STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345008	A. Building B. Wing	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Citadel at Myers Park, LLC	300 Providence Road Charlotte, NC 28207

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40476 Based on observation, record review, resident and staff interview the facility failed to maintain a resident's dignity by not providing clean clothing for 1 of 2 residents (Resident #6) reviewed for resident rights. Resident #6 was not provided with clean clothing which resulted in the resident not wanting to get out of bed to participate in daily activities as he normally would and a reasonable person would expect to be dressed in their home when they wanted to be. Findings included: Resident #6 was admitted to the facility on [DATE]. The annual Minimum Data Set (MDS) dated [DATE] revealed Resident #6 was severely cognitively impaired and required extensive assistance of one staff member for most activities of daily living (ADL). On 3/7/23 at 11:23 AM Resident #6 was observed to be in the bed and wearing a hospital gown. An observation of Resident #6's closet revealed the resident had no clothing in his closet. A second observation was conducted at 2:00 PM of Resident #6 in the bed, wearing a hospital gown. On 3/7/23 at 2:35 PM an interview was conducted with NA #7. NA #7 stated Resident #6 was normally out of the bed every day at lunch time, but she didn't get him up because he had no clean clothes at the time, she was in the room getting him dressed for the day around 9:00 AM. She stated laundry services did not bring his clothes up until after lunch and by that time the resident did not want to get up. On 3/8/23 at 9:39 AM an interview was conducted with NA #8. NA #8 stated Resident #6 usually wanted to get out of the bed prior to lunch time. She stated on 3/7/23 she and NA #7 could not get the resident out of bed because he had no clean clothing in his closet. The interview revealed Resident #6 would not get up wearing just a hospital gown. She stated the laundry staff member was off over the weekend and the residents personal clothing piled up and nobody took them to the wash until Monday morning. (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	On 3/8/23 at 9:17 AM an interview was conducted with Laundry Services Staff #1. She stated she worked in the building as the only staff member in laundry services Monday through Thursday with one day off. The interview revealed she rotated and worked every other weekend. She stated if she was off work over the weekend then no laundry in the facility was completed. The interview revealed the facility had ordered extra linens to ensure residents had enough towels, wash cloths and bedding but residents personal clothing was not washed if she was not in the building. She stated she was off work last weekend and was still trying to catch up on personal clothing. The interview revealed she delivered two clean shirts and a pair of pants to Resident #6 on 3/7/23 around 11:00 AM and noticed the resident did not have any clean clothing in his closet. She stated she was struggling to keep up with laundry. On 3/9/23 at 11:26 AM Resident #6 was observed to be in the bed and wearing a hospital gown. On 3/9/23 at 1:41 PM a follow up interview was conducted with NA #7. She stated no personal clothing had been delivered to the unit for the day on 3/9/23 and she did not get Resident #6 out of the bed due to no clean clothing in his closet. She stated Resident #6 had the most personal clothes on the unit and there was no reason for him not to have clean clothing. The interview revealed Resident #6 did not want to be out of the bed in just a hospital gown. NA #7 stated the resident wanted to wear pants. On 3/9/23 at 12:01 PM an interview was conducted with the Housekeeping Manager. He stated he had one staff member in laundry services that worked every day of the week but one day and rotated weekends. The interview revealed on the weekends she was off he would come in to ensure the facility had necessary linen but that his focus was not on personal clothing. He stated the goal turn around time for personal clothing would be 24 hours however the facility was not meeting that goal every day and they were trying to hire someone else for that role. The interview revealed he felt Laundry Staff Member #1 had a mindset to always complete linens first before personal clothing and that was creating an issue with residents not having clean clothing. On 3/9/23 at 5:25 PM an interview was conducted with the Director of Nursing (DON). During the interview she stated Resident #6 liked to get out of bed to his wheelchair around lunch time. She stated the resident was normally out of bed for activities so being in the bed all day wasn't normally Resident #6's routine. The DON stated she knew laundry was an issue and the facility had been trying to hire someone to fill the role of assisting the one laundry staff member they currently have. The interview revealed the job had been posted on an online staffing site for 45 days with no interest. On 3/10/23 at 9:25 AM an interview was conducted with Resident #6's Responsible Party (RP). During the interview she stated Resident #6 was usually up for meals and in his wheelchair dressed. She stated she visited the facility daily and ensured he was dressed however due to an illness she had not been in the facility that week. The interview revealed Resident #6 would not have gotten out of the bed in just a gown and if the facility did not have clothing, they could have contacted her, and she would have brought in extra. She stated she felt like Resident #6 enjoyed being up for meals and in his wheelchair.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36217 Based on observation, record review and interviews with residents and staff, the facility failed to provide access to control the light behind the bed; and failed to place a call light within reach to allow the resident to request staff assistance if needed for 1 of 1 resident reviewed for accommodation of needs (Resident #39). The findings included: Resident #39 was admitted to the facility on [DATE]. Review of the quarterly Minimum Data Set (MDS) dated [DATE] assessed Resident #39 with intact cognition and independent to walk inside the room. Review of Resident #39's medical records revealed he had moved to his current room on 03/03/23. During an observation conducted on 03/06/23 at 11:36 AM, the cord to control the switch of light behind Resident #39's bed was broken. It extended approximately 2.5 inches from the light fixture and was around 70 inches above the floor. Resident #39 was unable to reach the cord from the bed if needed. Observation of the cord for the call light revealed it had been rolled up, taped, and placed close to the power source by the wall. It extended about 12 inches from the wall and approximately 40 inches above the floor, making it inaccessible for Resident #39 to request staff assistance from the bed if needed. The call light functioning properly when it was tested . An interview was conducted with Resident #39 on 03/06/23 at 11:36 AM. He stated the switch cord for light had been broken and the electrical cord for the call light had been rolled up since the first day he moved into this room. He stated he had to get out from his bed each time to reach the switch cord to control the light or to trigger the call light as needed. He felt that it was very inconvenient to him, and he was frustrated why none of the staff would do something to fix the problems. Subsequent observation conducted on 03/07/23 at 3:20 PM revealed the light cord and the call light were out of reach for Resident #39. During a joint observation conducted with Nurse #3 on 03/08/23 at 11:50 AM, the light cord and the call light remained out of reach for Resident #39. During an interview conducted on 03/08/23 at 11:54 AM, Nurse #3 stated he had provided care for Resident #39 daily, but he did not notice that the call light and the light cord were out of reach in the past few days. Otherwise, he would have notified the maintenance staff to fix it. He did not know who had rolled up the cord for the call light and acknowledged that it could make Resident #39 inaccessible to the call light from the bed. He added the string attached to the light behind the bed was too short and very inconvenient for Resident #39. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted with Nurse Aide #4 on 03/08/23 at 12:43 PM revealed she had provided care for Resident #39 frequently in the past few months. She did not know who had rolled up and taped the cord for Resident #39's call light. She acknowledged that the call light and the light cord were inaccessible for Resident #39. She explained it was her oversight to miss Resident #39's repair needs. During an interview conducted with the Maintenance Manager on 03/08/23 at 12:53 PM, he stated he walked through the facility at least 1-2 times weekly to identify repair needs. He also depended on staff to report repair needs through work order or verbal notification. He had been checking the work order boxes located at each nurse station and his office door at least once daily. He did not know that the cord for the light was in disrepair and the cord for the call light was inaccessible to Resident #39. An interview was conducted with the Director of Nursing (DON) on 03/08/23 at 4:12 PM. She expected all the facility staff to be more attentive to residents' living environment and reported all the repair needs in timely manner to accommodate residents' needs. During an interview conducted on 03/09/23 at 10:39 AM, the Administrator stated it was her expectation for the staff to notify the maintenance staff for all repair needs in timely manner to accommodate residents' needs.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45380 Based on observations, record review, and staff interviews the facility failed to allow a resident who had been assessed as a safe independent smoker the choice to smoke unsupervised for 1 of 1 resident reviewed for choices (Resident #31). Findings included: Resident #31 was admitted to the facility on [DATE] with diagnoses including peripheral vascular disease, cognitive communication deficit, and other chronic pain. Review of the revised smoking policy dated 02/01/20 revealed all residents were evaluated for smoking and smoking history, that evaluation would designate each resident as a non-smoker, safe-independent smoker, supervised smoker, or a dependent smoker. Safe smoking evaluation would be completed quarterly or as needed. Smoking times will be designated as per facility protocol, the exception is the independent smoker that does not require assistance of any kind and may smoke in the designated smoking area at will. The quarterly smoking assessment completed by Nurse #3 dated 11/03/21 revealed Resident #31 was able to hold the cigarette safely without a device, extinguish cigarette safely, and ambulate independently. Resident #31 was assessed as able to smoke safely independently. Review of revised care plan dated 07/02/22 revealed Resident #31 was identified as a smoker with a goal of no accidents related to smoking through next review. Interventions include complete smoking safety assessment per facility policy and reviewing smoking policy with resident and or family. An interview conducted with Nurse #3 on 03/08/23 at 3:44 PM revealed he was familiar with Resident #31 and had assessed him as an independent safe smoker on the smoking assessment dated [DATE] due to him being cognitively intact, able to smoke and extinguish cigarette safely, and his ability to ambulate independently inside and outside of facility. He stated Resident #31 had always been assessed as an independent safe smoker and allowed to smoke unsupervised since his admission and he had no knowledge of any changes medically or behaviorally with Resident #31 and no changes with his ability to continue to smoke unsupervised. The annual Minimum Data Set (MDS) dated [DATE] revealed Resident #31 was cognitively intact and assessed as a current tobacco user. Review of the smoking assessment completed by the Unit Manager dated 03/06/23 revealed Resident #31 was able to hold the cigarette safely without a device, extinguish cigarette safely, and ambulate independently. Resident #31 was assessed as requiring supervision while smoking. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted with the Unit Manager on 03/09/23 at 11:12 AM revealed she was familiar with the facility safe smoking assessment and was informed by Director of Nursing (DON) on 03/06/23 that all smokers were to be reassessed as requiring supervision while smoking to include Resident #31. She stated Resident #31 had been assessed prior as an independent smoker requiring no supervision due to his ability to smoke safely, being able to move independently inside and outside of the facility and sign himself in and out of the facility at his leisure. The Unit Manager stated there were no changes to Resident #31's ability to smoke safely unsupervised other than her being told by the DON that all smokers were to be reassessed as requiring supervision while smoking. An observation conducted on 03/06/23 at 11:20 AM revealed Resident #31 sitting on the steps to the back side of facility building where the parking lot was located smoking unsupervised. Resident #31 was observed being able to hold cigarette to smoke, ash the cigarette, and extinguish cigarette with no issues. An observation was conducted of Resident #31 on 03/07/23 at 6:20 PM revealed him outside smoking unsupervised. Resident #31 was observed being able to hold his cigarette to smoke, ash his cigarette, and distinguish his cigarette with no issues. An interview conducted with Nurse Aide (NA) #10 on 03/09/23 at 11:45 AM revealed he had been assigned as the staff smoking attendant to supervise smokers during scheduled smoking times and distribute their smoking materials. He stated he was informed this morning by the DON that all smokers were to be supervised during scheduled smoking times (8 AM, 11 AM, 1 PM, 4 PM, 6PM and 8 PM) and he was to distribute all smoking materials from the locked box. He revealed Resident #31 had previously been allowed to smoke unsupervised but this morning he had to inform him that he could only smoke during the scheduled smoking times, had to be supervised while smoking, and keeping his smoking materials in locked box so they could be distributed during scheduled smoking times. An observation on 03/09/23 at 4:00 PM of Resident #31 revealed him being accompanied by staff out to the smoking porch during a designated smoking time, receiving smoking materials from staff, and being supervised while smoking with staff. An interview conducted with Director of Nursing (DON) on 03/09/23 at 5:11 PM revealed an incident had occurred on 02/02/23 when an unknown male intruder entered the building during the early morning hours behind a resident who had been outside smoking unsupervised and rode the elevator to the second floor and vandalized the second-floor dayroom. The DON stated after that incident the facility administration discussed all smokers being assessed as requiring supervision and implementing staff supervised smoking times. She revealed the facility had a meeting with staff and some of the smokers to discuss these changes, but she was not aware if Resident #31 was in attendance for the meeting and to her knowledge there were no forms completed or signed with any resident stating they understood the smoking changes and all smokers being supervised. The DON stated Resident #31 had always been an independent smoker due to his ability to smoke safely and ambulate independently inside and outside of the facility. She revealed she was told by the Administrator that all smokers were to be assessed as requiring supervision while smoking including previous safe independent smokers, and that is why she informed the Unit Manager to complete the reassessment for Resident #31 to become a supervised smoker. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted with the Administrator on 03/09/23 at 5:59 PM revealed she had started her position as facility Administrator on 02/27/23 and prior to that had been the DON for the facility. She stated the facility smoking policy had been in effect for several years and addressed both independent smokers who were able to smoke at will with no supervision and supervised smokers who required staff supervision during scheduled smoking times. The Administrator stated after the incident that occurred on 02/02/23 where an unknown male intruder entered the building behind a resident who was outside during the early morning hours smoking unsupervised, rode elevator to second floor and vandalized the second-floor dayroom, she and the previous Administrator began discussing supervised smoking for all residents, scheduled smoking times, and staff smoking attendant assigned to supervise. She revealed as part of the changes to smoking she had discussed with the DON to have all smoking residents reassessed as requiring supervision while smoking to include Resident #31 who prior to his current assessment date of 03/06/23 had been an independent safe smoker due to his ability to smoke safely, ambulate independently inside and outside of the facility, and sign himself in and out of facility at his leisure. She revealed the facility was currently working on revising the facility smoking policy and discussing with each resident who smokes the changes.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 43643 Based on observations and staff interviews, the facility failed to maintain a homel like environment for 3 of 3 shower rooms not having warm running water and failed to maintain cleanliness. The findings included: 1. An observation conducted of the shower room on the 300 Hall on 03/06/23 at 12:20 PM revealed a strong odor of urine, the shower drain cover was missing, and the toilet in the shower room was covered in yellow dried stains and brownish substance resembling stool. An interview and observation conducted with Nurse #7 on 03/06/23 at 4:00 PM revealed there had been a shortage of housekeeping staff, and nobody had cleaned the shower room in several days. Nurse #7 and asked to leave the shower room due to the strong urine odor. Nurse #7 indicated the shower room was dirty and needed to be cleaned. An observation was conducted on 03/07/23 on the 300 Hall at 9:15 AM revealed the shower room had a strong odor of urine, the shower drain cover was missing, and the toilet in the shower room was covered in yellow dried stains and brownish substance resembling stool. An interview conducted with Nurse Aide (NA) #11 on 03/09/23 at 1:45 PM revealed she had worked all three halls and there had been issues with housekeeping being short staffed. NA # 11 further revealed she had cleaned the shower rooms and residents' rooms due to being dirty and they had not been cleaned. 2. An observation conducted on the 200 Hall on 03/07/23 at 12:25 PM revealed the shower faucet ran for an estimated time of five minutes and the water temperature was barely warm. This was the only shower in this shower room. An observation conducted on the 100 Hall on 03/07/23 at 1:15 PM revealed the shower faucet ran for an estimated time of five minutes and the water temperature was barely warm. This was the only shower in this shower room. An interview conducted with NA #11 on 03/09/23 at 1:45 PM revealed there had been issues with the temperature of showers and multiple residents had complained daily. NA #11 stated she had reported the water temperatures to the Maintenance Director several times but was not aware if anybody had looked at the issue. An interview conducted with the Director of Housekeeping on 03/08/23 at 9:00 AM revealed the facility has had shortages with staff and housekeeping and residents' rooms and shower rooms had not be cleaned daily like he would like. The Director of Housekeeping further revealed he was aware of the shower water temperature being an issue and had reported this to the Maintenance Director multiple times. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview and observation with the Maintenance Director and the Administrator #2 on 03/08/23 at 1:00 PM revealed the Maintenance Director was aware there had been issues with water temperature and had it looked at. The Maintenance Director was unable to locate any documentation that the water had been looked at by a professional. He indicated the water temperature was an ongoing issue, but did not have a plan for getting it fixed. Administrator #2 stated he was unaware of the water temperature issues but would expect for the residents to be able to have warm to hot showers.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43643 Based on record review and staff interviews the facility failed to protect a cognitively impaired resident from staff to resident physical abuse for 1 of 1 resident (Resident #396) reviewed for abuse. On 02/27/22 when nursing staff were serving breakfast, Resident #396 was standing next to the meal cart and reached for a carton of milk. Nurse Aide (NA) #9 told Resident #396 to stop twice in a loud aggressive manner and when the resident did not comply NA #9 pushed the resident on the left side of his torso above his hip onto the ground. Resident #396's cognitive impairment prevented him from expressing an adverse outcome. A reasonable person would have been traumatized by being physically abused by a caregiver in their home environment. Immediate Jeopardy began on 02/27/22 when Nurse Aide (NA) #9 pushed Resident #396 to the ground while the resident was reaching for an item from the meal cart on the memory care unit of the facility. The Immediate Jeopardy was removed on 03/11/23 when the facility provided and implemented an acceptable credible allegation for Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of a D (No actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure completion of education and monitoring systems put into place are effective. The findings included: Resident #396 was admitted to the facility on [DATE] with diagnoses which included dementia, Parkinson's disease, muscle weakness, and difficulty walking. Resident #396's care plan with a revision date of 10/14/21 revealed the resident had impaired cognitive function and impaired thought processes and communication due to dementia. The care plan goals indicated Resident #396 would be able to communicate basic needs daily through the review date. Interventions included to use the resident preferred name, identify yourself at each interaction, face the resident when speaking and make eye contact, and reduce any distractions. Interventions also included the resident understands consistent, simple, directive sentences and provide the resident with necessary cues and return if the resident was agitated. The care plan for Resident #396 also revealed he had a behavior problem that included, in part, the following behaviors: refusing care, wandering, and sitting on the floor, and taking food from other residents. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #396 was moderately cognitively impaired and required extensive assistance with ambulation and locomotion. majority of activities of daily living. The MDS further revealed Resident #396 was coded for no behaviors or rejection of care. Resident #396 was not steady but able to stabilize without staff assistance for walking. Review of the facility initial allegation report completed by Administrator #2 dated 02/27/22 (a Sunday) revealed on 02/27/22 at 4:00 PM Administrator #2 was made aware of a staff to resident abuse allegation. Nurse #6 alleged NA #9 pushed Resident #396. The report further revealed Resident #396 sustained no injuries. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview conducted with Nurse #6 on 03/09/23 at 8:15 AM revealed on 02/27/22 she was sitting at the nurses' desk charting while other staff were giving out breakfast trays. Nurse #6 further revealed she heard NA #9 tell Resident #396 in a loud manner to stop and she looked up to observe Resident #396 standing next to the meal cart reaching for an item on the meal cart. Nurse #6 stated NA #9 walked back to the cart towards the nurses' desk and told Resident #396 to stop again but said it in a louder and aggressive tone. Nurse #6 observed NA #9 push Resident #396 on his left side in the middle of his torso above his hip and the resident fell to the floor on his right side. Nurse #6 indicated she immediately went to Resident #396 who was observed to look startled and assisted the resident off the floor and assessed for injuries. Nurse #6 revealed Resident #396 sustained no injuries but was observed to be startled. An interview conducted with NA #8 on 03/09/23 at 9:40 AM revealed on 02/27/22 she was handing out breakfast trays and heard NA #9 state to Resident #396 twice to stop it in a loud aggressive manner. NA #8 further revealed she heard a loud thump and left a resident's room and observed Nurse #6 assisting Resident #396 off of the floor. An interview conducted with NA #9 on 03/10/23 at 11:10 AM revealed on 02/27/22 she was handing out breakfast trays and Resident #396 kept trying to grab a milk carton off the meal cart. NA #9 further revealed she told Resident #396 to stop a couple times because he continued to grab for a milk carton. NA #9 indicated she never touched Resident #396 and the resident never went down to the floor. Administrator #2 was notified of immediate jeopardy on 3/9/23 at 4:20 PM. The facility provided the following immediate jeopardy removal plan on 3/16/23. On 3/10/23 the Regional Director of Operations re-educated the Administrator, Director of Nursing and Nurse Managers on the facility policy for Prevention of Abuse and Neglect, the Elder Justice Act as well as providing care for residents with Dementia, Impaired Cognition. This education includes the following: The definition of abuse as the willful infliction of injury, intimidation, or punishment resulting in physical harm, pain, or mental and emotional distress There will be a zero tolerance for resident abuse. A focus on a calm approach, allowing time for residents to complete tasks without rushing and explaining what to expect before beginning to provide care, as well as giving agitated residents a break before continuing care. The requirements to immediately intervene and provide safety for any resident in an abusive situation. The expectation that the residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident ' s symptoms. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345008	A. Building B. Wing	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Citadel at Myers Park, LLC	300 Providence Road Charlotte, NC 28207

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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	The following signs and symptoms of abuse -Welts, bruises, abrasions or lacerations of unexplained origin, especially those that appear symmetrical -Broken bones, fractures, or dislocations (unknown cause/multiple) -Broken glasses or black eyes/dentures or broken teeth -Sexual exploitation/Rape -Excessive exposure to heat or cold -Visible signs of restraint, markings on wrist -Multiple burns or human bites -Fearful demeanor when specific care giver is around On 3/9/23 the Administrator, Director of Nursing and Nurse Managers re-educated all facility staff, including agency staff, on the facility policy for Prevention of Abuse and Neglect including and the Elder Justice Act as well as providing care for residents with Dementia and Impaired Cognition. This education includes a focus on a calm approach, allowing time for residents to complete tasks without rushing and explaining what to expect before beginning to provide care, as well as giving agitated residents a break before continuing care. Staff were also educated to walk away if they are feeling frustrated with a resident and not to place your hands on them. Staff were provided with reassurance to express challenges and frustration with their job without retaliation. This education includes the following: The definition of abuse as the willful infliction of injury, intimidation, or punishment resulting in physical harm, pain, or mental and emotional distress There will be a zero tolerance for resident abuse. A focus on a calm approach, allowing time for residents to complete tasks without rushing and explaining what to expect before beginning to provide care, as well as giving agitated residents a break before continuing care. The requirements to immediately intervene and provide safety for any resident in an abusive situation. The expectation that the residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident ' s symptoms. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The following signs and symptoms of abuse -Welts, bruises, abrasions or lacerations of unexplained origin, especially those that appear symmetrical -Broken bones, fractures, or dislocations (unknown cause/multiple) -Broken glasses or black eyes/dentures or broken teeth -Sexual exploitation/Rape -Excessive exposure to heat or cold -Visible signs of restraint, markings on wrist -Multiple burns or human bites -Fearful demeanor when specific care giver is around All staff were re-educated regarding requirements to report any observation or allegation to the Administrator or Director of Nursing. On 3/10/23 The staff were notified that the contact information for the Administrator and Director of Nursing was posted at each Nurses station for after hours and weekend reporting. The Administrator or Director of Nursing will ensure any staff member accused of abuse or neglect will immediately be removed from the resident care area and supervised until exiting the facility pending an investigation. The Administrator or Director of Nursing will ensure any staff member accused of abuse or neglect will immediately be removed from the resident care area and supervised until exiting the facility pending an investigation. The Director of Nursing will ensure any new hired staff and agency staff receive this training during orientation and their responsibility to maintain the tracking tool to ensure no staff are allowed to work without receiving training. The Director of Nursing will ensure any new hired staff and agency staff receive this training during orientation. Effective 3/10/23 the Administrator will be responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance. Alleged Date of IJ Removal: 3/11/2023 On 3/16/23, the facility credible allegation for immediate jeopardy removal of 3/11/23 was verified through onsite validation. Staff interviews revealed they had received education and training on resident abuse. This included information on the facility's policy for prevention of abuse and neglect, the Elder Justice Act, how to provide care for residents with dementia and impaired cognition, what resident abuse and neglect looks like, and the importance of reporting immediately. Interviews confirmed nursing staff was educated on how to how to walk away from a resident if the resident that is frustrated or agitated and how to approach in a calm manner. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's immediate jeopardy removal plan was validated to be completed as of 3/11/23.

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43643 Based on record review and staff interviews the facility failed to protect residents when Nurse Aide (NA) #9 was not removed from a resident care assignment after Nurse #6 witnessed NA #9 push Resident #396 on the left side of his torso above his hip onto the ground. The facility also failed to thoroughly investigate abuse and to notify Adult Protective Services and Law Enforcement of abuse for 1 of 1 resident reviewed for abuse (Resident #396). Immediate Jeopardy began on 02/27/22 when the facility allowed NA #9 to continue working after she was observed by Nurse #6 to physically abuse Resident #396. The immediate jeopardy was removed on 3/11/23 when the facility implemented a credible allegation of jeopardy removal. The facility will remain out of compliance at a lower scope and severity D (no actual harm with potential for harm) to ensure monitoring systems are put into place are effective. The findings included: A review of the facility policy and procedure titled Abuse, Neglect, and Exploitation, with a revised date of 10/22/20, read in part it is the policy of this facility to provide protections for the health, welfare, and rights of each residents by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The Investigation of Alleged Abused, Neglect, and Exploitation: Section specified in part: 6. Providing complete and thorough documentation of the investigation. The Reporting/Response section specifies in A1, Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all required agencies (e.g. law enforcement when applicable) within specified time frames. The Protection of Resident section reads in part: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after an investigation. Resident #396 was admitted to the facility on [DATE]. Review of the facility initial allegation report completed by Administrator #2 dated 02/27/22 (a Sunday) revealed on 02/27/22 at 4:00 PM Administrator #2 was made aware of a staff to resident abuse allegation. Nurse #6 alleged NA #9 pushed Resident #396. The report further revealed Resident #396 sustained no injuries. Review of the facility internal investigation completed on 02/27/22 by Administrator #2 related to the staff to resident physical abuse allegation involving NA #9 and Resident #396 revealed no documentation of statements from those involved, education provided to staff, or notification that law enforcement and adult protective services was completed. (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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview conducted with Nurse #6, an agency nurse, on 03/09/2023 at 8:15 AM revealed on 02/27/22 she was sitting at the nurses' desk charting while other staff were giving out breakfast trays. Nurse #6 further revealed she heard NA #9 tell Resident #396 in a loud manner to stop and she looked up to observe Resident #396 standing next to the meal cart reaching for an item on the meal cart. Nurse #6 stated NA #9 walked back to the cart towards the nurses' desk and told Resident #396 to stop again but said it in a louder and aggressive tone. Nurse #6 observed NA #9 push Resident #396 on his left side in the middle of his torso above his hip and the resident fell to the floor on his right side. Nurse #6 indicated she immediately went to Resident #396 who was observed to look startled, and she assisted the resident off the floor and assessed for injuries. Nurse #6 revealed Resident #396 sustained no injuries. Following the assessment of the resident she went to Administrator #2's office to report the incident, but Administrator #2 had people in his office and she was unable to report what was observed. Nurse #6 stated she went back to the memory care unit and contacted Unit Manager (UM) #1 who was on call and reported the incident she observed. Nurse #6 revealed she was told somebody from the facility would handle the situation and speak to NA #9. Nurse #6 indicated NA #9 continued to work the rest