STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445139	A. Building B. Wing	05/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midtown Center for Health and Rehabilitation	141 N McLean Blvd Memphis, TN 38104

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 37532 Based on policy review, medical record review, observation, and interview, the facility failed to provide a dignified existence and reasonable accommodation of needs to residents requiring assistance with activities of daily living for 1 of 3 sampled residents (Resident #2) reviewed for resident rights. The finding include: Review of the facility's undated policy titled, Resident Rights, revealed .The facility will ensure that all staff members are educated on the rights of residents and the responsibility of the facility to properly care for its [it's] residents .The resident has the right to a dignified existence, self-determination .The resident has a right to be treated with respect and dignity .The right to retain and use personal possessions, including furnishings and clothing .right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences .right to make choices about aspects of his or her life that are significant to the resident . Review of the facility's policy titled, Quality of Life-Dignity, revised 8/2009, revealed .Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality .Residents shall be treated with dignity and respect at all times .Treated with dignity .means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth .Residents' private space and property shall be respected at all times . Review of the medical record, revealed Resident #2 was admitted to the facility on [DATE] with diagnoses of Cerebral Infarction, Dysarthria, Hemiplegia and Hemiparesis, Dysphagia, and Hypertension. Review of the Care Plan revised 2/14/2022, revealed .has an ADL self-care performance deficit r/t [related to] .CVA [Cerebrovascular Accident] [Stroke] with left hemi-paresis [partial paralysis on one side of the body] . Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated moderate cognitive impairment, required staff assistance for activities of daily living (ADLs), and supervision with setup by staff for meals. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on the 3rd floor at the elevator on 7/7/2022 at 12:22 PM, revealed Resident #2 seated in a wheelchair with his shoulders slumped and his hands clasped between his knees. The resident was fully clothed and wore a wander guard (a monitoring device to alert staff when a resident attempts to exit a door in the facility) on his right ankle. Dental Services for other residents were being conducted in the resident's room. During an interview on 7/7/2022 at 12:22 PM, Licensed Practical Nurse (LPN) #1 confirmed Dental Services were conducted in Resident #2's room from approximately 9:00 AM until approximately 2:30 PM, and the resident would remain in the wheelchair outside his room until Dental Services were finished for the day. During an interview on 7/7/2022 at 12:30 PM, Certified Nursing Assistant (CNA) #1 stated, [Resident #2] usually eats in his room. The dental people are in his room today . Observation on the 3rd floor in the Common Area on 7/7/2022 at 12:35 PM, revealed Resident #2 seated in a wheelchair at a table, CNA #2 served his lunch tray, and the resident slowly fed himself. Observation on the 3rd floor in the common area on 7/7/2022 at 2:00 PM, revealed Resident #2 was seated in a wheelchair with his shoulders slumped, his head down, and his hands clasped between his knees. Resident #2 was fully clothed and wore a wander guard on his right ankle. The resident was alone in the area. Dental Services were still being conducted in the resident's room. Observation in the resident's room on 7/8/2022 at 9:42 AM and 7/12/2022 at 1:40 PM, revealed Resident #2 lying in his bed and watching television (TV). During an interview on 7/12/2022 at 2:29 PM, the Social Worker confirmed Dental Services for the facility residents were conducted in Resident #2's room on 7/7/2022. The Social Worker stated, .DON [Director of Nursing] arranged it and discussed it with nursing team in morning meeting . The Social Worker confirmed other residents were taken in Resident #2's room on 7/7/2022 for Dental Services. The Social Worker stated, He [Resident #2] normally stays in his room for meals and mostly all day .watches TV . During an interview on 7/12/2022 at 2:47 PM, the Administrator stated, .Just wanted to let you guys know that I was not aware she [DON] told Dental services to set up in [Resident #2's] room . The Administrator confirmed the resident should not be forced out of his room for several hours while Dental Services treated other residents in his room. The Administrator stated, No .That's a dignity issue .

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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** 28913 Based on policy review, review of facility investigation statement, medical record review, observation, and interview, the facility neglected to provide adequate supervision to prevent elopement for 1 of 6 sampled residents (Resident #1) reviewed for elopement/wandering behaviors and neglected to prevent resident-to-resident abuse for 2 of 5 sampled residents (Resident #2 and #4) reviewed for abuse. The facility's failure to provide adequate supervision and to prevent resident-to-abuse resulted in Immediate Jeopardy when Resident #1, a cognitively impaired resident who was at risk for wandering, eloped from the facility, and walked approximately 1 mile from the facility, crossed 6 lanes of high-volume traffic at a main intersection and got into a car with a passing motorist. The resident was found by a family member in a neighborhood known for drug deals. Resident #1 was unsupervised out of the facility for approximately 14 hours. Resident #2 entered Resident #4's room on 2 different occasions, resulting in resident-to-resident altercations between the residents. Immediate Jeopardy is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Regional Director of Clinical Services, the Administrator, and the Director of Nursing (DON) were notified of the Immediate Jeopardy (IJ) on 5/13/2022 at 6:30 PM, in the Chapel. The facility was cited Immediate Jeopardy at F-600. The facility was cited Immediate Jeopardy at F-600 at a scope and severity of J, which is Substandard Quality of Care. The IJ existed from 2/20/2022 through 5/16/2022. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 5/14/2022 at 1:44 PM, and the corrective actions were validated onsite by the surveyors on 5/17/2022 through policy review, medical record review, observation, review of education records, and staff interviews. The findings include: Review of the facility's policy titled, Abuse, Neglect and Exploitation, revised 3/3/2022, revealed .It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect .'Neglect' means failure of a facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress .Establish policies and procedures to investigate any such allegations . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's undated policy titled, Elopements and Wandering Residents, revealed .This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents .Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff . Review of the medical record, revealed Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Seizures, Mood Disorder, Aphasia, Myocardial Infarction, Diabetes, and Encephalopathy. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 had impaired cognition, impaired vision, an unsteady gait, required physical assistance for balance with transfers, and had range of motion impairment in the upper and lower extremities on one side of the body. Review of the Elopement/Wandering Risk Assessments revealed the following: a. On 10/2/2021, the admission assessment, Resident #1 scored a 4, which indicated a low risk. b. On 2/20/2022, Resident #1 scored a 9, which indicated a moderate risk. Review of an Incident Report dated 2/20/2022, revealed that the receptionist received a call from Licensed Practical Nurse (LPN) #1 who had worked the 7:00 AM to 7:00 PM shift on 2/20/2022 and was on her way home, stating she thought she saw a third-floor resident on a Named Street. LPN #1 stated the resident's name (Resident #1), staff checked to see if he was in the facility, and he was not. Staff in the building searched for the resident without success. Review of a Social Service Progress Note dated 2/21/2022 at 9:15 AM, revealed that Resident #1 returned to the facility in a family's car with his sister and daughter at his side. Resident #1 ambulated to the door of the facility with an unsteady gait. Resident #1 refused assistance from staff and family as he entered the building. Review of a typed statement dated 2/21/2022 from a resident who witnessed Resident #1 exit the building revealed He went out the front door around the brick and I couldn't see him anymore . Review of the Fall Scale Risk assessment dated [DATE], revealed Resident #1 was a high risk for falling, had previous falls, and had a weak gait. During an interview on 5/11/2022 at 11:15 AM, when asked what interventions were implemented after the elopement incident, the DON stated, .family was agreeable to a Wanderguard [a sensor alarm system worn by residents to alert staff if a resident attempts to exit through monitored exit doors], family was to pick him up twice a week [the family member stated in an interview that they had told the facility they could not come every week]. He was 1 on 1 [1:1] with a CNA [Certified Nursing Assistant] .involve in more activities . When asked if his family takes him out twice weekly, the DON stated, I don't know .I guess they do .I don't know. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 5/11/2022 at 1:22 PM at the side of the building near the designated Smoking Area, revealed the side door was propped open with a 5-gallon water dispensing bottle and at the end of the sidewalk there was an open gate to the parking lot. During an interview on 5/11/2022 at 1:52 PM, the DON was asked if a resident could exit the building, go through the open door, and go onto the parking lot through the open gate. The DON stated, That door should not be open. It goes to where they are working in therapy. Construction guys left the gate open .It goes to the parking lot. During an interview on 5/11/2022 at 2:13 PM, the Administrator was asked if a resident could leave the building through the therapy department which was under construction. The Administrator stated, They could walk right out and go through the gate and right to the parking lot. When asked if the building was secure, the Administrator sated, I see what you mean. No, it's not. I thought the construction crew knew to keep the door locked . Observation at the Chapel Exit Door on 5/12/2022 at 11:43 AM, revealed the door from the Chapel to the parking lot was not secured. The door opened after pushing on the door for 15 seconds. No alarm sounded. The door did not lock after it was closed. During an interview on 5/12/2022 at 11:46 AM, the Maintenance Director was asked if the exit door in the Chapel was secure. The Maintenance Director stated, I don't know what's wrong. Looks like no power to the door. The alarm should sound. It's not working . Observation on 5/12/2022 at 1:45 PM, revealed Resident #1 walked out of the Lobby onto the Front Patio. The Wanderguard alarm sounded when the resident walked through the door. The receptionist was on the telephone at the desk. No staff responded to the sounding alarm. Observation on 5/12/2022 at 2:34 PM, 5/13/2022 at 2:00 PM, and 5/14/2022 at 1:55 PM, revealed the following: a. 1st floor - Exit door at the northeast side of the building was not secure and the double doors at the north end of the building were not secured. The door to the therapy department had an alarm that was disabled, the side door on the hallway under construction opened to the parking lot and was not secured, doors to the stairs to go to the 2nd floor were not secured b. 2nd floor - the doors to the staircase from the 1st floor to the 3rd floor were not secured, the door at the staircase at the west end of the 200 Hall accessed easily to enter the designated outside Smoking Area. c. 3rd floor - the doors to 2 staircases from the 2nd and 4th floor were not secured. d. 4th floor - the 2 doors to the staircases from the 3rd floor were not secured. e. The stairwells on the 2nd, 3rd, and 4th floors on the northeast side of the building that led to the 1st floor exit door and into a foyer with an exit door that was unlatched and led to the employee parking lot. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 5/13/2022 at 11:28 AM, LPN #1 was asked about Resident #1's elopement. LPN #1 stated, .I remember he [Resident #1] came to the desk on the 3rd floor. He was standing alone and not in his usual dress. He was wearing new white tennis shoes, a new gray heavy winter jacket, new clothes, and sweatpants. I asked where he was off to and he was going to smoke. He just giggled .I maybe left [left the facility] about 7:30 [PM]. I was headed up [Named Street]. He was on my right side at the light [traffic light]. He was crossing to go toward the median [on left, across 6 lanes]. He slapped the hood of my car .I opened my door and he sped up .I was afraid he would fall .I saw a navy bluish or black car. He got in .I lost sight of the car .I pulled over and called back to the building about 8 [8:00 PM] and spoke with the receptionist. She told me no resident was missing .[Named nurse] called me at home about an hour later and said he [Resident #1] was missing . During a telephone interview on 5/16/2022 at 11:08 AM, a family member of Resident #1 was asked about the resident's elopement. The family member stated, .They [staff] called me at 8:16 PM and was saying they didn't know where he was. They said they last saw him at 7:05 [PM]. I thought someone watched that front door. I asked how did you let a man that walks slow with a limp get out of your sight .Next morning my mom called me and said my cousin had found him in [Named] neighborhood where he [Resident #1] used to do drugs .I brought him back. He didn't seem to be on any drugs, seemed the same . When asked what interventions the facility put in place to prevent elopement from happening again the family member stated, . They put a thing [Wanderguard] on his leg .I told them I can't come every week . During a telephone interview on 5/17/2022 at 11:36 AM, Registered Nurse (RN) #1 was asked about Resident #1's elopement. RN #1 stated, .The receptionist asked me if I would watch the desk while she took them [residents] out to smoke at 7:00 PM. I was at the desk telling visitors to sign in and log in and I was on the phone .About 7:15 he [Resident #1] came to me and put some change on the counter. I told him I didn't have any money .He walked away .that is the last I saw him. It was a busy time with the visitors coming in and the phone calls . Review of the medical record, revealed Resident #2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Dementia with Behavior, Repeated Falls, Cerebral Infarction, Osteoporosis and Hypertension. Review of the quarterly MDS assessment dated [DATE], revealed Resident #2 scored a 7 on the Brief Interview for Mental Status (BIMS) scale, which indicated the resident had severe cognitive impairment for decision making. The functional status revealed locomotion on the unit was per wheelchair with oversight. Review of the medical record, revealed Resident #4 was admitted to the facility on [DATE] with diagnoses of Radiculopathy Lumbar Region, Fracture of Vertebra Sacral and Sacrococcygeal Region, and Diabetes. Review of the admission MDS assessment dated [DATE], revealed Resident #4 scored a 15 on the BIMS scale, which indicated the resident was cognitively intact for decision making. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #4's Nurses' Note dated 5/5/2022 at 1:11 PM, revealed .Ms [Named Resident #4] stated a male resident [Resident #2] came into her room while she was sleeping overnight. She was sleeping on her right side facing the window, she felt the mattress moving and a knee was on her leg. He [Resident #2] didn't touch her upper body. She thought it was her roommate; however, she turn [turned] to the left and saw a white man. She said to him Wrong Bed/Wrong Room and the male resident repeated what was said to him. She push [pushed] him out her bed and he fell on to the floor. He was reaching for help, and she refuse [refused] to help him due to her being fearful of falling and hurting herself. She push [pushed] the call light for help but staff didn't respond. So, both her and the male resident [Resident #2] was screaming and hollowing [hollering] loud .before staff came to assist and remove [removed] male resident from her room . Review of Resident #2's Nurses' Note dated 5/5/2022 at 8:06 PM, revealed .Late entry: this AM @ [at] 02:15 [2:15 AM] Resident [#2] wanders into [room number] [Resident #4's room]. The staff CNA answered call light in [room number] [Resident #4's room] and noted resident [#2] on floor in between Bed A and bed B at the foot. Resident [#2] in sitting position in front of w/c chair [wheelchair]. Resident [#2] was placed in wheelchair taken to his room [room number]. Resident [#2] assessed with no new bruises, redness or open areas . Review of Resident #4's Nurses' Note dated 5/8/2022 at 6:31 AM, revealed, .Patient called on the unit phone stating another resident [Resident #2] had entered her room. The patient was upset and stated this is the second time this has happened, and they said he would be watched. I explained to the patient that I was unaware of the situation and would ensure that the male [Resident #2] did not return to her room. Patient stated I'm reporting this because this is unacceptable .I again assured the patient that I would keep close watch on the male [Resident #2] and make sure he does not enter her room again . During an interview on 5/10/2022 at 3:45 PM, Resident #4 confirmed the Nurses' Notes dated 5/5/2022 at 1:11 PM and 5/8/2022 at 6:31 AM. She stated, .this man [Resident #2] came into my room [5/5/2022] and attempted to get in bed with me. I was turned on my right side facing the window when I felt a knee on my leg and the bed moving. I rolled over to see what was happening and this white man was trying to get into my bed. I yelled and instinctively pushed him back and he lost his balance and fell on to the floor. I started yelling Help and he would repeat everything I said help but in a weaker voice. I pushed the call light no answer by staff, and we continued to yell until staff came in .They told me oh, that is Mr. [Named Resident #2] and he wanders that is just what he does. I said no, that is not ok .Then a few days later [5/8/2022] he came into my room again. I picked up the phone and called the facility. They came in and got him. I told that nurse about what had happened before, and that agency nurse said she didn't know anything about him. I said ya'll told me you would watch him . During an interview on 5/10/2022 at 3:57 PM, RN #2 was asked what interventions were implemented after the 5/5/2022 altercation of Resident #2 and Resident #4, she stated, .continue hourly safety checks . supposed to have close supervision .to be honest we failed to supervise him . During an interview on 5/11/2022 at 12:00 PM, the DON was asked what behaviors Resident #2 exhibited prior to the resident-to-resident altercation. She stated, .I don't know . When asked if staff were interviewed about the resident's behaviors prior to the altercation, she stated, .No . Refer to F-610 and F-689. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The surveyors verified the Removal Plan by: 1. Resident #1 was placed on 15 minutes checks until 10:00 PM on 5/13/2022, then hourly checks that were ongoing. A staff member was assigned to monitor the resident's location and movements daily. A staff member escorts the resident out to smoke during smoke break. The resident's BIMS was reassessed on 5/13/2022. The Family Nurse Practitioner reevaluated the resident on 5/13/2022. The Preadmission evaluation was updated to reflect Resident #1's current status on 5/13/2022. All exit doors were checked for functioning on 5/13/2022. There were no concerns noted. Resident #2 was discharged on [DATE]. This was confirmed by record review, report review, and interviews on all shifts. 2. Resident with BIMS scores of 8 or above were interviewed for abuse or potential for abuse by 5/14/2022. Residents with a BIMS below 8 will have a skin assessment conducted by 5/14/2022. Elopement assessments were conducted on all residents on 5/14/2022 by Social Services and the Nursing Supervisors. This was confirmed by record review and interviews on all shifts. 3. 100 percent (%) of staff were in-serviced by the DON, Nurse Supervisor, Staff Development Coordinator or department head on the abuse, neglect and exploitation policy, the elopement and wandering resident policy, prevention, and reporting. Staff not at work will be called and re-educated via phone. Staff that were not able to be educated will be educated prior to returning to work. Care Plans were updated with new interventions. In the event of any future resident exiting, the resident will be placed on 1:1 supervision until primary care, nursing and psychiatric evaluations can be completed. Outcomes of these evaluations will result in continued 1:1 supervision or the initiation of discharge planning to a facility with a focus on behavior management. This was confirmed by review of the education sign in sheets, record review, and interviews on all shifts. 4. The Interdisciplinary Team (IDT) meeting was held to review results of BIMS, abuse interviews, skin assessments, and elopement assessments on 5/14/2022. This was confirmed by review of the sign-in sheets, audit review, and interviews with the IDT. 5. The Facility System changes included: a. Review progress notes daily during morning clinical meeting for trigger words. Any triggers will be reported to the Administrator immediately and the licensed nursing home Administrator makes the initial report to the State of Tennessee via URIS 3.0 system and completes the investigation within 7 days. b. Quality Assurance Performance Improvement (QAPI) meetings will occur weekly for four weeks to monitor progress and then monthly thereafter. c. The Maintenance Supervisor will check all doors for functionality daily for 4 weeks, then weekly ongoing. These changes were confirmed by review of records, reports, sign-in sheets, audit sheets, and interviews on all shifts. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. The DON, Nurse Supervisor, or Staff Development Coordinator will conduct abuse, neglect, and elopement audits. The audits will include identifying residents with exit seeking behavior daily for 4 weeks, then 3 times per week for 4 weeks, then 2 times week for 4 weeks, and then weekly ongoing. This was confirmed by review of audit sheets and interviews on all shifts. 6. The DON or Staff Development Nurse will report findings of the abuse, neglect, and elopement audits to the monthly QAPI Committee. The members include the Committee Chairperson - Administrator; DON; Assistant Director of Nursing (ADON); Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director. This will continue for 4 months for further suggestions and/or as follow up is needed. The DON, ADON, Multi Data Set Nurse, Nurse Supervisor, or Staff Development Coordinator will review the outcome of the abuse and neglect audits monthly and ongoing. Any aberrancies will be addressed, interventions developed, and corrective actions taken. This was confirmed by review of the QAPI tool and interviews of QAPI members. The facility's noncompliance of F-600 continues at a scope and severity of D for monitoring of the effectiveness of the corrective actions. The facility is required to submit a plan of correction.

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29706 Based on policy review, medical record review, and interview, the facility failed to report an allegation of resident-to-resident abuse and failed to timely report an allegation of resident-to-resident abuse to the State Survey Agency for 4 of 5 (Resident #1, #2, #4 and #5) sampled residents. The findings include: Review of the facility's policy Abuse, Neglect and Exploitation revised 3/22/2022, revealed .It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property .The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property and exploitation .Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes: Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not result in serious bodily injury . Review of the medical record, revealed Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Seizures, Mood Disorder, Aphasia, Myocardial Infarction, Diabetes, and Encephalopathy. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 scored a 5 on the Brief Interview of Mental Status (BIMS) scale, which indicated the resident had severe cognitive impairment for decision making. Review of the medical record, revealed Resident #5 was admitted to the facility on [DATE] with diagnoses of Fracture of the First Lumbar Vertebra, Multiple Rib Fractures, and Fractured Humerus. Review of the quarterly MDS assessment dated [DATE], revealed Resident #5 scored 15 on the BIMS scale, which indicated the resident was cognitively intact for decision making. Review of the Incident Report dated 2/9/2022 at 6:31 PM, revealed .This resident [Resident #5] initiated physical and verbal aggression against another resident [Resident #1] in the lobby area of the nurse's station to resident [Resident #1]. This resident [Resident #5] got out of his wheelchair as he was talking loudly and accusing the resident [Resident #1] of stealing approached Mr. [Named Resident #1] then forcibly pushed the resident [Resident #1] down to the floor near the window causing the resident [Resident #1] to hit his head against wall. This incident was witnessed per nurses . Review of Resident #5's Nurse's Note dated 2/9/2022 at 6:40 PM, revealed .Resident [#5] became verbally and physically abusive toward another resident [Resident #1] pushed another resident [Resident #1] down to the floor. The Administrator and DON was notified. The DON is present and spoke with the resident about incident .Resident [#5] reported to [Named Police Department] he had been drinking . (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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #5's Nurse's Note dated 2/10/2022 at 3:24 AM, revealed .This resident [Resident #5] was physically aggressive toward another resident in the common, lobby area near nurses' station on 4th floor. This resident [Resident #5] rolled up toward the resident [Resident #1] cursing and accusing resident of stealing. Stood up and walk toward the other resident [Resident #1] then forcibly shove [shoved] him down to the floor causing the other resident [Resident #1] to hit the back of his head against the wall at the base of the window . Review of the radiology x-ray skull series report dated 2/10/2022, revealed Resident #1 had .no acute fracture .conclusion normal skull series . Review of Resident #1's Nurse's Note dated 2/9/2022 at 6:38 PM, revealed .This nurse observed an altercation between resident [Resident #5] and resident [Resident #1]. The resident [Resident #5] was following [Resident #1]. [Resident #5] was in his wheelchair, he was coming down hallway stating that the resident [Resident #1] He stole something from me. He know [knows] he stole from me. This nurse attempted to keep the two apart. [Resident #5] stood up from his wheelchair and pushed [Named Resident #1] into the window .[Resident #1] fell and struck his head. [Resident #1] was transferred from the floor unto the chair .Police discovered from the resident [Resident #5] that they had been drinking in the room. Resident [#1] was re-assigned to another room temporarily until crisis over . During an interview on 5/13/2022 at 3:35 PM, the Administrator was asked about the incident of resident to resident abuse on 2/9/2022 and if the incident was reported to the State as required for resident-to-resident abuse. She stated, .No we didn't report the altercation to the State. I thought someone else was going to do it and no one did . Review of the medical record, revealed Resident #2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Dementia with Behavior, Repeated Falls, Cerebral Infarction, Osteoporosis and Hypertension. Review of the quarterly MDS dated [DATE], revealed Resident #2 scored a 7 on the BIMS scale, which indicated the resident had severe cognitive impairment for decision making. The functional status revealed, locomotion on the unit was per wheelchair with oversight and set up help only. Review of the medical record, revealed Resident #4 was admitted to the facility on [DATE] with diagnoses of Radiculopathy Lumbar Region, Sacral and Sacrococcygeal Fracture of the Vertebra, and Diabetes. Review of the admission MDS assessment dated [DATE], revealed Resident #4 scored 15 on the BIMS scale, which indicated the resident was cognitively intact for decision making. (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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #4's Nurse's Note dated 5/5/2022 at 1:11 PM, revealed .Ms [Named Resident #4] stated a male resident [Resident #2] came into her room while she was sleeping overnight. She was sleeping on her right side facing the window, she felt the mattress moving and a knee was on her leg. He [Resident #2] didn't touch her upper body. She thought it was her roommate; however, she turn [turned] to the left and saw a white man. She said to him Wrong Bed/Wrong Room and the male resident repeated what was said to him. She push [pushed] him out her bed and he fell on to the floor. He was reaching for help, and she refuse [refused] to help him due to her being fearful of falling and hurting herself. She push [pushed] the call light for help but staff didn't respond. So, both her and the male resident [Resident #2] was screaming and hollowing [hollering] loud .before staff came to assist and remove male resident from her room. Resident also stated she's not violent . Review of a Nurse's Note dated 5/5/2022 at 8:06 PM for Resident #2 revealed .Late entry: this AM @ [at] 02:15 [2:15 AM] Resident [Resident #2] wanders into room [Resident #4's room]. The staff CNA [Certified Nursing Assistant] answer [answered] called [call] light in [room number] [Resident #4's room] and noted [Resident #2] on floor in between Bed A and bed B at the foot. [Resident #2] in sitting position in front of w/c chair [wheelchair]. [Resident #2] was placed in wheelchair taken to his room [room number]. [Resident #2] assessed with no new bruises, redness or open areas . During an interview on 5/10/2022 at 3:45 PM, Resident #4 confirmed the incident on 5/5/2022 at 1:11 PM documented in the Nurses' Note and the Nurses' Note dated 5/8/2022 at 6:31 AM. She stated, .this man came into my room [5/5/2022] and attempted to get in bed with me. I was turned on my right side facing the window when I felt a knee on my leg and the bed moving. I rolled over to see what was happening and this white man was trying to get into my bed. I yelled and instinctively pushed him back and he lost his balance and fell on to the floor. I started yelling Help and he would repeat everything I said help but in a weaker voice. I pushed the call light no answer by staff, and we continued to yell until staff came in .They [staff] told me oh, that is Mr. [Named Resident #2] and he wanders that is just what he does. I said no, that is not ok . Then a few days later [5/8/2022] he came into my room again. I picked up the phone and called the facility. They came in and got him. I told that nurse about what had happened before and that agency nurse said she didn't know anything about him. I said ya'll told me you would watch him . Review of the facility's report submitted to the State Agency related to the resident to resident abuse allegation between Resident #2 and Resident #4 revealed the received the report was dated 5/5/2022 at 3:38 PM. The date the occurrence happened at the facility was 5/5/2022 at 2:15 AM. During an interview on 5/13/2022 at 3:35 PM, the Administrator confirmed the resident to resident altercation between Resident #2 and Resident #r occurred on 5/5/2022 at 2:15 AM and the report was not sent until 5/5/2022 at 3:38 PM. She stated, .It was late .

