Diagnoses of schizophrenia (mental disorder of a type involving a breakdown in the relation between thought, emotion, and behavior, leading to faulty perception, inappropriate actions and feelings, withdrawal from reality and personal relationships into fantasy and delusion, and a sense of mental fragmentation), bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), depression, chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problem); - Cognition impaired; - Little interest or pleasure in doing things, ,d+[DATE] days out of the past 7 day period; - Feeling down, depressed, or hopeless, ,d+[DATE] days out of the past 7 day period; - Trouble concentrating on things, such as reading the newspaper or watching television, ,d+[DATE] days out of the past 7 day period; - Required supervision of one staff member for exiting secure unit; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Independent with activities of daily living; - Continent of bowel and bladder; - Received antipsychotic (used to treat certain types of mental health problem whose symptoms include psychotic experiences), antidepressant (medication used to treat depression) and anticoagulation (medication used to prevent blood clots) medications seven days a week on a routine basis; - Guardian (a person appointed by a court to provide the care and custody of a minor or an adult person when legally determined to be incapacitated) in place. Record review of the resident's [DATE] Physician Order Sheet (POS), showed: - Diagnoses of chronic obstructive pulmonary disease, acute embolism and thrombosis of deep vein of lower extremity (blood clot), bipolar disorder, major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with daily living), intermittent explosive disorder (repeated, sudden episodes of impulsive, aggressive, violent behavior or angry verbal outbursts in which a person react grossly out of proportion to the situation), epilepsy (seizure), intellectual disability (limits to a person's ability to learn at an expected level and function in daily life); - Monitor behaviors every shift; - May have psych evaluation and treatment as needed; - Full code (emergency lifesaving procedure performed when the heart stops beating, cardiopulmonary resuscitation (CPR)). Record review of the resident's care plan, revised on [DATE], showed: - Behavioral problems of verbal and physical aggression related to schizoaffective disorder and with interventions to intervene as necessary to protect the rights and safety of others, approach and speak in a calm manner, divert attention and remove from the situation and take alternate location if needed; - Monitor behavioral episodes and attempt to determine underlying cause, consider location, time of day, person involved and situation, document behavior and potential causes; - If reasonable, discuss the resident behavior and explain/reinforce why the behavior considered inappropriate and/or unacceptable to the resident; - Praise any indication of the resident progress/improvement in behavior; - The resident triggered for negative behaviors so not allowed to call family via the phone. Record review of the resident's progress notes showed: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- On [DATE] at 1:35 A.M., the resident became involved in a verbal altercation with his/her roommate. A PRN medication administered per the resident's request. The resident with a small laceration noted to the his/her forehead with minimal bleeding, but the resident denied being hit. This nurse cleansed the area with Dakin's Wound Cleanser (DWC) (a wound cleanser solution) and then the resident asked the nurse to leave him/her alone. The resident appeared calm at that time. The resident moved to another room for the night and he/she agreed; - No other interventions documented for this altercation; - On [DATE] at 3:45 A.M., CNA B called the nurse to come to the resident's assigned room. Upon entering the resident's room, Resident #1 lay face down on the floor, unresponsive. The nurse detected no pulse and no visual rise or fall of the resident's chest, the nurse called a code blue (a code used to signal others to a person with no heartbeat) and initiated CPR at 3:47 A.M. Notification of the physician and orders received to send the resident to the emergency room . Notified the ambulance at 3:48 A.M., and at the facility at 3:53 A. M. The ambulance left in route for the hospital at 4:05 A.M. The DON and the Administrator notified. The nurse called the guardian three times with no success with a message left to return the call at their earliest convenience. The nurse called report to the Registered Nurse (RN) at the hospital. 