of the shift working with residents until 3:00 PM. Nurse #6 indicated she was hired through agency but was educated to report any kind of abuse immediately to an upper management staff. Nurse #6 stated she did not think it was appropriate for NA #9 to continue to work the rest of the shift but was told by UM #1 somebody for the facility would handle it. Nurse #6 indicated she did not work at the facility again after the incident date. An interview conducted with NA #8 on 03/09/23 at 9:40 AM revealed on 02/27/22 she was handing out breakfast trays and heard NA #9 state to a Resident #396 twice to stop it in a loud aggressive manner. NA #8 further revealed she heard a loud thump and left a resident's room and observed Nurse #6 assisting Resident #396 off the floor. NA #8 stated she spoke to Administrator #2 at the end of shift and reported the same information but did not write a written statement. NA #8 indicated she believed NA #9 pushed Resident #396 down and could not understand why the NA was allowed to work the full shift. NA #8 revealed she recalled Nurse #6 had reported to staff over the phone. An interview conducted with NA #9 on 03/10/23 at 11:10 AM revealed on 02/27/22 she was handing out breakfast trays and Resident #396 kept trying to grab a milk carton off the meal cart. NA #9 further revealed she told Resident #396 to stop a couple times because he continued to grab for a milk carton. NA #9 indicated she never touched Resident #396 and the resident never went down to the floor. NA #9 revealed she had worked the full shift and spoke to Administrator #2 at the end of her shift. NA #9 stated she did not complete a written statement but was suspended for further investigation for a couple of days. NA #9 indicated she did not receive any abuse training after the incident had occurred. An interview conducted with the Unit Manager (UM) #1 on 03/09/23 at 11:12 AM revealed she was the on-call supervisor on 02/27/22 but was not involved with the incident that occurred with Resident #396. The UM #1 did not recall Nurse #6 reporting the incident to her. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview conducted with the prior administrator, Administrator #2, on 03/09/23 at 9:50 AM revealed he was the abuse coordinator at the time of 2/27/22 incident involving the staff to resident physical abuse allegation for NA #9 and Resident #396. He revealed he could not locate any written documentation for the investigation completed on Resident #396 on 02/27/22. Administrator #2 further revealed he was not made aware of the incident until later in the day on 02/27/22 but could not recall who had reported it. Administrator #2 indicated he did not report the incident to law enforcement or adult protective services because he felt like it was not a crime. Administrator #2 could not recall Nurse #6 coming to him to report abuse and had not gathered written statements from nursing staff but had interviewed staff about the incident. Administrator #2 stated NA #9 had worked the full shift on 02/27/22 but was suspended for a few days after this date to complete an investigation. Administrator #2 revealed he had completed in-service with NA #9 and nursing staff he interviewed who worked the memory care unit during the incident on how to re-direct residents. Administrator #2 was unable to locate documentation of who he had in-serviced and what education was received. Administrator #2 could not recall if he had assessed residents who could have been affected. Administrator #2 further revealed he had suspended NA #9 during an investigation for a couple days, but NA #9 was allowed back to work because he felt like no crime was committed. Administrator #1 was notified of immediate jeopardy on 3/9/23 at 4:20 PM. The facility provided the following immediate jeopardy removal plan on 3/16/23. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance The facility failed to protect Resident #396 and maintain the right to be free from physical abuse. Resident #396 has a diagnosis of dementia and lives in the memory care unit. Resident #396 was observed being pushed by staff and sustained a fall. Resident #396 was assessed by the charge nurse following the incident and no injuries were identified. The facility failed to protect Resident #396 and other residents after physical abuse was observed at approximately 12:00 noon on 2/27/22. The accused Nurse Aide was allowed to continue to work with residents until 4:00pm on 2/27/22, when the allegation of abuse was reported to the Administrator. The Administrator initiated a 24-hour report on 2/27/22 and delivery was verified with the Health Care Personnel Registry on 3/10/23. The Administrator notified Adult Protective Services and Law enforcement on 3/10/23. A five-day report was resubmitted on 3/10/23 with documentation of completed investigation. On 3/10/23 the Administrator and Director of Nursing reviewed the grievance log for the last 30 days to ensure there were no unreported allegations of abuse or neglect. Any allegations identified as a result of this audit will be followed up, the accused staff will be suspended pending investigation, a 24-hour report will be initiated, Adult Protective Services and Law enforcement will be notified. On 3/10/23 the Administrator and Director of Nursing reviewed previously reported allegations of abuse occurring during the last 90 days and validated the investigation was completed and residents were protected. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	All residents have the potential to be affected by these deficient practices. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete On 3/10/23 the Regional Director of Operations re-educated the Administrator and Director of Nursing on the facility policy for completing a 24 hour and 5-day report for abuse and neglect, reporting to the survey agency within 2 hours when there is a suspicion of a crime, notification to law enforcement and notification of Adult Protective Services. This education included requirements for a complete investigation including resident and staff interviews, medical record review and incident re-enactment when appropriate. On 3/10/23 the Administrator, Director of Nursing and Nurse Managers re-educated all facility staff, including agency staff, on the facility policy for preventing abuse and neglect, providing protection to residents and immediate reporting to the Administrator and Director of Nursing including location of contact information for after hours and weekend reporting. All staff were re-educated regarding the requirement to immediately provide safety for any resident in an abusive situation and then report any observation or allegation of abuse or neglect to the Administrator or Director of Nursing. On 3/10/23 the staff were notified that the contact information for the Administrator and Director of Nursing is posted at each Nurses station for after hours and weekend reporting. The Administrator or Director of Nursing will ensure any staff member accused of abuse or neglect will immediately be removed from the resident care area and supervised until exiting the facility pending an investigation. On 3/10/23 the Administrator notified the Director of Nursing and Assistant Director of Nursing of their responsibility to provide the education and maintain the tracking tool to ensure no staff are allowed to work without receiving training. The Director of Nursing will ensure any newly hired staff and agency staff receive this training during orientation. On 3/10/23 the Administrator began reviewing all allegations of abuse or neglect with the Interdisciplinary team during the Morning Meeting. On 3/10/23 the Regional Director of Operations will begin a weekly review of all 24- hour reports to ensure staff are suspended, thorough investigations are completed with 5- day report submitted and documentation to reflect timely submissions. Effective 3/10/23 the Administrator will be responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance. Alleged Date of IJ Removal: 3/11/2023 (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/16/23, the facility's credible allegation for immediate jeopardy removal effective 3/11/23 was validated by the following: Administrator #1 and Director of Nursing (DON) interview revealed they were re-educated on the facility for completing a 24 hour and 5-day report for abuse and neglect, reporting to survey agency within two hours when there is a possible crime, and notification to adult protective services (APS) and law enforcement. Education included when completing a thorough investigation to conduct staff interview, medical record review, and incident re-enactment when appropriate. Through interviews with nursing staff they verified education was provided for preventing abuse and neglect, provide protection to residents, and reporting possible neglect or abuse to the Administrator or DON immediately. Staff also revealed they were notified that the contact numbers for the DON and Administrator were posted at the nurses ' desks in case of possible abuse or neglect to report if they were not in the building. Administrator #1 further reveled she had started a new investigation on the incident and had suspended NA #9 pending the investigation. The Administrator indicated reports had been re-submitted. The facility's immediate jeopardy removal plan was validated to be completed as of 3/11/23.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43643 Based on record review, staff interviews, and observations the facility failed to implement a care plan intervention for 1 of 4 residents (Resident #21) reviewed for accidents. Resident #21 was admitted to the facility on [DATE] with diagnoses which included vascular dementia and hypertension. Review of Resident #21's nursing note dated 07/22/22 revealed Resident #21 was observed eating hair care products located at bedside and was also chewing a piece of plastic. The note further revealed Resident #21 was instructed to spit out the plastic and after two attempts she followed instructions and personal hair care items and hygiene items were placed at the nurse's station. Review of Resident #21's care plan revised on 08/05/22 revealed Resident #21 had a behavior problem of eating hair products. The goal was for Resident #21 to have fewer episodes of behaviors by review date. Interventions included if reasonable to discuss the resident's behavior and explain why behavior is inappropriate and/or unacceptable to the resident. Interventions also included to keep hair care products at the nurse's station. Review of Resident #21's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident was severely cognitively impaired. An observation conducted on 03/06/23 at 12:15 PM revealed lotion, hand sanitizer, antifungal powder spray, blue nursing medical exam gloves, baby powder, after shower lotion, and baby oil on Resident #21's bedside table. Observation included a large note written on Resident #21's closet door to keep items at the nurse's station. An observation conducted on 03/06/23 at 3:22 PM revealed lotion, hand sanitizer, antifungal powder spray, blue medical exam gloves, baby powder, after shower lotion, and baby oil on Resident #21's bedside table. Observation included a large note written on Resident #21's closet door to keep items at the nurse's station. An interview conducted with the Resident #21's Resident Representative (RR) on 03/06/23 at 3:25 PM revealed nursing staff had continued to leave items beside Resident #21's bedside table. The RR further revealed Resident #21 had a habit of putting items in her mouth and the RR had put up a note in the resident's room and continued to educate staff. An interview and observation conducted with Nurse #7 on 03/06/23 at 4:00 PM revealed Resident #21's bedside table had lotion, hand sanitizer, antifungal powder spray, blue medical exam gloves, baby powder, after shower lotion, and baby oil placed on it. Observation included a large note written on Resident #21's closet door to keep items at the nurse's station. Nurse #7 indicated Resident #21 consistently put items in her mouth and those items should have not been left out. Nurse #7 picked up the items and placed them back at the nurse's desk. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation conducted on 03/07/23 at 1:45 PM revealed two boxes of blue medical exam gloves and hand sanitizer on the bedside table. An interview and observation conducted with the Director of Nursing (DON) on 03/08/23 at 9:30 AM revealed two boxes of blue medical exam gloves and hand sanitizer. The DON revealed Resident #21 had a tendency of putting items in her mouth and the items observed should not have been left out.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 45380 Based on observation, record review, staff, resident, Nurse Practitioner and Medical Director interview the facility failed to prevent severely cognitively impaired residents from exiting the facility through unlocked doors without supervision for 2 of 2 residents reviewed for supervision to prevent accidents (Resident #88 and #68). Resident #88 who was severely cognitively impaired, exited the building through an unlocked door on the first floor to smoke without supervision. An unidentified male intruder entered facility behind Resident #88 through the unlocked door of facility and vandalized the second-floor dayroom by shattering the TV, knocking a hole in the wall, and breaking out two windows. The facility failed to repair broken windows only covering windows with cardboard and wooden board that was easily removable leaving broken windows and shards of broken glass accessible to residents and failed to complete a facility investigation. Resident #68 was severely cognitively impaired and exited the memory care unit through an unlocked door to the staircase. The resident went down three flights of stairs and exited the facility through a side door. Resident #68 was found by a Nurse Aide (NA) when he went to his car, the resident was laying in the backseat of the NA's car asleep. The NA left Resident #68 in the unlocked car with the windows up, unattended in 74-degree weather while he went back inside for help. Immediate Jeopardy began on 7/30/22 for Resident # 68 and 2/2/23 for Resident # 88 when the facility failed to provide supervision to cognitively impaired residents and failed to correct environmental hazards which put residents at a high likelihood for serious harm and injury. The immediate jeopardy was removed on 08/02/22 for Resident # 68 when the facility implemented an acceptable credible allegation for Immediate Jeopardy removal. The immediate jeopardy was removed on 03/11/23 for Resident # 88 when the facility provided and implemented an acceptable credible allegation for Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of an E (No actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure completion of education and monitoring systems put into place are effective. Findings included: 1. Facility smoking policy dated 02/01/20 revealed smoking by residents who have been identified and assessed as unable to safely smoke independently may smoke only at the designated times and smoking will be supervised by a staff member. All smoking and fire igniting materials for residents who have been identified and assessed as unable to safely smoke independently shall be maintained by the facility and will be provided to residents by facility staff during designated smoking times. Resident #88 was a female admitted to the facility on [DATE] with diagnoses to include impaired cognitive function, impaired thought processes related to memory and major depressive disorder. Resident #88 was petite in stature, suffered from unavoidable weight loss and was being treated under Hospice care due to diagnosis of cirrhosis of liver. Review of admission smoking assessment dated [DATE] revealed Resident #88 was assessed to require supervision while smoking due to her inability to verbalize or demonstrate her understanding of the facility time and place to smoke listed under section B for cognition. (continued on next page)

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	345008	A. Building B. Wing	03/16/2023

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of admission minimum data set (MDS) dated [DATE] revealed Resident #88 was severely cognitively impaired, required use of walker and occasional use of wheelchair for mobility, and was assessed as a current tobacco user. Review of admission care plan dated 12/26/22 revealed Resident #88 was identified as a smoker with a goal of not smoking without supervision through next review. Interventions included instruct Resident #88 of the facility policy on smoking: locations, times, safety concerns and Resident #88 requires supervision while smoking. Review of Police Department Incident Report dated 02/02/23 revealed vandalism incident at facility occurred between 5:20 AM and 5:41 AM and included damages to windows, television, and interior wall located on second floor. The incident report stated, On 02/02/23 at approximately 5:34 AM, officers were dispatched to facility in reference to a report of commercial breaking or entering call for service. When officers arrived on the scene, the listed suspect was on scene damaging the facility's property on the second floor. The suspect was detained by officers and transported to nearby medical facility. Warrants were issued for the listed suspect. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A telephone interview was conducted with Nursing Assistant #7 (NA) on 03/07/23 at 7:04 PM revealed she worked on the second floor of the facility from 11 PM to 7 AM and was working the morning of 02/02/23 when the incident occurred. She stated residents on the second floor wake up between 4 AM and 6 AM and come down to the dining room to have their morning coffee and then would go outside to smoke unsupervised including Resident #88. She revealed at 5:20 AM she was in the shower room, which was located next to the dining room, assisting another NA and resident when she heard someone walking down the hall. NA #7 stated she looked outside the shower room door and saw an unknown male intruder wearing a jacket, scrubs and what appeared to be men's briefs on his head like a mask heading towards the dining room. She revealed she had told the other NA to stay in the shower room with the resident while she investigated who the unknown male intruder was and checked on the residents in the dining room. She stated when she came out of the shower room the unknown male intruder was standing in the dining room looking around and had taken off his jacket and kicked it in the air. NA #7 revealed the unknown male intruder then began walking down the hall towards the second-floor dayroom and that is when she told the residents in the dining room to go back to their rooms or to go downstairs to the first floor. She stated she had asked Nurse #5 who was on the floor to call 911 while she stood in the hallway and watched the unknown male intruder in the dayroom. She revealed the unknown male intruder had sat down at the desk located in the dayroom and was mumbling to himself and then picked up a three-hole punch from the desk and threw it at the TV on the wall shattering the screen. NA #7 stated the unknown male intruder picked up a chair from the dayroom and busted out two of the windows and then threw TV remotes which caused a hole in the wall. She revealed the unknown male intruder turned around and started to charge back up the hall and that is when she went into nurse's station and locked the door. She stated the unknown male intruder had gone back into the dining room when the police arrived and removed him from the floor. She also stated she provided her statement to the police but was never asked to give a verbal or written statement to the facility. NA #7 revealed she was later informed the unknown male intruder had entered the building and rode the elevator to the second floor with Resident #88 who had been outside smoking unsupervised. She stated she was not aware of Resident #88 being a supervised smoker and requiring supervision, but she and other residents would go outside during all hours of night and early mornings to smoke unsupervised. She revealed the door leading out to the smoking porch had been left unlocked after-hours to accommodate residents and staff with coming in and out of the building. NA #7 stated the facility had placed a camera and two-way speaker outside of the door but was not aware of who supposed to be monitoring the camera and the door continued to require a manual lock and wasn't aware of who's responsibility it was to manually lock door. She revealed she had worked from 11 PM- 7AM last night and door was unlocked all through the night and residents were continuing to go outside and smoke unsupervised. NA #7 stated the broken windows and glass had been there since incident happened and maintenance had placed a piece of cardboard and wood over the broken windows that were able to be removed by one hand. She revealed in her opinion this could have been dangerous to residents on the second-floor due residents being ambulatory or able to reach from wheelchair, easy removal of coverings placed on windows, and cognitive issues of residents causing them to hurt themselves or others. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A telephone interview was conducted with Nurse #5 on 03/07/23 at 5:52 PM revealed she was working 11 PM to 7 AM on 02/02/23 when incident occurred. She stated apparently Resident #88 had gone outside that morning to smoke unsupervised and around 5:20 AM when entering back into the building, an unknown male intruder entered the building behind her and rode the elevator up to the second floor. Nurse #5 stated at first, she believed the unknown male intruder to be an agency staff due to him wearing scrubs but started noticing erratic behaviors such as standing in the dining room and taking off his jacket and kicking it in the air. She revealed Nursing Assistant #7 (NA) came out of the shower room and began watching the unknown male intruder while she went behind the nurse's station to call 911. She stated while NA #7 watched the unknown male intruder and told residents to go to their rooms, she went down to the first floor to escort officers up to second floor where they removed the unknown man from the dining room. Nurse #5 revealed she later learned the unknown male intruder had gone into the dayroom and broken out the windows, shattered the TV and knocked a hole in the wall. She stated the door leading to the smoking porch has always been kept unlocked at night for staff and residents to be able to go outside and smoke. She revealed a camera and two-way speaker had now been placed outside the door, but the door still had to be manually locked and to her knowledge continued to stay unlocked. Nurse #5 stated maintenance came up after incident and covered windows with just a board and cardboard which in her opinion was dangerous because the second-floor residents could easily remove coverings and hurt themselves or others. Observation of second-floor dayroom on 03/07/23 at 3:00 PM revealed two broken windows that had not been repaired. Both windows measured waist high while standing and chest high while sitting and would have been accessible to all ambulatory residents and residents who required wheelchairs and rollators. One window had been broken through first pane and had sharp edges still intact on window and broken glass inside window and on