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28913 Based on policy review, job description review, facility investigation review, medical record review, observation, and interview, the facility failed to ensure thorough investigations of elopement and resident-to-resident abuse were completed for 5 of 5 (Resident #1, #2, #3, #4 and #5) sampled residents reviewed for wandering/elopement behaviors and physically aggressive behaviors, which resulted in Immediate Jeopardy when Resident #1, a cognitively impaired resident who was at risk for wandering, eloped from the facility, walked approximately 1 mile from the facility, crossed a total of 6 lanes of high-volume traffic at a main intersection and got into a car with a passing motorist. The resident was found by a family member in a neighborhood known for drug deals. The facility failed to thoroughly investigate 3 incidents of resident-to-resident altercations when Resident #3 hit Resident #2 in the head with a book, Resident #4 willfully pushed Resident #2 to the floor, and Resident #5 willfully pushed Resident #1 causing the resident to fall to the floor and hit his head. This had the potential to cause serious injury to all 5 residents, which resulted in Immediate Jeopardy. Immediate Jeopardy is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Regional Director of Clinical Services, Administrator, and Director of Nursing (DON) were notified of the Immediate Jeopardy (IJ) on 5/13/2022 at 6:30 PM, in the Chapel. The facility was cited at F-610 at a scope and severity of K, which is Substandard Quality of Care. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 5/14/2022 at 1:44 PM, and the corrective actions were validated onsite by the surveyors on 5/17/2022 through policy review, medical record review, observation, review of education records, and staff interviews. The IJ existed from 2/20/2022 through 5/16/2022. The findings include: Review of the facility's policy titled, Abuse, Neglect, and Exploitation, revised 3/3/2022, revealed .Written procedures for investigation include .Identifying staff responsible for the investigation .Identifying and interviewing all involved persons .Focusing the investigation on determining if abuse, neglect, or exploitation, and/or mistreatment has occurred, the extent, and cause .Providing complete and thorough documentation of the investigation . The facility's undated policy titled Quality Assurance Performance Improvement [QAPI], revealed .'Adverse events' is an untoward, undesirable and usually unanticipated event that causes death or serious injury, or the risk thereof, including near misses .An investigation will be conducted on each identified medical error or adverse event to analyze causes. Preventive actions and mechanisms will be implemented to prevent medical errors and adverse events, including feedback and education . (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's Director of Nursing Job Description updated 12/2011, revealed .Complete investigative analysis as required .Ensure that all nursing service personnel follow established departmental policies and procedures .Assure residents a comfortable, clean, orderly and safe environment . Review of the medical record, revealed Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Seizures, Mood Disorder, Aphasia, Myocardial Infarction, Diabetes, and Encephalopathy. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 had impaired cognition, impaired vision, an unsteady gait, required physical assistance for balance with transfers, and had range of motion impairment in the upper and lower extremities on one side of the body. Review of the Elopement/Wandering Risk assessment dated [DATE], revealed Resident #1 scored a 9, which indicated a moderate risk. Review of the Incident Report dated 2/20/2022, revealed .the receptionist received a call from the nurse [Licensed Practical Nurse (LPN) #1] who worked 7a [7:00 AM] to 7p [7:00 PM] today stating it look like a third floor resident was on [Named Street]. I asked receptionist who and she stated resident's name [Resident #1] . I went to check to see if he was there, he was not. Staff of the building searched for resident with no success . Review of a Social Service Progress Note dated 2/21/2022 at 9:15 AM, revealed .Resident [Resident #1] returned to facility via family's car with sister and daughter at his side. Resident ambulated to door of the facility with an unsteady gait. Resident refused assistance from staff and family as he entered the building . Observation in the resident's room on 5/10/2022 at 11:40 AM, revealed Resident #1 standing and looking out the window. He ambulated across the room with a right dominant limp and an unsteady gait. He was alert but was unable to determine his orientation due to his loss of ability to express himself verbally. He did not respond to open-ended questions but could respond with yes/no gestures. Resident #1 did not answer questions related to the elopement incident. Review of the facility's investigation revealed no written statements or interviews with the staff from the shift prior to the elopement time. During an interview on 5/11/2022 at 11:15 AM, the DON was asked what interventions were implemented after the elopement incident. The DON stated, .Family did not want him going out without notification .family was to pick him up twice a week [the family member stated in an interview that they had told the facility they could not come every week], he was 1 on 1 [1:1] with a CNA [Certified Nursing Assistant] .involve in more activities . When asked if the intervention of the family taking Resident #1 out for a leave twice weekly was implemented, the DON stated, I don't know .I guess they do .I don't know . (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/11/2022 at 12:05 PM the Administrator was asked if staff from all shifts were included in the investigation to determine possible care needs and behaviors of the resident prior to his elopement. The Administrator stated, I don't know. Not sure how many interviews were done. We interviewed the staff that was here. I didn't get a call until 8 [8:00 PM] . During a telephone interview on 5/13/2022 at 11:28 AM, LPN #1 was asked to give the details of Resident #1's elopement. LPN #1 stated, .I remember he [Resident #1] came to the desk on the 3rd floor. He was standing alone and not in his usual dress. He was wearing new white tennis shoes, a new gray heavy winter jacket, new clothes, and sweatpants. I asked where he was off to and he was going to smoke. He just giggled .I maybe left [left facility] about 7:30 [PM]. I was headed up [Named Street]. He was on my right side at the light [traffic light]. He was crossing to go toward median [on left, across 6 lanes]. He slapped the hood of my car .I opened my door and he sped up .I was afraid he would fall .I saw a navy bluish or black car. He got in .I lost sight of the car .I pulled over and called the building and spoke with the receptionist I called back to the building about 8 [8:00 PM] .She [receptionist] told me no resident was missing .[Named nurse] called me at home about an hour later and said he [Resident #1] was missing . LPN #1 was asked if the Administrator or the DON had questioned her about the elopement details. LPN #1 stated, .On Monday [2/21/2022] I brought a statement in early .No one has talked to me since I brought the statement. No one from the facility .I wasn't questioned what his behaviors were prior to the elopement . During a telephone interview on 5/16/2022 at 11:08 AM, a family member of Resident #1 was asked about the elopement incident. The family member stated, .They [staff] called me at 8:16 PM and was saying they didn't know where he was. They said they last saw him at 7:05 [PM]. I thought someone watched that front door. I asked how did you let a man that walks slow with a limp get out of your sight .Next morning my mom called me and said my cousin had found him in [Named] neighborhood where he [Resident #1] used to do drugs .I brought him back. He didn't seem to be on any drugs, seemed the same . When asked what interventions the facility put in place to prevent elopement from happening again the family member stated, . They put a thing [Wanderguard, a sensor alarm system worn by residents to alert staff if a resident attempts to exit through a monitored door] on his leg .I told them I can't come every week . During a telephone interview on 5/17/2022 at 11:36 AM, Registered Nurse (RN) #1 was asked about Resident #1's elopement. RN #1 stated, .The receptionist asked me if I would watch the desk while she took them [residents] out to smoke at 7:00 PM. I was at the desk telling visitors to sign in and log in and I was on the phone .About 7:15 he [Resident #1] came to me and put some change on the counter. I told him I didn't have any money .He walked away .that is the last I saw him. It was a busy time with the visitors coming in and the phone calls . Review of the medical record, revealed Resident #2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Dementia with Behavior, Repeated Falls, Cerebral Infarction, Osteoporosis, and Hypertension. Review of the quarterly MDS assessment dated [DATE], revealed Resident #2 scored 7 on the Brief Interview for mental Status (BIMS) scale, which indicated the resident had severe cognitive impairment for decision making. The functional status assessment revealed locomotion on the unit was per wheelchair with oversight. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the medical record, revealed Resident #3 was admitted to the facility on [DATE] with diagnoses of Pulmonary Edema, Diabetes, and Guillain-Barre Syndrome. Review of the annual MDS dated [DATE], revealed Resident #3 scored a 15 on the BIMS scale, which indicated cognitively intact for decision making. Review of a Nurses' Note dated 4/28/2022 at 7:37 PM, revealed .18:40 [6:40 PM] per nurse was inform from CNA [Certified Nursing Assistant] she was picking up trays coming out of room [number] [a resident's room] with resident tray to put on food cart and saw [Named Resident #3] hitting [Named Resident #2] with a bible in the head, resident remove [removed] from room [number] [Resident #3's room] to hallway, per nurse enter [entered] room [number] [Resident #3's room] an [and] ask [asked] resident [Resident #3] what happen [happened] resident stated 'he [Resident #2] enter [entered] my room and I try [tried] to get him out' per nurse ask [asked] [Named Resident #3] did she hit him with anything resident stated, 'No' head to toe assessment done [Named Resident #2] small rise [swollen] area with redness to left side of head denies pain at site, per nurse ask [asked] [Named Resident #2] what happen [happened] resident stated 'she hit me on the side of my head' .administrator notified . Review of a Social Service note dated 4/29/2022 at 4:46 PM, revealed, .Social worker spoke to resident [Resident #2] today .Redness noted to resident face . Review of a Social Service note dated 5/3/2022 at 4:53 PM, revealed, .Resident [Resident #2] was seen by psych [psychiatric] services on 4/29/22 [2022] regarding follow up to recent behaviors . Administration was unable to produce documentation of a psych service visit on 4/29/2022 even though the State Agency requested it multiple times during the investigation on 5/10/2022 - 5/17/2022. During an interview on 5/10/2022 at 4:00 PM, the Administrator was asked what immediate interventions were implemented to keep Resident #2 from entering other residents' rooms. The Administrator stated, .I don't know . During an interview on 5/11/2022 at 12:00 PM, the DON was asked what behaviors Resident #2 was exhibiting prior to the resident-to-resident altercation. She stated, .I don't know . When asked if staff were interviewed about the resident's behaviors prior to the altercation. She stated, .No . There was no documentation of a thorough investigation of the resident-to-resident altercation. Review of the medical record, revealed Resident #4 was admitted to the facility on [DATE] with diagnoses of Radiculopathy Lumbar Region, Fracture of Vertebra, Sacral and Sacrococcygeal Region, and Diabetes. Review of the admission MDS dated [DATE], revealed Resident #4 scored a 15 on the BIMS scale, which indicated the resident was cognitively intact for decision making. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #4's Nurses' Note dated 5/5/2022 at 1:11 PM, revealed, .Ms. [Named Resident #4] stated a male resident [Resident #2] came into her room while she was sleeping overnight. She was sleeping on her right side facing the window, she felt the mattress moving and a knee was on her leg. He [Resident #2] didn't touch her upper body. She [Resident #4] thought it was her roommate; however, she turn [turned] to the left and saw a white man. She said to him Wrong Bed/Wrong Room and the male resident repeated what was said to him. She push [pushed] him out her bed and he fell on to the floor. He was reaching for help, and she refuse [refused] to help him due to her being fearful of falling and hurting herself. She push [pushed] the call light for help but staff didn't respond. So, both her and the male resident [Resident #2] was screaming and hollowing [hollering] loud Help .before staff came to assist and remove male resident from her room. Resident [Resident #4] also stated she's not violent . Review of a Nurses' Note dated 5/8/2022 at 6:31 AM, revealed, .Patient [Resident #4] called on the unit phone stating another resident [Resident #2] had entered her room. The patient was upset and stated this is the second time this has happened, and they said he would be watched. I explained to the patient that I was unaware of the situation and would ensure that the male resident [Resident #2] did not return to her room . During an interview on 5/10/2022 at 3:57 PM, RN #2 was asked what interventions were implemented after the altercation of Resident #2 and Resident #3 on 4/28/2022. She stated, .we did hourly safety checks . When RN #2 was shown the date of onset for hourly safety checks was 3/3/2022, she stated, .Oh I see nothing new . When she was asked what interventions were implemented after the altercation of Resident #2 with Resident #4 on 5/5/2022 and she stated, .continue hourly safety checks .supposed to have close supervision .to be honest we failed to supervise him . During an interview on 5/10/2022 at 4:00 PM, the Administrator was asked what investigation was conducted to determine interventions for the wandering behaviors of Resident #2 entering other resident rooms that resulted in resident-to-resident altercations. The Administrator stated, .I don't know .I see what you mean . There was no evidence of a thorough investigation of the resident-to-resident altercations. Review of the medical record, revealed Resident #5 was admitted to the facility on [DATE] with diagnoses of a Foot Injury, Fractured 1st Lumbar Vertebra, Multiple Rib Fractures, and Fractured Humerus. Review of Resident #5's Emergency Department Physician Note dated 9/17/2021, revealed .History of IV [intravenous] drug use [drugs entered through the veins where blood flows in the body] .Alcohol use current type beer, liquor, wine .Substance use current type cocaine . Review of a Nurses' Note dated 11/29/2021 at 10:05 PM, revealed .The CNA reported to this nurse writer that the resident [Resident #5] was drinking liquor in his room. An empty bottle of [Named] Vodka was confiscated from his shoebox. Resident denied drinking However this nurse observed resident's behavior as being loud, using inappropriate language, cursing, unsteady gait . (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of an Incident Report dated 2/9/2022 at 6:31 PM, revealed .This resident [Resident #5] initiated physical and verbal aggression against another resident [Resident #1] in the lobby area of the nurse's station .This resident [Resident #5] got out of his wheelchair as he was talking loudly and accusing the resident [Resident #1] of stealing approached Mr. [Named Resident #1] then forcibly pushed the resident down to the floor near the window causing the resident to hit his head against wall. This incident was witnessed per nurses . Review of a Nurses' Note dated 2/9/2022 timed 6:38 PM, revealed .This nurse observed an altercation between resident [Resident #5] and resident [Resident #1]. The resident [Resident #5] was following [Named Resident #1]. [Named Resident #5] was in his wheelchair, he was coming down hallway stating that the resident [Resident #1] He stole something from me. He know [knows] he stole from me. Resident [#5] stood up from his wheelchair and pushed [Named Resident #1] into the window, were [where] [Named Resident #1] fell and struck his head. [Named Resident #1] was transferred from the floor unto [into] the chair .Police discovered from the resident [Resident #5] that they had been drinking in the room. [Named Resident #1] was re-assigned to another room temporarily until crisis over . Review of resident #5's Nurses' Note dated 2/9/2022 at 6:40 PM, revealed .Resident [#5] became verbally and physically abusive toward another resident [Resident #1] pushed another resident down to the floor . Resident [#5] reported to [Named Police Department] he had been drinking . Review of the x-ray of the skull report dated 2/10/2022, revealed Resident #1 had .no acute fracture . conclusion normal skull series . During a telephone interview on 5/13/2022 at 10:53 AM, LPN #3 confirmed she was not asked to provide a written statement or details of the incident of resident-to-resident altercation on 2/9/2022. During a telephone interview on 5/13/2022 at 2:57 PM, LPN #4 stated, .I reported him [Resident #5] drinking to the Administrator and the Director of Nursing back in November 2021. I told them about the empty Vodka bottle, and he may have been under the influence. Loud and talking a lot and a shift in his behavior . During an interview on 5/13/2022 at 3:35 PM, the Administrator was asked if the incident of staff finding an empty bottle of alcohol in Resident #5's room on 11/29/2021 and the resident was exhibiting behaviors was investigated. The Administrator stated, .No, it was never brought to my attention .No, we never investigated it . The facility failed to provide documentation of witness statements, an investigation of the events and behaviors before the incident, an investigation to determine triggers for the behaviors, and documentation of monitoring the resident or implementing appropriate interventions. Refer to F-600 and F-689. The surveyors verified the Removal Plan by: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midtown Center for Health and Rehabilitation	141 N McLean Blvd Memphis, TN 38104

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. Resident #1 was placed on 15 minutes checks until 10:00 PM on 5/13/2022, and then hourly checks ongoing. A staff member was assigned to monitor the resident's location and movements daily. Staff escorts Resident #1 out to smoke during smoke break. The resident's Brief Interview for Mental Status (BIMS) was reassessed on 5/13/2022. The Nurse Practitioner reevaluated the resident on 5/13/2022. The preadmission evaluation was updated to reflect Resident #1's current status on 5/13/2022. All exit doors were checked for function on 5/13/2022. There were no concerns noted. Resident #2 was discharged on [DATE]. This was confirmed by record review, report review, and interviews. 2. Residents with BIMS scores of 8 or above were interviewed for abuse or potential for abuse by 5/14/2022. A resident with a BIMS below 8 will have a skin assessment conducted by 5/14/2022. Elopement assessments were conducted on all residents on 5/14/2022 by Social Service and Nursing Supervisors. This was confirmed by record review, report review, and interviews. 3. On 5/14/2022, the Administrator and DON re-inserviced staff on how to conduct an investigation to include documentation, monitoring, details of the events, and providing appropriate interventions to prevent occurrence or reoccurrence of elopement or resident to resident abuse. This was confirmed by report review, form review, review of education sign-in sheets, and interviews on all shifts. 4. 100 percent (%) of staff were in-serviced by the DON, Nurse Supervisor, Staff Development Coordinator, or department head on the abuse, neglect, and exploitation policy, elopement and wandering resident policy, prevention, and reporting. Staff not at work will be called and re-educated via phone. Staff that were not able to be educated via phone will be educated prior to returning to work. Care plans were updated with new interventions. In the event of any future resident exiting, the resident will be placed on 1:1 supervision until primary care, nursing and psychiatric evaluations can be completed. Outcomes of these evaluations will result in continued 1:1 supervision or the initiation of discharge planning to a facility with a focus on behavior management. This was confirmed by review of the education sign-in sheets, record review, and interviews on all shifts 5. An Interdisciplinary Team (IDT) meeting was held to review the results of the BIMS scores, the abuse interviews, the skin assessments, and elopement assessments on 5/14/2022. This was confirmed by review of the IDT sign in sheet, audit review, and interviews. 6. Facility system changes include reviewing progress notes daily during morning clinical meeting for trigger words. Any triggers will be reported to the Administrator immediately and the licensed nursing home Administrator makes the initial report to the State of Tennessee via URIS 3.0 system and completes investigation within 5 days. QAPI meetings will occur weekly for four weeks to monitor progress and then monthly thereafter. The Maintenance Supervisor will check all doors for functionality weekly and as needed. This was confirmed by review of records, reports, sign in sheets, audit sheets, and interviews. 7. The DON, Nurse Supervisor, or Staff Development Coordinator will conduct abuse, neglect, and elopement audits. The audits will include identifying residents with exit seeking behaviors daily for 4 weeks, then 3 times per week for 4 weeks, then 2 times a week for 4 weeks, then weekly ongoing. This was confirmed by review of audit sheets and interviews. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	8. The DON or Staff Development Nurse will report findings of the abuse and neglect audit to the monthly Quality Assurance Performance Improvement (QAPI) Committee members which include the Committee Chairperson - Administrator, DON, Assistant Director of Nursing, Medical Director, Dietary Director, Pharmacy Representative, Social Services Director, Activities Director, Environmental Director/ Safety Representative, Infection Control Representative/Staff Development Coordinator, Rehabilitation Director, and Medical Records Director for 4 months for further suggestions and/or follow up as needed. The DON, Assistant Director of Nursing, Minimum Data Set (MDS) Nurse, Nurse Supervisor, or Staff Development Coordinator will review the outcome of the abuse and neglect audit monthly and ongoing. Any aberrancies will be addressed, interventions developed, and corrective actions taken. This was confirmed by review of the QAPI tool and interviews. The facility's noncompliance of F-610 continues at a scope and severity of E for monitoring of the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37532 Based on policy review, medical record review, and interview, the facility failed to meet the discharge requirements and involuntary discharge requirements for 7 of 8 sampled residents (Resident #13, #14, #15, #16, #17, #18, and #19) reviewed for discharge requirements. The findings include: Review of the facility's policy titled, Transfer and Discharge . revised 3/22/2022, revealed .It is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility except in limited situations when the health and safety of the individual or other residents are endangered .Document the reasons for the transfer or discharge in the resident's medical record, and in the case of necessity for the resident's welfare and the resident's needs cannot be met in the facility, document the specific resident needs that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the needs .At least 30 days before the resident is transferred or discharged .Social Services Director or Designee will notify the resident and the resident's representative in writing . Review of the medical record, revealed Resident #13 was admitted to the facility on [DATE] with diagnoses of Encephalopathy, Traumatic Brain Injury, Dementia, Hypertension, Altered Mental Status, and Adult Failure to Thrive. Review of the 5-day admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #13 had a Brief Interview of Mental Status (BIMS) score of 10, which indicated moderate cognitive impairment, required supervision and limited assistance of staff for activities of daily living (ADLs). Review of a Nursing Progress Note dated 6/24/2022 at 11:23 PM, revealed .At approximately 1940 [7:40 PM] resident was observed exiting the front door by staff walking toward the parking lot . Review of a Nursing Progress Note dated 6/25/2022 at 5:22 PM, revealed .at 1630 [4:30 PM] attempted to go down stairs [downstairs], refused redirection and got on elevator. Off elevator on first floor and attempted to get out of the facility .slightly redirected but still refused to return to floor. At 1710 [5:10 PM], [Named Telehealth Service] [an on call General Practice Physician service for after hours] was called and informed of resident's behavior. At 1720 [5:20 PM], [Named Physician] from [Named Telehealth Service] informed staff to notify [Named Telehealth Service] of any further problems . Review of a Telehealth Evaluation dated 6/26/2022, revealed .Date of Service .6/25/2022 .5:12 PM .per RN [Registered Nurse] multiple attempts to try and leave facility .Confused .Aggressive .notify if patient behavior worsens .Notify [Named Telehealth] of any change in condition .Disposition .Stay in Facility . Review of the Discharge Summary dated 6/26/2022, revealed .discharged home with family .discharge date & [and] Time .6/26/2022 .[bullet checked] Condition Improvement . (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Nursing Progress Note dated 6/26/2022, revealed Resident #13 discharged home with daughter on 6/26/2022 at 2:39 PM. During an interview on 7/7/2022 at 3:25 PM, the Administrator stated, .We talked to her [Resident #13's Responsible Party (RP #1)] .about what happened at the facility [Resident #13's elopement] .I told her he was saying he wanted to go home .they [family] were in [Named city] .