2. Record review of Resident #2's PASRR, dated [DATE], showed: - Met the federal definition of serious mental illness, but did not require specialized services; - Met the federal definition of intellectual disability/related condition (ID/RC), but did not require specialized services; - Diagnoses of behaviors, schizophrenia, and dementia, mild mental retardation (a below-average intelligence or mental ability), borderline intellectual function. Record review of the resident's quarterly MDS, dated [DATE], showed: - Cognition intact; - Admission to facility on [DATE]; - Diagnoses of schizophrenia, hypertension (high blood pressure), and diabetes (a chronic health condition that affects how your body turns food into energy); - Required supervision of one staff member for exiting secure unit; - Independent with activities of daily living; - Continent of bowel and bladder; - Received antipsychotic and insulin medications seven days a week on a routine basis; - No guardian in place. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the resident's [DATE] POS showed: - Diagnoses of hypertension, schizophrenia, and diabetes; - Monitor behaviors every shift; - May have psych evaluation and treatment as needed; - Full code status. Record review of the resident's care plan, revised on [DATE], showed: - Little or no activity involvement related to his/her wishes not to participate; - Manifestation of behaviors related to his her mental illness that may create disturbances that affect others, behaviors including being verbal and physically aggressive; - Monitor for elopement attempts and with history of schizophrenia and a history of self harm. Record review of the resident's progress notes, dated [DATE] through [DATE], showed: - On [DATE] at 1:40 A.M., the resident involved in a verbal altercation with another resident. As needed medication administered without incident. The resident calmed and sat in the hallway; - No other behaviors related to a verbal altercation. During an interview on [DATE] at 1:25 P.M., Resident #2 said Resident #1 hit him/her in the balls while he/she was asleep last night. Resident #2 said he/she hit Resident #1 in the jaw one time and pushed him/her down. Resident #1 came at Resident #2 again, and Resident #2 called for help but no one came. CNA DD said to go back to his/her room and to be quiet and took Resident #1 to another room. Resident #1 came back later and fell on the other side of the bed. Resident #2 said a spirit may have pushed Resident #1. Resident #2 said the first time he/she hit Resident #1, his/her nose was bleeding, the second time Resident #1 didn't move. Resident #2 said someone pulled Resident #1 out of the corner and did CPR. During a telephone interview on [DATE] at 5:15 P.M., the Coroner said he was contacted by the local hospital due to Resident #1 looked like he/she had been beat up with bruising around the neck which looked like strangulation. He contacted the nursing home and was informed the resident had an altercation with another resident. After viewing the body of Resident #1 with bruising marks around the neck, swelling of the eyes, and a pump knot (a raised bruised area) with bleeding on the forehead, he then requested an autopsy to be performed for the exact cause of death. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 5:30 P.M., CNA DD said Residents #1 and #2 were arguing with each other at about 12:30 A.M. At around 1:00 A.M., Resident #1 walked out of the room and was bleeding from the back and side of the head with blood on the floor. CNA DD said he/she was the only staff member on the unit, LPN TT was either in the nurse's station outside the locked unit doors, or somewhere else in the building because the CNA had to call LPN TT twice using his/her cell phone to notify the LPN if he/she was needed. The nurse came to the unit and took Resident #1 to the nurses' station while Resident #2 sat in his/her room and did not say what happened at that point. LPN TT told CNA DD to move Resident #1 to another room for the night and to leave Resident #2 in his/her room. CNA DD said those were the only instructions the LPN gave regarding Resident #1. The residents settled down and went to sleep. At about 3:00 A.M., he/she heard a noise, saw Resident #1 go back to his/her room. CNA DD was the only staff member on the unit and had to complete bed checks on the other residents and was unable to get to Residents #1 & 2's room until approximately 3:30 A.M. At that time he/she found the privacy curtain partially closed with the call light on, found Resident #1 lay across the chair facing towards the wall, head was down and lay over the chair like he/she was trying to use the call light. He/she was unresponsive at that time. The nurse was called and he/she and both staff moved Resident #1's body to the floor and started CPR. Resident #2 remained in the room and he/she calmly said that he/she hit