windowsill and was only covered with cardboard. The second window had been broken through both panes only leaving the window screen intact with broken glass inside window and on windowsill and was only covered by a wooden board. Both window coverings were easily removable by hand and accessible to all residents. The second-floor dayroom was still accessible to all residents but there were no residents located in dayroom during observation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted with Administrator #1 on 03/07/23 at 3:23 PM revealed she had started as the current Administrator of the facility on 02/27/23 and prior to that had been the Director of Nursing. She stated she was informed by Administrator #2 of the incident with the unknown male intruder entering the building and vandalizing the second-floor dayroom. Administrator #1 revealed to her understanding, Resident #88 was outside on the smoking porch of the facility during the early morning hours of 02/02/23 smoking unsupervised. She stated an unknown male intruder followed Resident #88 back into the facility and rode the elevator with her to the second floor. She revealed Resident #88 nor staff knew who the unknown male intruder was so staff called 911 and before the police could arrive to remove him from the facility, he vandalized the second-floor dayroom by shattering the television on the wall, knocked a hole in the wall, and had used a chair to break out two of the windows. Administrator #1 stated she was told no residents had witnessed the incident but was not aware if Administrator #2 had spoken with any of the residents about the incident or had completed an investigation. She revealed that she and Administrator #2 had discussed having a camera with a two-way speaker installed at the door leading to the smoking porch, but the door would still require to be locked manually. She stated the nursing staff on the first floor would be responsible for making sure door was locked afterhours. Administrator #1 revealed maintenance had placed a wooden board and a piece of cardboard to cover the broken windows until a contractor could come and repair the broken windows and to her knowledge the contractor had been contacted but no date scheduled for the repair. She stated the facility had scheduled smoking times for supervised smokers and Resident #88 had been assessed as requiring supervision while smoking and should not have been allowed outside to smoke unsupervised. An interview was conducted with Administrator #2 on 03/09/23 at 9:55 AM revealed he had been the facility Administrator from 2017 until 02/27/23 and was the acting Administrator when the incident occurred on 02/02/23. He stated he had received a text from staff about the incident and when he arrived at the facility the unknown male intruder had been removed from the facility and there were two officers there receiving statements from staff. He revealed that his understanding of the incident was that Resident #88 had gone outside earlier that morning to spoke unsupervised and she allowed an unknown male intruder to come back into the building with her and ride the elevator to the second floor with her. The Administrator #2 stated the unknown male intruder vandalized the second-floor dayroom by shattering the TV, knocking a hole in the wall, and breaking out two of the widows with a chair. He revealed he only received verbal statements from staff, but no written statements and no investigation was completed. He stated he did not speak with any of the residents on the second floor about the incident and was not aware that any of the residents had been up that morning or had witnessed the incident. The Administrator #2 revealed he did not have a formal meeting with staff about the incident, he and the Director of Nursing spoke and decided to implement the camera and two-way speaker to the outside of door leading to smoking porch. He stated the door would still have to be manually locked and first floor nursing was responsible for making sure the door was locked after-hours. The Administrator #2 revealed although the facility had implemented smoking times for supervised smokers, he knew there had still been issues with residents going out to smoke unsupervised all hours of day and night and issues with the doors staying unlocked, but they were working with residents and staff on these issues. He stated that Resident #88 was a supervised smoker and should not have been outside smoking unsupervised. He revealed he was responsible for having maintenance board up windows and was not aware that broken glass had been left in the window that was accessible to residents and that maintenance should have cleaned out windows and done a better job with boarding up the windows. The Administrator #2 stated that he had contacted a contractor about the windows, and they had come out and measured for the replacements but did not have scheduled date to come out and replace them. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation of door leading to smoking porch on 03/07/23 at 6:20 PM being unlocked and Resident #88 sitting in wheelchair smoking unsupervised. An interview was conducted with Maintenance Director on 03/08/23 at 12:15 PM revealed on 02/02/23 he arrived at work around 7 AM and was informed by Administrator #2 of the vandalism that had occurred in the second-floor dayroom. He stated he accompanied Administrator #2 to the second-floor dayroom and observed the television on wall with shattered screen, a hole in the wall, and two broken windows. The Maintenance Director revealed he was asked by Administrator #2 to remove television from wall and to cover broken windows until a contractor could be notified to repair broken windows. He stated he removed television from wall and covered both broken windows with materials he had available at the facility. The Maintenance Director revealed one window was covered with cardboard and the other window had been covered by a piece of wood and both had been secured in place by three nails placed at the bottom of the window into the windowsill but were easily removable to give access to contractor when he came to measure for replacement windows. He stated he did not think to remove the broken glass out of the windows or from the windowsills before applying the coverings to windows or the broken glass being accessible to residents. He revealed Administrator #2 was responsible for contacting contractor for replacement windows and to his knowledge a contractor had been out to the facility to measure for the replacement windows, but no date had been scheduled for the repair. The Administrator was notified of immediate jeopardy on 03/07/23 at 5:50 PM. The facility provided the following plan for IJ removal. o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance Resident #88 with a brief interview for mental status (BIMS) of 6 and assessed as a supervised smoker was outside on the smoking porch on 2/2/23 at approximately 5:20 AM smoking unsupervised. The door to the smoking porch was unlocked. An unknown individual who did not reside in the facility, was on the smoking porch with Resident #88 and came into the facility with her when she finished smoking, rode the elevator with her to the 2nd floor, walked by the nurse's desk to the end of hall and busted the windows of the day room with a chair and then busted the TV glass with a chair. Staff went into the medication room, locked the door and called 911 leaving the residents unsupervised. On 2/2/23 the Administrator came to the facility immediately following notification from the facility regarding the event at 5:20am. The Maintenance Director assisted the Administrator to cover the broken windows prior to residents getting up for the day. On 3/7/23 the windows in the dayroom on the 2nd floor revealed shards of glass exposed, one window covered with cardboard, and a second window covered with wood. The glass repair vendor visited the facility on the afternoon of 2/2/23 to (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	regarding whom they are visiting or the purpose of the visit prior to allowing entry into the facility. This training will be completed by 3/8/23 by the Director of Nursing and Nurse Managers. On 3/8/23 a smoking attendant will be assigned daily by the Director of Nursing to monitor the smoking porch from 8am-8pm . All staff assigned to cover as a smoking attendant were educated by the Director of Nursing on 3/8/23 on the facility policy for smoking, managing Workplace Violence as outlined in the Emergency Preparedness Plan including the requirement to call 911 immediately in the event an unknown individual attempts to enter the facility through the smoking porch door. No one will be assigned this responsibility without receiving training. All current smokers have been educated regarding the facility smoking policy including a review of the smoking schedule for supervised smokers. All smokers have been educated to ring the doorbell and notify staff if a visitor or unknown individual approaches the smoking area. This education will be completed by 3/8/23 by the Director of Nursing and Nurse Managers. By 3/8/23 all staff will be trained by the Director of Nursing and Nurse Managers on notifying the Administrator and Director of Nursing of any building repairs that represent a safety concern for residents. After 3/8/23, the Assistant Director of Nursing and Nurse Managers will ensure no staff will be allowed to work, including any new hired staff and agency staff, without receiving this education. Effective 3/8/23 the Administrator will be responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance. Alleged Date of IJ Removal: 3/11/2023 On 03/16/23, the facility's credible allegation for immediate jeopardy removal effective 03/11/23 was validated by the following: Staff interviews revealed they had received training on workplace violence to include making sure to secure all residents, call code silver, call 911, and notify administration. Staff interviews also revealed they had received training on security of the facility and that doors are supposed to be locked at all times and staff making sure all doors are locked so all staff and visitors are using the smoking porch entrance so they could be seen on the camera and allowed entrance into the facility and on the smoking policy and that all residents are supervised smokers and there would be a smoking attendant during designated smoking times to ensure smoker safety and no residents allowed out to smoke except during smoking times. Observed broken windows on second floor dayroom to have been repaired and receipt showing they had been repaired on Friday 03/10/22. Observation of all entry doors being locked from outside and camera with two-way speaker working at smoking porch entrance and camera feed and speaker in working order at first shift nursing station. The Administrator had possession of all manually locked doors to ensure the doors stay locked and visitors are being allowed entrance into facility by staff. Audits were in process of being completed with all smoking residents about supervised smoking policy, smoking times, smoking attendant, and doors staying locked at all times and use of camera and two-way speaker. 