[Named RP #1] said I'll be there to pick him up .we'll just come and get him and see what we can do . During a telephone interview on 7/11/2022 at 10:48 AM, Resident #13's RP #1 confirmed she was notified on Saturday, 6/25/2022, by the person [Administrator] over the facility that they had to come pick up her dad. Resident #13's RP #1 informed the facility that they were out of town and couldn't come that day and she was told they would give her that day, but she had to pick him up the following day. The family canceled their trip early and returned home to pick the resident up on Sunday, 6/26/2022. Resident #13's RP #1 confirmed Resident #13 had a diagnosis of Dementia and he experienced confusion and forgetfulness. The family was not prepared for the discharge of Resident #13 on 6/26/2022. During a telephone interview with the former Director of Nursing (DON) on 7/12/2022 at 11:28 AM, the former DON was asked if she discussed a discharge plan with Resident #13's RP at any time. The DON stated, That was not discussed . When asked if she made a referral for a Psychiatric consult, the former DON stated, I would have done that on Monday .I didn't call on the weekend . The DON confirmed she was not aware Resident #13 was being discharged until the Administrator notified her on the morning of 6/26/2022. During an interview on 7/12/2022 at 11:48 AM, the Administrator confirmed she had called a friend of hers at a Psychiatric facility who was a Social Worker, about Resident #13. The Administrator stated, .Family weren't [wasn't] familiar with how to set him up . The Administrator confirmed the facility did not make a referral to an inpatient facility that specialized in behavior management. The Administrator stated, .I told them about [Named Psychiatric Facility] services . The Administrator was asked if she made a referral to a Psychiatric facility. The Administrator stated, .called her [Social Worker at the Psychiatric facility] and told her everything about him .asked her to reach out to the family .knew she would take it from there . The Administrator confirmed the facility Social Worker was not involved with the discharge. The Administrator was asked if the discharge plan and resources available after discharge were discussed with the resident's RP #1 after Resident #13 was discharged instead of prior to the discharge. The Administrator stated, Right .Yeah. The Administrator confirmed the resident had discharged when she talked to the RP about resources available. At that time, the Regional Director of Clinical Services (RDCS) stated to the Administrator, .Think about what you're saying, [Named Administrator], are you sure he was already gone? . The Administrator changed her statement at that time and stated, .I called her Sunday and she said they [RP #1 and #2] were enroute from [Named city] and that's when I started to talk to her .I'm so sorry . During a telephone interview on 7/13/2022 at 9:03 AM, RP #2, who also lived with Resident #13, confirmed it was extremely difficult to care for Resident #13 due to his Dementia and wandering behaviors. RP #2 stated, .They called Friday, and kept calling Saturday, then called Sunday wanting to know when we were going to get him .She [person on the phone] kept saying her CEO [Chief Executive Officer] said he had to leave .they didn't offer anything .when we came to get him the nurses weren't even aware he was leaving and packed up his meds [medications] and that was it .they [facility] did not give us a referral or nothing . (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/13/2022 at 5:42 PM, the Administrator confirmed the facility did not have Resident #13's family sign an Involuntary Discharge Form prior to discharge. Review of the medical record revealed Resident #14 was admitted to the facility on [DATE] with diagnoses of Functional Quadriplegia, Hemiplegia and Hemiparesis, Schizoaffective Disorder, and Cerebral Infarction. Review of the quarterly MDS dated [DATE], revealed Resident #14 had a BIMS of 15 which indicated no cognitive impairment and the resident required extensive assistance of staff for all ADLs except eating. Review of a Nursing Progress Note dated 6/23/2022, revealed .Random drug screen completed on resident [Resident #14] due to observed eating marijuana at breakfast .urine drug screen returned with positive for THC [metabolite of marijuana] .resident denies eating edible marijuana . Review of a Nursing Progress Note dated 6/24/2022, revealed .[Named RP for Resident #14] informed of resident positive drug screen .states she will come to the facility to talk with resident . Review of a Social Service Progress Note dated 7/4/2022, written by the Administrator, revealed . Administrator has spoken with resident's [Resident #14] father .and he has been informed the facility will be issuing a 30 days [day] discharge notice as a result of resident being positive for marijuana . During an interview on 7/11/2022 at 5:00 PM, when asked if Resident #14's RP had been given written Notice of Transfer or Discharge, the RDCS stated, .We rescinded that discharge. Can't determine if he did that [consumed edible marijuana] or not. During an interview on 7/11/2022 at 5:08 PM, when asked if a discharge notice had been received from the facility, Resident #14's RP stated, .Some lady called .Said he had to move. He needs to stay where he is because he is close to his family. I can't take care of him. If I could he would be home. When asked if anyone had called him to arrange housing or to not discharge, the RP stated, No one has called back. I've been worried they would send him somewhere else . During an interview on 7/11/2022 at 5:43 PM, when asked if the RP for Resident #14 had been given a written Notice of Transfer or Discharge, the Administrator confirmed no notice was sent. When asked if the RP had been told the resident would need to discharge in 30 days, the Administrator stated, I had talked with his [Resident #14's] father and told him that. Me and [Named RDCS] talked about it and I said I would call and tell his dad the discharge was rescinded. I haven't done that .We will plan that now . Review of the medical record, revealed Resident #15 was admitted to the facility on [DATE] with diagnoses of Cerebral Infarction, Epilepsy, Repeated Falls, Osteoarthritis, and Cardiac Pacemaker. Review of the admission MDS dated [DATE], revealed Resident #15 had a BIMS of 15 which indicated no cognitive impairment, and required limited assistance of staff for all ADLs except eating. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a letter dated 7/14/2022 and addressed to [Resident #15's daughter], revealed .This is our Notice of Intent to Discharge [Resident #15] on August 13, 2022, 30 days from the date of this letter: the resident is being discharged for the following reasons .The resident's welfare cannot be met at this facility . The letter was signed by the Administrator. Review of a Nursing Progress Note dated 7/14/2022 2:46 PM, revealed .Resident and RP notified of move at this time . Review of a Nursing Progress Note dated 7/14/2022 4:48 PM, revealed .called .RP #2 [Resident #15's father] and informed him that the resident will be transferring at 7 pm [7:00 PM] or sooner . Review of a Social Service Progress Note entered by the Administrator and dated 7/15/2022, revealed . Resident was discharged to our sister facility .on 7/14/22 [2022]. Resident's father .was notified and he was in concurrence with discharge plans . During a telephone interview on 7/18/2022 at 12:41 PM, when asked if he had received a written 30-day notice of transfer and discharge, Resident #15's father stated, .I didn't get a call till the day they were moving her. I had tried to call my daughter [Resident #15] on her cell number. When I finally heard from her, I was told by her that she was at [Named Sister Facility]. Said they [the facility] had a supply problem of some sort. I didn't understand. My daughter said the State came down on them because they didn't follow the rules. They [facility] told her that. I really don't know nothing. I wasn't told in a way I understand. I wasn't given a choice. They said they were transferring her to [Named Sister Facility] . Review of the medical record, revealed Resident #16 was admitted to the facility on [DATE] with diagnoses of Osteomyelitis, Chronic Obstructive Pulmonary Disease, Anxiety, and Hypertension. Resident #16 was discharged to another Long Term Care facility on 7/14/2022 and readmitted to the facility on [DATE]. Review of the 5-day MDS dated [DATE], revealed Resident #16 had a BIMS of 15 which indicated no cognitive impairment, and required limited assistance of staff for all ADLs. Review of a letter dated 7/14/2022 and addressed to [Resident #16's RP], revealed .This is our Notice of Intent to Discharge [Resident #16] on August 13, 2022, 30 days from the date of this letter: the resident is being discharged for the following reasons .The resident's welfare cannot be met at this facility . The letter was signed by the Administrator. During an interview on 7/18/2022 at 1:16 PM, when asked about the resident's recent discharge and readmission, Resident #16 stated, .My friend [resident's RP] called me and asked me when I was moving to [Named Sister Facility]. I said, 'What are you talking about?' That day about noon the nurse came in and said, 'You are moving to [Named Sister Facility] and be ready in about an hour.' I asked why I couldn't stay. She said she didn't know, but something about the State did something and my insurance wouldn't pay .The next day over there [at the other facility] the Social Worker came in and said I could go back to [this facility]. I didn't understand anything that happened .I wanted to stay here . (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/18/2022 at 1:35 PM, when asked the reason Resident #16 was transferred on 7/14/2022 and readmitted to the facility on [DATE], the Social Worker stated, .Our Administrator and her direct boss told me late Thursday [7/14/2022] that 8 [residents] had to be transferred that had come after June 24 [6/24/2022]. He [Resident #16] was very upset when I went to his room and told him .I didn't give any discharge notices or choices. Administrator said discharges were going to [Named Sister Facility] . Review of the medical record, revealed Resident #17 was admitted to the facility on [DATE] with diagnosis of Malignant Neoplasm of Bronchus or Lung, Epilepsy, Malignant Neoplasm of Brain, Cerebral Edema, and Dysphagia. Review of the 5-day MDS dated [DATE], revealed Resident #17 had a BIMS of 15, which indicated no cognitive impairment, and required extensive assistance by staff for all ADLs. Review of a letter dated 7/14/2022 and addressed to [Resident #17's RP], revealed .This is our Notice of Intent to Discharge [Resident #18] on August 13, 2022, 30 days from the date of this letter: the resident is being discharged for the following reasons .The resident's welfare cannot be met at this facility . The letter was signed by the Administrator. Review of a Social Service Progress Note dated 7/12/2022, revealed .Left vmail [voice mail] for [Resident #17's RP] stating a full life conference will be held on Wednesday 7/13/2022 or Friday 7/14/2022 . Review of a Social Service Progress Note dated 7/15/2022 entered by the Administrator, revealed .Resident was discharged to our sister facility .on yesterday 7/14/22 [2022] and her responsible party, was notified and in concurrence with discharge plans . During a telephone interview on 7/18/2022 at 1:40 PM, when asked if he had received a written 30-day notice of transfer and discharge, Resident #17's RP stated, .I was notified by phone that day [7/14/2022]. They said were having problems there . When asked if he was given a choice of which facility to transfer to, the RP stated, Really no choice. Sent her there because it was a sister facility . Review of the medical record, revealed Resident #18 was admitted to the facility on [DATE] with diagnosis of Displaced Bicondylar Fracture Left Tibia, Repeated Falls, Type 2 Diabetes, Chronic Obstructive Pulmonary Disease, Osteoarthritis, and Heart Failure. Review of the 5-day MDS dated [DATE], revealed Resident #18 had a BIMS of 9 which indicated moderate cognitive impairment, and was dependent for full staff assistance for all ADLs except eating. Review of a letter dated 7/14/2022 and addressed to Resident #18's RP, revealed .This is our Notice of Intent to Discharge [Resident #18] on August 13, 2022, 30 days from the date of this letter: the resident is being discharged for the following reasons .The resident's welfare cannot be met at this facility . The letter was signed by the Administrator. Review of a Daily Skilled Note dated 7/8/2022, revealed .Resident is receiving skilled care .Physical therapy services are being provided. Occupational therapy services are being provided . (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Social Service Progress Note dated 7/15/2022 entered by the Administrator, revealed .Resident was discharged to our sister facility .on yesterday 7/14/22 [2022]. Notified resident's responsible party .and he was in concurrence with discharge plans . During a telephone interview on 7/18/2022 at 1:32 PM, when asked if he had received a written 30-day notice of transfer and discharge, Resident #18's RP stated, .I was notified the day of the move .I was told moving her due to compliance issues. Then the person who called stated the facility had not been paid since my mother had been at the facility .gave choices of [Named 2 Sister Facilities], no other choices .Received a letter today stating would be discharged as of 8/14 [8/14/2022] .We go see her every day and now it is an hour drive to [Sister Facility] . Review of the medical record, revealed Resident #19 was admitted to the facility on [DATE] with diagnosis of Nontraumatic Intracranial Hemorrhage, Presence of Cerebrospinal Fluid Drainage Device, Hydrocephalus, and Acute Respiratory Failure. Review of the 5-day MDS dated [DATE], revealed Resident #19 had a BIMS of 12, which indicated moderate cognitive impairment, and was dependent on staff for assistance for all ADLs. Review of a letter dated 7/14/2022 and addressed to [Resident #19's RP], revealed .This is our Notice of Intent to Discharge [Resident #19] on August 13, 2022, 30 days from the date of this letter: the resident is being discharged for the following reasons .The resident's welfare cannot be met at this facility . The letter was signed by the Administrator. Observation in the resident's room on 7/18/2022 at 1:28 PM, revealed Resident #19 in bed with oxygen in use by nasal cannula. She was alert and oriented and required extra time to express thoughts. During an interview on 7/18/2022 at 1:30 PM, when asked if she was staying in the facility or moving to a different facility, Resident #19 stated, I don't know. When asked if she had been told at any time she had to discharge from the facility, Resident #19 stated, No. During an interview on 7/18/2022 at 1:35 PM, when asked if Resident #19 was planned to discharge to another facility, the Social Worker stated, .She was a readmit on 6/28 [6/28/2022]. She had been here before and went home, but her husband couldn't care for her .Her husband wants her to stay. She is supposed to discharge to [Sister Facility] .She was supposed to leave on 7/14 [7/14/2022], but she never has [discharged]. She is 1 of the 8 [residents] the Administrator said to discharge to the Sister Facility . During an interview on 7/18/2022 at 12:04 PM, when asked the reason Resident #15, #16, #17, #18, and #19 were given a letter of notice of intent to discharge due to the resident's welfare cannot be met at this facility, the RDCS reviewed a copy of the discharge letters and stated, .I hadn't seen that .People are overwhelmed. Census was high. We was [were] just trying to make it manageable. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/18/2022 at 12:20 PM, when asked the reason Resident #15, #16, #17, #18, and #19 were given a letter of notice of intent to discharge due to the resident's welfare cannot be met at this facility, the Administrator stated, It wasn't that it couldn't be met. That was just the only one that was the best option. With the influx of residents, we couldn't meet their welfare needs because of the IJs [Immediate Jeopardy] we got and the prior IJs .We needed to lower our census to better manage. I have to resend the discharge notice because I used the wrong form .I wasn't aware of the correct form .

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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** 28913 Based on policy review, facility investigation review, facility incident report review, medical record review, observation, and interview, the facility failed to ensure a safe environment, provide adequate supervision to prevent elopement, and failed to ensure wandering assessments were completed for 2 of 6 sampled residents (Resident #1 and #2) reviewed; when a cognitively impaired resident who was at risk for wandering, eloped from the facility, walked approximately 1 mile from the facility, crossed a total of 6 lanes of high-volume traffic at a main intersection and got in a car with a passing motorist. The resident was found by a family member in a neighborhood known for drug deals. Resident #1 was unsupervised outside the building for approximately 14 hours; and the facility failed to supervise safe smoking practices when Resident #1 was observed smoking unsupervised. The facility failed to provide an adequate smoking apron for 4 of 14 sampled residents (Resident #1, #6, #7, and #8) reviewed for safe smoking, and the facility failed to prevent accidents and provide interventions for 5 of 5 sampled residents (Resident #1, #2, #3, #4 and #5) reviewed with aggressive behaviors. The facility's failure to provide adequate supervision to prevent elopement and the failure to provide adequate supervision while smoking resulted in Immediate Jeopardy for Resident #1. The facility's failure to prevent accidents and provide interventions resulted in Immediate Jeopardy for 3 incidents of resident-to-resident altercations when Resident #3 hit Resident #2 in the head with a book, Resident #4 willfully pushed Resident #2 to the floor, and Resident #5 willfully pushed Resident #1 causing the resident to fall to the floor and hit his head had the likelihood to cause serious injury to all 5 residents. Immediate Jeopardy is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Regional Director of Clinical Services, the Administrator, and the Director of Nursing (DON) were notified of the Immediate Jeopardy (IJ) on 5/13/2022 at 6:30 PM, in the Chapel. The facility was cited Immediate Jeopardy at F-689 at a scope and severity of K, which is Substandard Quality of Care. The IJ existed from 2/20/2022 through 5/16/2022. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 5/14/2022 at 1:44 PM, and the corrective actions were validated onsite by the surveyors on 5/17/2022 through policy review, medical record review, observation, review of education records, and staff interviews. The findings include: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's undated policy titled, Accidents and Supervision, revealed .each resident receives supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazards(s) and risk(s). 3. Implementing interventions to reduce hazard(s) and risk(s). 4. Monitoring for effectiveness and modifying interventions when necessary .The facility shall establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents .Implementation of Interventions-using specific interventions to try to reduce a resident's risks from hazards in the environment. The process includes .Communicating the interventions to all relevant staff .Documenting interventions .Ensuring that the interventions are put into action . Facility-based interventions may include, but are not limited to .educating staff .developing or revising policies and procedures .The facility will provide adequate supervision to prevent accidents .Based on the individual resident's assessed needs and identified hazards in the resident environment . Review of the facility's undated policy titled, Elopements and Wandering Residents, revealed .This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk .The facility is equipped with door locks/alarms to help avoid elopements .Staff are to be vigilant in responding to alarms in a timely manner . Adequate supervision will be provided to help prevent accidents or elopements .Any staff member becoming aware of a missing resident will alert personnel using facility approved protocol . Review of the facility's undated policy titled, Resident Alarms, revealed .It is the policy of this facility to utilize resident alarms in limited circumstances, in accordance with the resident's needs, goals, and preferences, so the resident will be able to attain or maintain his or her highest practicable level of physical, mental, and psychosocial well-being .Wander/elopement alarms - includes devices such as bracelets .worn/attached to the resident that alert staff when the resident nears or exits an area or building .The facility shall establish and utilize a systematic approach for the safe and appropriate use of resident alarms .Implementation of interventions .Supervision and other resident-specific interventions shall be implemented and documented prior to the use of alarms .Interventions shall be communicated to all relevant staff, including frequency/time frame and responsibility .Monitoring and modification a. Supervision shall be provided to the resident in accordance with the resident's plan of care .b. When alarms are utilized, additional monitoring shall be provided . Review of the facility's policy titled, Elopement/Wandering Residents, dated 12/2010, revealed .It is the intent of this facility to determine which residents have significant wandering behavior and enhance staff awareness as well as educate them on how to deal with such residents .An elopement/wandering assessment will be completed upon admission located in the nursing admission information packet and quarterly thereafter .A wandering/elopement notebook containing pictures and pertinent demographics information will be maintained by social services and kept at each nurse's station and front lobby. Update notebook quarterly . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's undated policy titled, Resident Smoking, revealed .This facility provides a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking .Smoking is prohibited in all areas except the designated smoking area .Safety measures for the designated smoking areas will include .Provision of ashtrays made of noncombustible material and safe design .Accessible metal containers with self-closing covers into which ashtrays can be emptied .Residents who smoke will be further assessed, using the resident Safe Smoking Assessment, to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all .All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking . Review of the facility's Elopement/Wander Risk Assessment tool revealed a scale with scores as follows: 0-8 indicated a low risk, 9-10 indicated a moderate risk, 11 or above indicated a high risk to wander. Review of the medical record, revealed Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Seizures, Mood Disorder, Aphasia, Myocardial Infarction, Diabetes, and Encephalopathy. Review of the admission Elopement/Wandering Risk assessment dated [DATE], revealed Resident #1 scored a 4, which indicated a low risk. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 had impaired cognition, impaired vision, an unsteady gait, required physical assistance for balance with transfers, and had range of motion impairment in the upper and lower extremities on one side of the body. Review of the Elopement/Wandering Risk assessment dated [DATE], revealed Resident #1 scored a 9, which indicated a moderate risk. Review of the Incident Report dated 2/20/2022, revealed .the receptionist received a call from the nurse [Licensed Practical Nurse (LPN) #1] who worked 7a [7:00 AM] to 7p [7:00 PM] today stating it look like a third floor resident was on [Named Street]. I asked receptionist who and she stated resident's name [Resident #1] . I went to check to see if he was there, he was not. Staff of the building searched for resident with no success . Review of the facility's investigation file dated 2/21/2022, revealed a typed statement from a resident who witnessed Resident #1 exiting the building. The statement revealed .He [Resident #1] went out the front door around the brick and I couldn't see him anymore. Did you see the receptionist at that time he said 'yes', What was she doing at the time you saw him go out the door 'She was on the telephone.' . Review of a Social Service Progress Note dated 2/21/2022 at 9:15 AM, revealed .Resident [Resident #1] returned to facility via family's car with sister and daughter at his side. Resident ambulated to door of the facility with an unsteady gait. Resident refused assistance from staff and family as he entered the building . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a Social Service Progress Note dated 3/10/2022, revealed, .Resident [Resident #1] cognition is impaired .Resident is at risk for elopement. Wander guard [a sensor alarm system worn by residents to alert staff if a resident attempts to exit through monitored exit doors] is in place . During an interview on 5/10/2022 at 11:29 AM, LPN #2 was asked when a Wanderguard was checked for placement. LPN #2 stated, .We check location that it [Wanderguard] is on the resident. We don't check if it's working or not .Are we supposed to . Observation in the resident's room on 5/10/2022 at 11:40 AM, revealed Resident #1 standing and looking out the window. He ambulated across the room with a right dominant limp and an unsteady gait. He was alert but was unable to determine his orientation due to his loss of ability to express himself verbally. He did not respond to open-ended questions but could respond with yes/no gestures. Resident #1 did not answer questions related to the elopement incident. During an interview on 5/11/2022 at 11:15 AM, the DON was asked what interventions were implemented after the elopement incident. The DON stated, .Family did not want him going out without notification .family was to pick him up twice a week [the family member stated in an interview that they had told the facility they could not come every week], he was 1 on 1 [1:1] with a CNA [Certified Nursing Assistant] .involve in more activities . When asked if the intervention of the family taking Resident #1 out for a leave twice weekly was implemented, the DON stated, I don't know .I guess they do .I don't know . During an interview on 5/11/2022 at 3:15 PM, LPN #6 was asked if there was a list of residents at risk to wander or elope. LPN #6 stated, I don't know. If they [residents] were high risk I would need to watch them. But I don't know about a list . During an interview on 5/11/2022 at 3:17 PM, LPN #7 was asked if there was a list of residents at risk to wander or elope, LPN #7 stated, Word of mouth if resident is a wanderer. I check to see if the Wanderguard is on, but I don't test it . LPN #7 had no knowledge of a notebook that listed the residents at risk for elopement/wandering. Observation on the 200 Hall, 300 Hall, and 400 Hall on 5/12/2022 at 12:32 PM, revealed the Elopement/Wandering notebooks located on each hall had inaccurate lists of residents assessed at risk for elopement/wandering. During a telephone interview on 5/13/2022 at 11:28 AM, LPN #1 was asked to give the details of Resident #1's elopement. LPN #1 stated, .I remember he [Resident #1] came to the desk on the 3rd floor. He was standing alone and not in his usual dress. He was wearing new white tennis shoes, a new gray heavy winter jacket, new clothes, and sweatpants. I asked where he was off to and he was going to smoke. He just giggled .I maybe left [left facility] about 7:30 [PM]. I was headed up [Named Street]. He was on my right side at the light [traffic light]. He was crossing to go toward median [on left, across 6 lanes]. He slapped the hood of my car .I opened my door and he sped up .I was afraid he would fall .I saw a navy bluish or black car. He got in .I lost sight of the car .I pulled over and called the building and spoke with the receptionist I called back to the building about 8 [8:00 PM] .She [receptionist] told me no resident was missing .