Resident #1 three times and was not sorry for it. During an interview on [DATE] at 5:45 A.M., Resident #3 said he/she was up most of the night and only CNA DD was on the hall. LPN TT was not on the hall unless CNA DD called and asked him/her to come. During a telephone interview on [DATE] at 9:30 A.M., LPN TT said CNA DD called at approximately 1:30 A.M. CNA DD said Resident #1 and Resident #2 had been into it. LPN TT said he/she had been at the nurse's station which was enclosed in clear plexiglass and located on the other side of a set of barrier doors. LPN TT said CNA DD was the only staff member on the hall. LPN TT said when he/she arrived at the residents' room, he/she saw Resident #1 had a small scratch on his/her forehead. LPN TT took Resident #1 to the nurses' station and applied first aid. LPN TT had CNA DD put Resident #1 in another room and instructed the CNA to keep the two residents separated for the night. LPN TT gave no further instructions to CNA DD regarding the residents. No interventions or increased monitoring put in place at this point. At approximately 3:45 A.M., CNA DD called LPN TT and said Resident #1 would not answer him/her and was not breathing. Upon entering the room, he/she saw Resident #1 lay on the floor on his/her stomach with his/her head in a laundry basket on the floor. Two call light cords were draped across his/her left shoulder. LPN TT said he/she quickly assessed the resident and started CPR. Later, after Resident #1 had been taken by the emergency services, and near the end of the shift, CNA DD said Resident #2 hit Resident #1 with the bedside table earlier in the night. LPN TT said CNA DD did not report that information to him/her earlier. If the LPN had had that information, he/she would have begun neuro checks (brief, serial bedside exams performed by nursing to evaluate for changes in clinical status or neurological function) and sent both resident to the hospital per facility policy. During an interview on [DATE] at 10:00 A.M., the DON said he/she would have expected CNA DD to report all the information regarding an altercation between residents to LPN TT so an appropriate assessments could have been made. The DON said she also expected facility staff to keep residents separate after an altercation and intervene immediately if they see one resident headed for the other. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Note: At the time of the complaint survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview, and record review completed during the onsite visit, it was determined the facility had implemented corrective actions to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s). Complaint #MO203509 36220

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26904 Based on interview and record review, the facility failed to ensure all employees maintained competencies and skills sets needed in the facility to work effectively with residents with mental disorders and other behavioral health needs. The facility policy directed all staff be Crisis Alleviation Lessons and Methods (CALM) (the facility's curriculum for training staff on how to deal with residents with behaviors) certified. This deficient practice had the potential to affect all residents. The facility census was 139. Record review of the Facility's policy for CALM Certification, dated [DATE] showed: - After time of hire, all employees working with behavioral residents will become CALM certified; - All employees working with behavioral residents will be CALM certified and attend a CALM refresher course yearly for CALM hold techniques, as well as de-escalation techniques, which will be reviewed in in-services as needed to ensure that employees maintain knowledge and preparedness in the event that CALM hold techniques should be utilized. It will be stressed that CALM hold techniques only be utilized in the event that a resident would become a danger to themselves or others; - The Administrator and Director of Nursing will be responsible for educating the staff on updates of the facility's CALM policies and procedures during the scheduled inservices bi-weekly/monthly and as needed to ensure that the CALM practices will be utilized correctly. - The Reliant Care Management Company (RCMP) Executive Directors, Human Resources and the Human Resource Managers in the facility will be responsible for tracking the CALM certification in the Learning Management System (Relias). Record review of the Facility Assessment, last reviewed on [DATE], showed: - All employees CALM certified to handle behavior crisis; - CALM training upon hire and before working any behavioral unit; - Facility census 139 residents; - 135 residents with behavioral healthcare needs; - 135 residents care planned for behavioral healthcare needs; - 135 residents with a psychiatric diagnoses (excluding dementia and depression). 