40476 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. Resident #68 was admitted to the facility on [DATE] with diagnosis that included: schizophrenia and Alzheimer's disease. A wandering assessment was completed on 07/31/22 and indicated that Resident #68 was at high risk for wandering. An annual Minimum Data Set (MDS) dated [DATE] indicated that Resident #68 was severely cognitively impaired and required limited assistance with mobility on the unit. The MDS indicated that Resident #68 had shown no wandering behaviors during the assessment reference period. A care plan initiated on 06/30/21 and updated on 1/19/23 revealed a focus area related to Resident #68 being an elopement risk/wanderer. The goal was for the resident's safety will be maintained through the review date. Interventions included address wandering behavior by walking with resident; redirect residents from inappropriate areas; Administer and monitor for the effectiveness and side effects of medications. A wanderguard was applied to Resident #68's left ankle. A nursing behavior note dated 6/27/22 at 10:33 PM revealed Resident #68 was up on the unit with increased wandering into other residents' rooms. Redirection was attempted and the residents Responsible Party (RP) was notified. A nursing progress note dated 7/30/22 at 11:08 PM written by Nurse #4 revealed at 10:57 PM Resident #68 was found inside an employee's vehicle, asleep in the backseat. Resident #68 was last seen by staff at 10:00 PM and provided incontinence care. Resident #68 was last seen by Nurse #4 at 9:30 PM when administered his medication. The note revealed Resident #68 had a wanderguard on his left lower extremity that did not sound when he exited the floor. Resident #68 exited using the back stairs, no alarm was sounded. The resident was assisted back to the unit by a Nurse Aide (NA) #5. No bruising or injuries were noted. Resident #68 was in no pain or discomfort. He was placed back in the bed and put on every 15-minute monitoring. Nurse #4 documented she had notified the Director of Nursing (DON). A Medication Administration Record (MAR) note dated 7/30/22 at 11:04 PM written by Nurse #4 revealed under the order to check wander guard placement for functioning every shift that Resident #68 needed a new wander guard because the current one in place did not sound. A wandering assessment was completed on 07/31/22 and indicated that Resident #68 was at high risk for wandering. On 3/8/23 at 1:47 PM an interview was conducted with Resident #68's Responsible Party (RP). During the interview she stated the facility contacted her on 7/31/22 to explain that Resident #68 was found in a Nurse Aide's car around 11:00 PM the night before. The interview revealed Resident #68 had not exited the building prior to that incident nor had he exited after the incident. She stated he wandered constantly in the facility and that is why he was admitted on to the locked unit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 3/8/23 at 3:09 PM an interview was conducted with the Administrator. She stated at the time of the incident she was the Director of Nursing (DON) and was notified by Nurse #4 that Resident #68 had gotten out of the building via text message. She stated she did not see the message on her phone until the following morning. The interview revealed it was reported to her when staff were doing their rounding on the unit they did not see Resident #68. The Administrator stated Nurse #4 had last seen the resident at 9:30 PM when she was administering bedtime medication and Resident #68 was wandering on the unit. She stated NA #6 assisted him with incontinence care and helped him get into bed around 10:00 PM. It was reported at 10:30 PM Resident #68 had gotten back out of bed and was wandering the halls when Nurse #4 assisted him back to bed for the second time. The Administrator stated at 10:45 PM NA #5 had gone to his car when he saw Resident #68 laying in the backseat. She stated it was reported to her he then called into the building to get a staff member to assist the resident back into the building. The interview revealed Nurse #4 completed a head-to-toe assessment, initiated every 15-minute monitoring, and notified her. On 3/8/23 at 3:40 PM an interview was conducted with Nurse Aide (NA) #1. NA #5 stated he was about to end his shift at 10:45 PM. He stated when he got into his car parked outside of the facility in the parking lot, he sat down in the driver's seat when he started to feel like someone was behind him. He stated he looked behind him and saw Resident #68 laying down in the backseat of his car. The interview revealed he immediately jumped out of the car without locking the doors and ran into the building to the third floor to get Resident #68's Nurse Aide (NA). He stated NA #6 was responsible for Resident #68 and did not know he was missing when he saw her on the third floor. The two NAs went back down to NA #5's car and assisted Resident #68 get his shoes on and ambulate back inside of the building. He stated the staff from the third floor were all in shock because they had not noticed he was missing from his room. NA #5 stated Resident #68 was hot and sweating from being in the backseat of the car. He stated Resident #68 was startled and did not say much when they were assisting him inside. NA #5 stated he did not know the door was unlocked because he did not work on the memory care unit. On 3/8/23 at 4:01 PM an interview was conducted with Nurse #4. She stated she worked as agency staffing in the building since June 2022 and was responsible for Resident #68 on the night of 7/30/22. Nurse #4 stated she believed a man that was working the 3:00 PM to 11:00 PM shift went to his car and noticed the resident in his backseat asleep. She stated she did not know the resident was missing from the third floor until NA #5 came and said he had found the resident. Nurse #4 stated she had been charting in the dining room so she could see the door to the stairway because the lock had been broken for several weeks and she knew residents could get out. The interview revealed she was providing care to other residents and did not see the resident leave the unit. Nurse #4 stated she had not specifically told anyone the door was unlocked on the third floor because she felt like everyone knew the lock was broken to the door going to the stairway. The interview revealed the door had always been open since she had orientation in the building in June and staff did not have to put in a key code to get through the door. She stated the NAs on the floor were completing their last rounds on the 3:00PM to 11:00 PM shift when she saw Resident #68 out of bed wandering on the unit. She stated she assisted him back to his bed at approximately 10:30 PM. When the NA's brought Resident #68 back to the unit she assessed him for any injuries and saw no bruising. Nurse #4 stated Resident #68 was sweaty but did not seem in distress. She stated she assisted the resident back to bed and initiated every 15-minute monitoring. Nurse #4 notified the Director of Nursing (DON) via text message and gave report to the oncoming shift. (continued on next page)

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	345008	A. Building B. Wing	03/16/2023

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 3/8/23 at 4:24 PM an interview was conducted with NA#2. She stated she had been working on the third floor and was Resident #68's NA on 7/30/22. The interview revealed she had gotten Resident #68 situated in bed around 10:00 PM and went onto complete other resident's care. She stated the next thing she remembered was NA #5 came running onto the unit saying Resident #68 was laying in the backseat of his car asleep. NA #6 stated she was shocked along with everyone that had been working on the third

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 36217 Based on observations, staff interviews and record reviews, the facility failed to remove expired medication in accordance with manufacturer's expiration date and failed to store unopened medications in the temperatures specified by manufacturer's guidelines for 2 or 5 medications carts observed during medication storage checks (Third-floor long hall and Third-floor short hall). The findings included: 1. An observation was conducted on 03/08/23 at 10:22 AM for the third-floor long hall medication cart in the presence of Nurse #1. The observation revealed one bottle of opened liquid iron supplement (Ferrous Sulfate) with concentration of 220 milligram (mg) per 5 milliliter (ml) containing approximately 450 ml in the medication cart. It was expired on 01/31/23 and available for administration. On the bottle, a marker stated it was opened on 03/07/23. An interview was conducted with Nurse #1 on 03/08/23 at 10:26 AM. She stated she was the nurse who had dated the liquid Ferrous Sulfate after pulling it from the medication storage room on 03/07/23. She explained she did check the expiration date that indicated it expired in 2023 it . However, she had missed noting that it was expired in January 2023. 2. An observation was conducted on 03/08/23 at 10:32 AM for the third-floor short hall medication cart in the presence of Nurse #2. The observation revealed one unopened bottle of Latanoprost eye drop wrapped in the plastic seal for Resident #79. It was stored in the medication cart under room temperature and available to be used. The bag containing this eye drop had a sticker stated, After opening, may store at room temperature. Throw away any drug left after 6 weeks. Review of manufacturer's package insert for Latanoprost eye drops reveled unopened bottle should be stored under refrigeration between 36 to 46 Fahrenheit (F) and protected from light. Once opened, Latanoprost may be stored at room temperature up to 77 F for up to six weeks. Review of physician's orders and medication administration records revealed Resident #79 had a current order to receive one drop of Latanoprost solution in left eye once daily in the evening started 06/18/22. During an interview conducted on 03/08/23 at 10:36 AM, Nurse #2 stated she started to work for the facility about 10 days ago. Typically, she would check the medication cart during her shift for expired medication and improper storage. She did not know who had pulled the Latanoprost eye drop and stored it in the medication cart prior to her shift. She explained she was so busy in the morning that she had missed the unopened Latanoprost eye drop when she did the medication cart check. An interview was conducted with the Director of Nursing (DON) on 03/08/23 at 4:12 PM. She expected nursing staff to check the expiration date when pulling medication from the medication storage room to ensure each medication cart was free of expired medication, and to follow the manufacturer's recommendations for storage of medications in proper temperature. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator on 03/09/23 at 10:39 AM revealed she expected nurses to check the expiration date of the medication when they pulled it from the medication storage room, or before administering the medication to the residents. It was her expectation for the staff to store all medications according to manufacturer's recommendation and free of expired medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43643 Based on observations and staff interviews, the facility failed to maintain a clean and damage free kitchen for food production. These practices had the potential to affect food production and food served to residents. Findings included: An observation of the kitchen on 03/06/23 at 10:20 AM revealed a large air vent covered in dust, dirt, and lint. Clean dishes were noted to be stored underneath the dirty vent. Observations of the kitchen's ceiling revealed paint peeling and paint flakes were observed on the floor. The paint peelings were observed on the floor around the food production area. A floor drain had a missing cover, and several floor tiles were missing near the washing station. Observations also included an estimated of 2 by 4-foot area was cut out of the ceiling. The area was uncovered and located above the dishwasher and cleaning area. An interview conducted with Dietary Aide #1 on 03/06/23 at 10:30 AM revealed he had been working in the facility for about a year and the broken floor tiles, missing drain cover, and peeling paint on the ceiling had been there since he had started working in the facility. The Dietary Aide further revealed the hole in the ceiling had been there for over three months. The Dietary Aide indicated the Maintenance Director was responsible for changing and cleaning air vents and was unsure why it had not been clean. The Dietary Aide indicated he had tripped over the drain without a cover and missing floor tiles before and Administrator #2 had been made aware. An interview conducted with the Dietary Manager (DM) on 03/06/23 at 10:45 AM revealed she had been working in the facility for almost two months as the DM and was aware that the air vent was dirty that was over the cleaning station, paint peeling from the ceiling, missing drain cover, large hole in the ceiling above the dishwasher, and broken floor tiles. The DM further revealed she had disclosed these issues multiple times to the maintenance director, but they had not been fixed yet. An interview and observation conducted with the Maintenance Director and Administrator #2 on 03/08/23 at 1:00 PM revealed the air vent over the cleaning station was dirty, paint peeling from the ceiling, missing drain cover, large hole above the dishwasher, and broken floor. The Maintenance Director further revealed he had changed the air filter but was not aware he was supposed to clean the air vent. The Maintenance Director indicated the hole in the ceiling was due to water damage and he had contacted professionals to make repairs but was unable to provide documentation that any issues were expected to be fixed. Administrator #2 further revealed he was not aware of all the issues and the condition of the kitchen was not acceptable and fixes needed to be made.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 40476 Based on observation, record review, staff, resident, Nurse Practitioner and Medical Director interview the facility Administration failed to provide leadership and oversight to facility staff to ensure effective systems were in place to supervise smokers assessed as unsafe when they went out to smoke through an unlocked door, keep residents safe from outside intruders by not ensuring the building was locked and secured, they failed to have the door to the third-floor locked memory care unit repaired ensure the door locked to prevent wandering residents from exiting the facility. Administration also failed to ensure broken windows with exposed shards of glass in a room accessible to residents were repaired. Immediate Jeopardy began on 07/30/22 for Resident #68 when the facility failed to have systems in place to prevent cognitively impaired residents from exiting the facility. The immediate jeopardy was removed on 08/02/22 for Resident # 68 when the facility implemented an acceptable credible allegation for Immediate Jeopardy removal. Immediate Jeopardy began for Resident #88 on 2/2/23 when the resident was outside smoking unsupervised and an outside intruder entered the building with her when she came in from smoking. The immediate jeopardy was removed on 03/11/23 for Resident # 88 when the facility provided and implemented an acceptable credible allegation for Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of an F (No actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure completion of education and monitoring systems put into place are effective. Findings included: This tag is cross referred to F689 and E0001. F689: Based on observation, record review, staff, resident, Nurse Practitioner and Medical Director interview the facility failed to prevent severely cognitively impaired residents from exiting the facility through unlocked doors without supervision for 2 of 2 residents reviewed for supervision to prevent accidents (Resident #88 and #68). Resident #88 who was severely cognitively impaired, exited the building through an unlocked door on the first floor to smoke without supervision. An unidentified male intruder entered facility behind Resident #88 through the unlocked door of facility and vandalized the second-floor dayroom by shattering the TV, knocking a hole in the wall, and breaking out two windows. The facility failed to repair broken windows only covering windows with cardboard and wooden board that was easily removable leaving broken windows and shards of broken glass accessible to residents and failed to complete a facility investigation. Resident #68 was severely cognitively impaired and exited the memory care unit through an unlocked door to the staircase. The resident went down three flights of stairs and exited the facility through a side door. Resident #68 was found by a Nurse Aide (NA) when he went to his car, the resident was laying in the backseat of the NA's car asleep. The NA left Resident #68 in the unlocked car with the windows up, unattended in 74-degree weather while he went back inside for help. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	E0001: Based on record review and staff interviews the facility failed to follow the Emergency Preparedness policy and provide education on the emergency preparedness plan for workplace violence to the facility staff. Staff failed to follow the emergency preparedness plan by not initiating the workplace violence procedures including calling the facility code to warn staff of a threatening situation (Code Silver) out loud and over the public address system, moving residents to a safe place, and initiating a lockdown of the building when an unknown male intruder entered the facility behind a severely cognitively impaired resident (Resident #88), rode an elevator to second floor, and vandalized the second-floor dayroom by destroying a television, knocking a hole in the wall, and breaking out two windows. This deficient practice had the potential to impact all residents in the facility because of the violent nature of the intruder and once the intruder was inside the facility, he had access to all resident areas of the facility. On 03/10/23 at 6:45 PM an interview was conducted with the Regional [NAME] President of Operations. She stated after reviewing the identified concerns, additional one on one training needed to be completed with Administrator #1 and #2 to avoid additional incidents from occurring. She also stated they would be assisting Administrator #1 with reviewing and updating all current facility policies in an effort to prevent reoccurrence of the identified concerns. Facility administration was notified of immediate jeopardy for Resident #68 on 03/08/23 at 11:35 AM. The facility provided the following the following corrective action plan with completion date of 08/02/22: o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance Administration failed to provide effective leadership and oversight to ensure effective systems were in place to keep residents safe from outside dangers, to ensure residents assessed as unsafe smokers were supervised and to keep residents safe from harm by not ensuring the building was secure, specifically the third-floor locked memory care unit and to prevent wandering residents from exiting the facility.The Administrator failed to ensure repair of broken windows leaving shards of glass exposed that were in a room accessible to residents and failed to ensure the door to the stairwell on the third floor was locking properly.All residents have the potential to be affected by these deficient practices. o Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete By 3/8/23 The Regional Director of Operations educated the Administrator and the Director of Nursing on the facility policy for Workplace Violence, the process for managing a Non-Medical Emergency and allowing entry into the facility from the smoke porch. This education includes, in case of an emergency, staff will immediately call 911, announce a code silver over the intercom, assist residents into rooms, close doors, and monitor hallways. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 8/1/22 the Regional Director of Operations educated the Administrator and the Director of Nursing on the facility policy for elopement, this included a focus on securing all doors in the facility with a focus on locking the doors on the 3rd floor memory care unit to ensure wandering residents are unable to exit the facility without supervision. On 3/9/23 The Regional Director of Operations educated the Administrator on the requirements of F835. This education included the expectations of oversight and completion of building repairs, as well as providing a safe environment for residents until repairs are completed. This education also includes the Administrator's responsibility to maintain a safe smoking program based on the facility's smoking policy and daily monitoring to ensure adherence to required supervision. By 3/9/23 the Regional Director of Operations re-educated the Administrator, Director of Nursing and Maintenance Director regarding the Daily Morning Meeting including the discussion of facility repair needs with weekly monitoring of all doors to ensure alarms and locks are functioning properly, adherence to the smoking policy with staffing of the smoking attendant, and monitoring of the elopement management plan by scheduling elopement drills and reviewing these results with the Interdisciplinary Team which includes the Director of Nursing, Social Service Director, Maintenance Director and Dietary Manager. Effective 3/8/23 the Administrator will be responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance. Alleged Date of IJ Removal: 3/10/2023 On 3/16/23, the facility's corrective action plan for immediate jeopardy removal effective 8/2/22 was validated by the following: Administrative staff interviews revealed they had received education on the facility Emergency Preparedness plan and workplace violence and to provide training for staff on the plan, the process for managing a Non- Medical Emergency and allowing entry into the facility from the smoking area. The Director of Nursing and Administrator voiced they had received education on the elopement policy and the focus on securing all doors in the facility. The facility's action plan was validated to be completed as of 3/11/22.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43643 Based on observations, record reviews and resident and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions previously put in place following the recertification survey of [DATE]. The repeated deficiency was in the area of kitchen sanitation and food procurement, storage, preparation, and service. The facility's continued failure during the recertification survey showed a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag was cross referenced to: F-812: Based on observations and staff interviews, the facility failed to maintain a clean and damage free kitchen for food production. These practices had the potential to affect food production and food served to residents. During the recertification survey of [DATE] the facility failed to the facility failed to follow USDA guidelines to refreeze a potentially hazardous food, follow USDA guidelines to store hot foods to prevent the growth of bacteria, discard expired produce with signs of spoilage, and date opened food. A pork roast that thawed under cold running water was refrozen, tomatoes were stored for use discolored and with signs of spoilage, and one half bag of sausage patties were undated. This occurred for 1 of 1 walk-in refrigerators and 1 of 1 walk-in freezers. An interview was conducted on [DATE] at 9:30 AM with Administrator #1 who also headed the QAA committee. The Administrator stated the facility had discussed frequently at quarterly QAA meetings the kitchen issues. The Administrator further revealed she could did not know why the kitchen had been an ongoing issue.