[Named nurse] called me at home about an hour later and said he [Resident #1] was missing . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/13/2022 at 5:55 PM, the Administrator was asked if the elopement notebooks were accurate. The Administrator stated, .No, I did not realize it until it was brought our attention . During a telephone interview on 5/16/2022 at 11:08 AM, a family member of Resident #1 was asked about the elopement incident. The family member stated, .They [staff] called me at 8:16 PM and was saying they didn't know where he was. They said they last saw him at 7:05 [PM]. I thought someone watched that front door. I asked how did you let a man that walks slow with a limp get out of your sight .Next morning my mom called me and said my cousin had found him in [Named] neighborhood where he [Resident #1] used to do drugs .I brought him back. He didn't seem to be on any drugs, seemed the same . When asked what interventions the facility implemented to prevent another elopement, the family member stated, .They put a thing [Wanderguard] on his leg .I told them I can't come every week . During an interview on 5/16/2022 at 12:38 PM, LPN #8 was asked if there was a list of residents at risk to wander or elope. LPN #8 stated, .If have a Wanderguard they [residents] are a risk. I don't know about those that wander. I don't know who they are. LPN #8 had no knowledge of a notebook that listed residents at risk for elopement/wandering. During a telephone interview on 5/17/2022 at 11:36 AM, Registered Nurse (RN) #1 was asked about Resident #1's elopement. RN #1 stated, .The receptionist asked me if I would watch the desk while she took them [residents] out to smoke at 7:00 PM. I was at the desk telling visitors to sign in and log in and I was on the phone .About 7:15 he [Resident #1] came to me and put some change on the counter. I told him I didn't have any money .He walked away .that is the last I saw him. It was a busy time with the visitors coming in and the phone calls . Review of the Safe Smoking Screen dated 2/21/2022, revealed Resident #1 needed to use a smoking apron and required direct supervision while smoking. Observation at the Front Patio on 5/10/2022 at 12:09 PM, revealed Resident #1 was seated and smoking a cigarette. Three other residents were also on the patio. There were no staff present. Observation at the Front Patio on 5/10/2022 at 12:16 PM, revealed RN #2 asked Resident #1 if he had a lighter. He shook his head to answer No. RN #2 stated, I'm going to let him smoke that cigarette because he will get agitated if I try to take it. I'll see about the lighter . During an interview on 5/10/2022 at 12:13 PM, Receptionist #1 was asked if Resident #1 was allowed to smoke on the Front Patio. Receptionist #1 stated, .They can't smoke on the patio. I didn't know he [Resident #1] was out there. When asked if the Wanderguard alarm on the door sounded she stated, .It is busy here .If it wasn't this much noise it would seem louder .I don't know how that happened . Review of a Nurses' Note dated 5/15/2022, revealed .This writer walked pass [past] [Resident #1's room] and smelled smoke .upon entering the room I could smell smoke and observed the resident standing by the window tossing something out of the open window .Resident became visible [visibly] upset and walked towards this writer with fist balled up in a threatening attempt to fight . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the medical record, revealed Resident #3 was admitted to the facility on [DATE] with diagnoses of Pulmonary Edema, Diabetes, and Guillain-Barre Syndrome. Review of the annual MDS dated [DATE], revealed Resident #3 scored a 15 on the BIMS scale, which indicated cognitively intact for decision making. Review of Resident #3's Nurses' Note dated 4/28/2022 at 6:40 PM, revealed, .This nurse enter [entered] resident room an [and] ask [asked] what happen [happened], resident stated He [Resident #2] enter [entered] my room an [and] I try [tried] to get him out. This nurse ask [asked] resident if she allegedly hit resident, resident stated No . Review of a Nurses' Note dated 4/28/2022 at 7:37 PM, revealed .18:40 [6:40 PM] per nurse was inform from CNA she was picking up trays coming out of room [number] [a resident's room] with resident tray to put on food cart and saw [Named Resident #3] hitting [Named Resident #2] with a bible in the head, resident [Resident #2] remove [removed] from room [number] [Resident #3's room] to hallway, per nurse enter [entered] room [number] [Resident #3's room] an [and] ask [asked] resident [Resident #3] what happen [happened] resident stated 'he enter [entered] my room and I try [tried] to get him out' per nurse ask [asked] [Named Resident #3] did she hit him with anything resident stated, No head to toe assessment done [Named Resident #2] small rise area with redness to left side of head denies pain at site, per nurse ask [asked] [Named Resident #2] what happen [happened] resident stated 'she hit me on the side of my head' v/s [vital signs] [blood pressure] 142/70, p [pulse] 80, r [respiration] 18, [temperature] 98.4 .1845 [7:45 PM] NP [Nurse Practitioner] notified .1848 7:48 PM] call rp [responsible party] no answer, 1849 [7:49 PM] administrator notified . Review of a Social Service Progress Note dated 4/29/2022 at 4:46 PM, revealed .Social worker spoke to resident [Resident #2] today. Resident was unable to recall event of wandering last night. BIMs assessment was completed. Resident BIMs score is a 5 [Severely impaired cognitively for decision making] .Redness noted to resident face . Review of a Social Service Progress Note dated 5/3/2022 at 4:53 PM, revealed .Resident [Resident #2] was seen by psych [psychiatric] services on 4/29/2022 regarding follow up to recent behaviors . Administration was unable to produce documentation of a psychiatric service visit on 4/29/2022 visit they were asked multiple times for the information during the survey dated 5/10/2022 - 5/17/2022 . During an interview on 5/10/2022 at 3:29 PM, Resident #3 stated, .He [Resident #2] comes in my room rolling in his wheelchair day and night. I tell him not your room, not your room. On that day [4/28/2022] I was in bed and kept telling him not your room. He kept coming. I was yelling and he tried to go into my closet and bathroom. I kept hearing him bumping into things like the door and wall as he was moving his wheelchair around in that area. In the meantime, while I was yelling at him, I was trying to transfer myself to my wheelchair. I had to remove the arm of my wheelchair to get in it. The whole time yelling not your room. It took a while for me to get in my wheelchair and then the CNA got him out .No, I didn't hit him. He probably bumped his head/face on the door or wall .They need to keep him out of my room. I don't like it .the staff's answer is oh that is just [Resident #2] he wanders in others room. I told them that is not ok . During an interview on 5/11/2022 at 12:00 PM, the DON was asked what behaviors Resident #2 exhibited prior to the resident-to-resident altercation. She stated, .I don't know . When asked if staff were interviewed about the resident's behaviors prior to the altercation. She stated, .No . (continued on next page)

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Midtown Center for Health and Rehabilitation	141 N McLean Blvd Memphis, TN 38104

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the medical record, revealed Resident #4 was admitted to the facility on [DATE] with diagnoses of Radiculopathy Lumbar Region, Fracture of Vertebra, Sacral and Sacrococcygeal Region, and Diabetes. Review of the admission MDS dated [DATE], revealed Resident #4 scored a 15 on the BIMS scale, which indicated the resident was cognitively intact for decision making. Review of Resident #4's Nurses' Note dated 5/5/2022 at 1:11 PM, revealed, .Ms. [Named Resident #4] stated a male resident [Resident #2] came into her room while she was sleeping overnight. She was sleeping on her right side facing the window, she felt the mattress moving and a knee was on her leg. He [Resident #2] didn't touch her upper body. She thought it was her roommate; however, she turn [turned] to the left and saw a white man. She said to him Wrong Bed/Wrong Room and the male resident repeated what was said to him. She push [pushed] him out her bed and he fell on to the floor. He was reaching for help, and she refuse [refused] to help him due to her being fearful of falling and hurting herself. She push [pushed] the call light for help but staff didn't respond. So, both her and the male resident [Resident #2] was screaming and hollowing [hollering] loud .before staff came to assist and remove [removed] male resident from her room . Review of Resident #2's Nurses' Note dated 5/5/2022 at 8:06 PM, revealed, .Late entry: this AM @ [at] 02:15 [2:15 AM] Resident [#2] wanders into room [number] [Resident #4's room]. The staff CNA answered called light in [Resident #4's room] and noted Resident [#2] on floor in between Bed A and bed B at the foot. Resident [#2] in sitting position in front of w/c chair [wheelchair]. Resident [#2] was placed in wheelchair taken to his room [room number]. Resident [#2] assessed with no new bruises, redness or open areas . Review of Resident #4's Nurses' Note dated 5/8/2022 at 6:31 AM, revealed, .Patient called on the unit phone stating another resident [Resident #2] had entered her room. The patient was upset and stated this is the second time this has happened, and they said he would be watched. I explained to the patient that I was unaware of the situation and would ensure that the male [Resident #2] did not return to her room. Patient stated I'm reporting this because this is unacceptable .I again assured the patient that I would keep close watch on the male [Resident #2] and make sure he does not enter her room again . During an interview on 5/10/2022 at 3:45 PM, Resident #4 confirmed the Nurses' Notes dated 5/5/2022 at 1:11 PM and 5/8/2022 at 6:31 AM. She stated, .this man [Resident #2] came into my room [5/5/2022] and attempted to get in bed with me. I was turned on my right side facing the window when I felt a knee on my leg and the bed moving. I rolled over to see what was happening and this white man was trying to get into my bed. I yelled and instinctively pushed him back and he lost his balance and fell on to the floor. I started yelling Help and he would repeat everything I said help but in a weaker voice. I pushed the call light no answer by staff, and we continued to yell until staff came in .They told me oh, that is Mr. [Named Resident #2] and he wanders that is just what he does. I said no, that is not ok .Then a few days later [5/8/2022] he came into my room again. I picked up the phone and called the facility. They came in and got him. I told that nurse about what had happened before, and that agency nurse said she didn't know anything about him. I said ya'll told me you would watch him . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/10/2022 at 3:57 PM, RN #2 was asked what interventions were implemented after the 4/28/2022 altercation of Resident #2 and Resident #3. She stated, .we did hourly safety checks . When RN #2 was shown the date of onset for hourly safety checks was 3/3/2022 she stated, .Oh I see nothing new . When she was asked what interventions were implemented after the 5/5/2022 altercation of Resident #2 and Resident #4, she stated, .continue hourly safety checks .supposed to have close supervision .to be honest we failed to supervise him . During an interview on 5/11/2022 at 12:00 PM, the DON was asked what behaviors Resident #2 exhibited prior to the resident-to-resident altercation. She stated, .I don't know . When asked if staff were interviewed about the resident's behaviors prior to the altercation, she stated, .No . Review of the medical record, revealed Resident #5 was admitted to the facility on [DATE] with diagnoses of Fracture First Lumbar Vertebra, Multiple Rib Fractures, and Fracture Shaft of Humerus. Review of Resident #5's ED [Emergency Department] Note Physician dated 9/17/2021, revealed .History of IV [Intravenous] drug use [drugs entered through the veins where blood flows in the body] .Alcohol use current type beer, liquor, wine .Substance use current type cocaine . Review of Resident #5's Nurses' Note dated 11/29/2021 at 10:05 PM, revealed .The CNA reported to this nurse writer that the resident was drinking liquor in his room. An empty bottle of [Named] Vodka was confiscated from his shoebox. Resident denied drinking However this nurse observed resident's behavior as being loud using inappropriate language, cursing, unsteady gait. Resident meds [medications] held. Resident state I don't have to have it .Resident instructed on hazard of taking sedative and narcotic with alcohol. Resident insistent he has not drunk any alcohol. Will monitor. Resident went straight to sleep without prompting . Review of the quarterly MDS assessment dated [DATE], revealed Resident #5 scored a 15 on the BIMS scale, which indicated the resident was cognitively intact for decision making. Review of the Incident Report dated 2/9/2022 at 6:31 PM, revealed .This resident [Resident #5] initiated physical and verbal aggression against another resident [Resident #1] in the lobby area of the nurse's station to resident [Resident #1]. This resident [Resident #5] got out of his wheelchair as he was talking loudly and accusing the resident [Resident #1] of stealing approached Mr. [Named Resident #1] then forcibly pushed the resident down to the floor near the window causing the resident [Resident #1] to hit his head against wall. This incident was witnessed per nurses . Review of Resident #1's Nurses' Note dated 2/9/2022 at 6:38 PM, revealed, .This nurse observed an altercation between resident [Resident #5] and resident [Resident #1]. The resident [Resident #5] was following [Resident #1]. [Resident #5] was in his wheelchair, he was coming down hallway stating that the resident [Resident #1] He stole something from me. He know [knows] he stole from me. [Resident #5] stood up from his wheelchair and pushed [Resident #1] into the window .