1. Record review of Certified Medication Technician (CMT) A's employee records showed: - A hire date of [DATE]; (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- No CALM certification; - Staff assignment sheet showed CMT A worked 22 shifts on Men's unit. 2. Record review of Certified Nurse Aide (CNA) K's employee records showed: - A hire date of [DATE]; - No CALM certification; - Staff assignment sheet showed CNA K worked eight shifts on the Women's unit and 14 shifts on the Medical unit. 3. Record review of CNA Z's employee records showed: - A hire date of [DATE]; - No CALM certification; - Staff assignment sheet showed CNA Z worked 10 shifts on the Women's Unit. 4. Record review of CNA AA's employee records showed: - A hire date of [DATE]; - No CALM certification; - Staff assignment sheet showed CNA AA worked three shifts on the Men's unit, 14 shifts on the Step-Down Unit, 2 shifts on the Step-Down/Men's Units, one shift on the Cognitive Unit, one shift on the Step-Down/Cognitive Unit, and one shift on the Women's Unit. 5. Record review of CNA BB's employee records showed: - A hire date of [DATE]; - No CALM certification; - Staff assignment sheet showed CNA BB worked 10 shifts on the Cognitive Unit and two shifts on the Step-Down Unit. 6. Record review of Licensed Practical Nurse (LPN) CC's employee records showed: - A hire date of [DATE]; - No CALM certification; - Staff assignment sheet showed showed LPN CC worked 19 shifts on the Men's Unit and two shifts on the Cognitive Unit. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Record review of CNA DD's employee records showed: - A hire date of [DATE]; - No CALM certification; - Staff assignment sheet showed showed CNA DD worked 13 shifts on the Cognitive Unit and three shifts on the Men's Unit. 8. Record review of CNA EE's employee records showed: - A hire date of [DATE]; - No CALM certification; - Staff assignment sheet showed CNA EE worked five shifts on the Step-Down Unit, one shift on the Men's Unit, and 15 shifts on the Medical Unit. 9. Record review of Hall Monitor (HM) FF's employee records showed: - A hire date of [DATE]; - No CALM certification; - Staff assignment sheet showed HM FF worked 19 shifts on the Men's Unit. 10. Record review of LPN GG's employee records showed: - A hire date of [DATE]; - No CALM certification; - Staff assignment sheet showed LPN GG worked 19 shifts on the Medical Unit. 11. Record review of HM II's employee records showed: - A hire date [DATE]; - Expired CALM certification dated [DATE]; - Staff assignment sheet showed HM II worked 22 shifts on the Men's unit. 12. Record review of LPN JJ's employee records showed: - A hire date [DATE]; - Expired CALM certification dated [DATE]; (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Staff assignment sheet showed LPN JJ worked 22 shifts on the Medical Unit. 13. Record review of CNA KK's employee records showed: - A hire date [DATE]; - Expired CALM certification dated [DATE]; - Staff assignment sheet showed CNA KK worked five shifts on the Women's Unit and 16 shifts on the Medical Unit. 14. Record review of CMT LL's employee records showed: - A hire date [DATE]; - Expired CALM certification dated [DATE]; - Staff assignment sheet showed CMT LL worked 21 shifts on the Women's Unit. 15. Record review of CNA MM's employee records showed: - A hire date [DATE]; - Expired CALM certification dated [DATE]; - Staff assignment sheet showed CNA MM worked 18 shifts on the Step-Down Unit and one shift on the Medical Unit. 16. Record review of CMT Y's employee records showed: - A hire date [DATE]; - Expired CALM certification dated [DATE]; - Staff assignment sheet showed CMT Y worked 22 shifts on the Cognitive Unit. 17. Record review of CNA OO's employee records showed: - A hire date of [DATE]; - Expired CALM certification dated [DATE]; - Staff assignment sheet showed CNA OO worked 23 shifts on the Cognitive Unit. 18. Record review of HM PP's employee records showed: - A hire date of [DATE]; (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Expired CALM certification dated [DATE]; - Staff assignment sheet showed HM PP worked 11 shifts on the Women's Unit and two shifts on the Step-Down Unit. 19. Record review of HM QQ's employee records showed: - A hire date of [DATE]; - Expired CALM certification dated [DATE]; - Staff assignment sheet showed HM QQ worked 21 shifts on the Men's Unit. During an interview on [DATE] at 7:55 P.M., the Director of Operations said she would expect staff to have CALM training upon hire and prior to working any behavioral units. She said in order for any staff member to handle resident behaviors, they must be CALM trained. She said staff without the training could only work the medical unit.

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	265832	A. Building B. Wing	07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Senath South Health Care Center	300 East Hornbeck Street Senath, MO 63876

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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16207 Based on observation, interview and record review the facility failed to provide individualized treatment to meet the needs of one resident (Resident #7) out of a sample of 13 residents with a mental disorder. The facility census was 132. Review of Resident #7's medical record showed: - An admitted [DATE]; - Resident #7 is his/her own responsible party; - Diagnoses included Transient Cerebral Ischemic Attack (TIA), recurrent Major Depressive Disorder, Hypothyroidism, Psychotic Disorder with delusions due to known physiological condition, schizoaffective disorder, Schizophrenia, Post-Traumatic Stress Disorder (PTSD) and Bipolar disorder; - Intact cognition as assessed from the most recent 7/4/2022 quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff. Review of Resident #7's most recent care plan, updated 7/4/2022 showed a problem identified as Resident #7 has manifestations of behaviors related to his/her mental illness that may create disturbances that affect others. These behaviors include acting out physically and verbally towards staff and peers. The resident also has a history of anxiety and a diagnosis of PTSD. The care plan did not identify any sources of anxiety or triggers for behavioral episodes. Interventions for the above problem included: - Administer and monitor medications as ordered; - Administer prn (as needed) medications as needed/ordered when non-pharmacological interventions are noneffective; - Assist resident in addressing root cause of change in behavior or mood as needed; - Give positive feedback for good behavior; - If resident is disturbing others, encourage him/her to go to a more private area to voice concerns/feelings to assist in decreasing episodes of disturbing others; - Notify guardian/physician as needed. - No interventions relating to specific triggers to avoid, that would cause increased anxiety and behaviors for the resident. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/7/2022 at 10:00 A.M., Resident #7 said he/she had become more paranoid and nervous recently. The resident said the facility staff has really been upsetting him/her at medication times. Resident #7 said it is very important for him/her to see his/her medications and make sure he/she knows what they are and make sure they are right. Resident #7 said at almost every medication pass, staff just hand over the pills and tell him/her to move on. Resident #7, offered for observation, a set of papers with details and dates of every medication administration. He/she had hand written the notes to help ease his/her anxiety. Resident #7 said he/she could go back and review his/her notes to ease his/her anxiety. Observation during the interview showed the more Resident #7 spoke about the medications and the way they are administered, the more physically agitated he/she became. The resident was twisting his/her hands, visibly trembling and had a shaking voice. During an interview on 9/7/2022 at 1:15 PM, the Director of Nursing (DON) said she was aware of Resident #7's anxiety with medication administration. The DON said staff turnover is very high right now, so it is likely a different or new person administering the medications every day. The DON said she has talked to the staff multiple times regarding this being one of Resident #7's triggers, specifically medication administration. The DON said the anxiety about medication administration and way to prevent the anxiety should be on Resident #7's care plan. Complaint #MO205036

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 42699 Based on observation, interview, and record review, the facility failed to ensure meals were served in a timely manner. This deficient practice had the potential to affect all residents. The facility's census was 139. 1. Record review of the facility's Meal Times and Locations showed: Women's Unit and Step Down Dining: Breakfast- 8:15 a.m.-9:00 a.m., Lunch- 12:00 p.m.-1:30 p.m., Dinner- 6:00 p.m.-8:00 p.m. Observation on Women's Unit showed: -On 7/10/22, breakfast served at 10:40 A.M. and lunch served at 2:00 P.M.; -On 7/11/22, breakfast served at 9:30 A.M. and lunch served at 2:09 P.M. During interview on 7/10/22 at 11:54 A.M., Certified Nurse Aid (CNA) B said residents' meals are served late on a regular basis. During interview on 7/10/22 at 2:10 P.M., Resident #67 said that meals are always late. During an interview on 7/10/22 at 2:12 P.M., Resident #440 said meals are always late. During an interview on 7/11/22 at 9:00 A.M., Resident #74 said breakfast should have been here over an hour ago. It is unacceptable that meals are never on time. During an interview on 7/11/22 at 2:22 P.M., Resident #16 said meals are always late. 2. Record review of the facility's Meal Times for the Cognitive Unit showed: - Breakfast 7:45 A.M. through 8:00 A.M., and Lunch 12:00 P.M. through 12:15 P.M. Observation of the Cognitive Unit on 7/11/22 at 9:10 A.M., showed staff began serving breakfast. 3. Record review of the facility's Meal Times for the Men's Unit showed: - Breakfast 8:00 A.M., through 8:15 A.M., Lunch 12:15 P.M. through 12:30 P.M., and Supper 6:15 P.M. through 6:30 P.M. Observation on 7/11/22 of the Men's Unit showed the lunch meal service began at 1:50 P.M. Interview on 7/11/22 at 2:10 P.M., Resident #539 said the meals are always late here. He/she said lunch is usually around 2:00 P.M. and supper is usually around 8:00 P.M. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. Record review of the facility's Medical Unit meal times showed Lunch at 11:45 A.M. - 12:00 P.M. Observation of lunch in the Medical Unit Dining area on 07/11/22, showed: - At 12:22 P.M., 11 residents sat at tables waiting for lunch to be served; - At 12:58 P.M., 11 residents continued to sit and wait on a noon meal; - At 1:14 P.M., lunch meal was served to residents in the dining room; - The facility served the lunch meal 74 minutes late. During an interview on 7/10/22 at 1:28 P.M., CNA K said he/she brings snacks with him/her to work for the residents on the Medical Unit because meals are always very late and they seldom send any snacks for them from the kitchen. He/She will bring snacks such as potato chips, cookies, cake, suckers, just food he/she can find cheap. During an interview on 7/14/22 at 11:36 A.M., Resident #17 said he/she normally goes to the dining area around noon but waits an hour for his/her food. During an interview on 7/14/22 at 11:37 A.M., Resident #6 said he/she normally goes for lunch at meal time and waits at least an hour to be served. During an interview on 7/14/22 at 3:35 P.M., the Dietary Manager (DM) said on 7/11/22 lunch was served late. The DM said he/she usually only worked as an aid, but on that day he/she had to step in and help the cook prepare the food. The DM said on 7/11/22 they were a staff member short and needed to prepare enough food for 175 - 200 residents due to the need for double portions for some residents. He/she said it is difficult to keep staff in the facility. During an interview on 7/14/22 at 7:45 P.M., the Director of Operations said that he/she would expect meals to be served on time and snacks to be available on the halls. 46521

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 42699 Based on observation and interview, the facility failed to maintain an effective pest control program. This practice had the potential to affect all residents in the facility. The facility's census was 139. Observations showed: - On 7/5/22 at 8:52 P.M., two mice ran across the surveyor's feet while sitting at the desk in the Restorative Nursing room; - On 7/5/22 at 9:32 P.M., two mice ran down the middle of the hall near the dining room; - On 7/10/22 at 1:28 P.M., Certified Nurse Aide (CNA) K retrieved a large unopened bag of cheese puffs for Resident #33 only to discover a half-dollar size hole had been chewed out of the side of the bag, CNA apologized to Resident, disposed of the cheese puffs, and offered him/her a different snack; - On 7/11/22 at 1:55 P.M., a mouse ran across the floor and behind the refrigerator in the Director of Nursing (DON) office; - On 7/12/22 at 8:44 A.M., a mouse ran across the floor in the DON office; - On 7/12/22 at 8:48 A.M., mouse droppings on floor with paper napkin shreds under left backside of refrigerator located in the DON office; - On 7/12/22 at 8:49 A.M., a mouse ran across the floor and hid behind a cabinet in the DON office; - On 7/12/22 at 10:09 A.M., a mouse ran behind the black refrigerator located in the DON office; - On 7/12/22 at 1:25 P.M., a mouse ran across the 200 hallway near the Nurse's Station; - On 7/13/22 at 10:47 A.M., the Human Resource Director removed a mouse on a glue trap in the DON office; - On 7/13/22 at 1:14 P.M., the Dietary Supervisor removed a mouse on a glue trap in the DON office; - On 7/14/22 at 8:22 A.M., the Maintenance Supervisor removed a mouse on a glue trap in the DON office; - On 7/14/22 at 7:10 P.M., a mouse ran through the DON office; - On 7/14/22 at 7:54 P.M., a mouse ran from behind the refrigerator in the DON office. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/10/22 at 12:48 P.M., Resident #35, said that he/she has mice in his/her room, and he/she traps mice in his/her personal trash can to be disposed of. During an interview on 7/10/22 at 1:30 P.M., CNA K said Resident #33 had just purchased the large bag of cheese puffs yesterday with his/her own money and now he/she has to throw them in the trash. During an interview on 7/10/22 at 3:00 P.M., Resident #74 said that he/she hears mice in the ceiling throughout the night. During an interview on 7/12/22 at 1:25 P.M., Licensed Practical Nurse (LPN) V said it is common to see mice in the facility, they put out mouse traps, but can not seem to get rid of them all. During an interview on 7/13/22 at 10:45 A.M., the Administrator said the facility was surrounded by fields and so they had lots of rodents at times. He spoke with a local farmer to find out what the best spray was for rodent control that would be safe for the residents. They have started using it and he thinks it might work. They were also doing a clean up around the outside of the building. During an interview on 7/13/at 1:34 P.M., the Maintenance Director said the facility was next to fields which attracted the rodents. A new exit door was ordered to replace the one with the big gap at the bottom, and the hole in the wall behind the ice maker will be repaired along with any other gaps found that would allow the rodents to come in. They do have a pest control company that comes monthly and as needed. During an interview on 7/14/22 at 7:48 P.M., Director of Operations said an effective pest control program should be in place. The facility did not provide a policy on pest control.