[Resident #1] fell and struck his head. [Resident #1] was transferred from the floor unto the chair .Police discovered from the resident [Resident #5] that they had been drinking in the room. [Resident #1] was re-assigned to another room temporarily until crisis over . Review of the Resident #5's Nurse's Note dated 2/9/2022 at 6:40 PM, revealed .Resident [#5] became verbally and physically abusive toward another resident [Resident #1] pushed another resident down to the floor .Resident [#5] reported to [Named Police Department] he had been drinking . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the skull series x-ray report dated 2/10/2022, revealed Resident #1 had .no acute fracture . conclusion normal skull series . Review of Resident #5's Care Plan revised 5/10/2022, revealed no documentation that empty Vodka bottles were found in the resident's room on 11/29/2021 and 2/9/2022, that the resident was drinking liquor in his room, or the behaviors of loud, inappropriate language, and cursing. During a telephone interview on 5/13/2022 at 2:57 PM, LPN #4 stated, .I reported him [Resident #5] drinking to the Administrator and the Director of Nursing back in November 2021. I told them about the empty Vodka bottle, and he may have been under the influence. Loud and talking a lot and a shift in his behavior . During an interview on 5/13/2022 at 3:35 PM, the Administrator was asked about the documentation of the incident on 11/29/2021 when an empty bottle of alcohol was found in Resident #5's room and the behaviors documented in a Nurses' Note dated 11/29/2021. When asked if the incident was investigated, the Administrator stated, .No, it was never brought to my attention .No, we never investigated it . Observation in the Smoking Area on 5/11/2022 at 1:27 PM, revealed Resident #1 was given a smoking apron that was torn, had multiple holes and frayed edges, [TRUNCATED]

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29706 Based on job description review, medical record review, observation, and interview, facility Administration failed to provide administration and oversight of its resources effectively to attain and maintain the highest practicable well-being of residents with wandering/elopement behaviors. Administration failed to provide oversight and training of staff to prevent neglect and provide appropriate care to meet resident's needs, failed to provide adequate supervision to prevent elopement, failed to provide safe smoking practices, failed to complete a thorough investigation of a resident elopement when a resident exited the facility without staff knowledge, and failed to thoroughly investigate resident-to-resident abuse. The facility's failure resulted in Immediate Jeopardy (IJ) when Resident #1, a cognitively impaired resident who was at risk for wandering, eloped from the facility, and walked approximately 1 mile from the facility, crossed a total of 6 lanes of high-volume traffic at a main intersection and got in a car with a passing motorist. The resident was found by a family member in a neighborhood known for drug deals. Resident #1 was unsupervised outside the building for approximately 14 hours. The facility's failure to thoroughly investigate 3 incidents of resident-to-resident altercations when Resident #3 hit Resident #2 in the head with a book, Resident #4 willfully pushed Resident #2 to the floor, and Resident #5 willfully pushed Resident #1 causing the resident to fall to the floor and hit his head had the likelihood to cause serious injury or harm. Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Regional Director of Clinical Services, Administrator, and Director of Nursing (DON) were notified of the Immediate Jeopardy for on 5/13/2022 at 6:30 PM, in the Chapel. The facility was cited Immediate Jeopardy at F-600, F-610, F-689, F-835, and F-867. The facility was cited Immediate Jeopardy at F-600 at a scope and severity of J, which is Substandard Quality of Care. The facility was cited Immediate Jeopardy at F-610 and F-689 at a scope and severity of K, which is Substandard Quality of Care. The Immediate Jeopardy existed from 2/20/2022 through 5/16/2022. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 5/14/2022 at 1:44 PM, and the corrective actions were validated onsite by surveyors on 5/17/2022 through review of education records, review of audits, meeting minutes, and staff interviews. The findings include: (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Administrator Job Description dated 12/2018, revealed .Lead and direct the overall operations of the facility in accordance with customer needs, government regulations and Company policies, with focus on maintaining excellent care for the residents while achieving the facility's business objectives .Identify and participate in process improvement initiatives that improve the customer experience, enhance work flow, and/or improve the work environment. Management duties including, but not limited to, hiring, training and developing, coaching and counseling, and terminating department staff, as deemed necessary .Monitor company identified Key Performance Indicators and address issues that affect performance of the facility . Monitor each department's activities, communicate policies, evaluate performance, provide feedback and assist, observe, coach and discipline as needed .Oversee regular rounds to monitor delivery of nursing care, operation of support departments, cleanliness and appearance of the facility; morale of the staff; and ensure resident needs are being addressed .Responsible for the QA [Quality Assurance] program. Maintain a working knowledge of and confirm compliance with all governmental regulations . Review of the Director of Nursing Job Description updated 12/2011, revealed .to manage the overall operations of the Nursing Department in accordance with Company policies, standards of nursing practices and governmental regulations so as to maintain excellent care of all residents' needs .Identify and participate in process improvement initiatives that improve the customer experience .Management duties including, but not limited to, hiring, training and developing, coaching and counseling, and terminating department staff, as deemed necessary .In the absence of the Administrator .assume responsibility of the facility .Plan, develop, organize, implement, evaluate and direct the nursing services department, as well as its programs and activities, in accordance with current rules, regulations, and guidelines that govern the long-term facility. Assume administrative authority, responsibility and accountability for all functions, activities, and training of the nursing department. Organize, develop, and direct the administration and resident care of the nursing service department .Meet monthly with staff on each unit .Participate in coordination of resident services through departmental and appropriate staff committee meetings .Make daily rounds of the nursing department to verify that all nursing service personnel are performing their work assignments in accordance with acceptable nursing standards .Provide appropriate departmental in-service education programs in compliance with Corporate, State and Federal guidelines .Perform nursing services and deliver resident care services in compliance with corporate policies and State and Federal regulations. Inform state of any reportable incidents within appropriate time frames. Complete investigative analysis as required .Schedule daily rounds to observe residents and to determine if nursing needs are being met in accordance with the resident's request .Study Infection Control Reports, Medication Incident Reports and Resident Incident Reports for corrective action .Ensure that all nursing service personnel follow established departmental policies and procedures .Assure residents a comfortable, clean, orderly and safe environment .Review Quality Indicator reports and submit to [NAME] President of Clinical Services on monthly basis .Participate in monthly QA [Quality Assurance] . Review of the facility's investigation, Incident Report, and Progress Notes, revealed Resident #1 eloped from the facility on 2/20/2022. On her way home from work Licensed Practical Nurse (LPN) #1 saw the resident on a (Named Street) crossing 6 lanes of traffic. The nurse called the facility and informed them she thought she had seen a resident from the facility walking down the street. LPN #1 saw the resident get into a car with a passing motorist. The resident was found by his family approximately 14 hours later in a neighborhood known for drug deals. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/10/2022 at 11:29 AM, LPN #2 was asked when staff checked a Wanderguard (a sensor alarm system worn by residents to alert staff if a resident attempts to exit through monitored exit doors) for placement. LPN #2 stated, .We check location that it [Wanderguard] is on the resident. We don't check if it's working or not .Are we supposed to . Observation in the resident's room on 5/10/2022 at 11:40 AM, revealed Resident #1 looking out the window. He ambulated across the room with a right dominant limp and an unsteady gait. He was alert but was unable to express himself verbally. He did not respond to open-ended questions but could respond with yes/no gestures. Resident #1 did not answer questions related to the elopement incident. During an interview on 5/11/2022 at 11:15 AM, the DON was asked what interventions were implemented after the elopement incident. The DON stated, .family was agreeable to a Wanderguard, family was to pick him up twice a week. [the family member stated in an interview that they had told the facility they could not come every week] he was 1 on 1 [1:1] with a CNA [Certified Nursing Assistant] .involve in more activities . When asked if his family takes him out twice weekly, the DON stated, I don't know .I guess they do .I don't know . Observation at the side of the building near the designated Smoking Area on 5/11/2022 at 1:22 PM, revealed the side door was propped open with a 5-gallon water dispensing bottle and at the end of the sidewalk was an open gate to the parking lot. During an interview on 5/11/2022 at 1:52 PM, the DON was asked if a resident could exit the building and go through the open door and onto the parking lot through the open gate. The DON stated, That door should not be open. It goes to where they are working in therapy. Construction guys left the gate open .It goes to the parking lot. During an interview on 5/11/2022 at 2:13 PM, the Administrator was asked if a resident could leave the building through the therapy department which was under construction. The Administrator stated, They could walk right out and go through the gate and right to the parking lot. When asked if the building was secured, the Administrator stated, I see what you mean. No, it's not. I thought the construction crew knew to keep the door locked . During an interview on 5/11/2022 at 3:15 PM, Licensed Practical Nurse (LPN) #6 was asked if there was a list of residents that were assessed at risk to wander or elope. LPN #6 stated, I don't know. If they [residents] were high risk, I would need to watch them. But I don't know about a list . During an interview on 5/11/2022 at 3:17 PM, LPN #7 was asked if there was a list of residents that were assessed at risk to wander or elope. LPN #7 stated, Word of mouth if resident is a wanderer. I check to see if the Wanderguard is on, but I don't test it . LPN #7 had no knowledge of a notebook containing a list of residents assessed at risk of elopement/wandering. Observation in the Chapel on 5/12/2022 at 11:43 AM, revealed the exit door from the Chapel to the parking lot was not secured. The door opened after pushing on it for 15 seconds, but no alarm sounded. After the door was closed it did not lock. During an interview on 5/12/2022 at 11:46 AM, the Maintenance Director was asked if the exit door in the Chapel was secured and stated, I don't know what's wrong. Looks like no power to the door. The alarm should sound. It's not working . (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation on the 200 Hall, 300 Hall, and 400 Hall, on 5/12/2022 beginning at 12:32 PM, revealed the Elopement/Wandering notebooks on each hall had inaccurate lists of residents assessed at risk of elopement and wandering. Observation on 5/12/2022 at 1:45 PM, revealed Resident #1 walked out of the lobby onto the Front Patio. The Wanderguard alarm sounded when the resident walked through the exit door. The receptionist was on the telephone at the desk. The alarm was difficult to hear due to residents, staff, and visitors talking and laughing in the Lobby area. No staff responded to the sounding alarm. Observations on 5/12/2022 at 2:34 PM, 5/13.2022 at 2:00 PM, and 5/14/2022 at 1:55 PM revealed the following: a. 1st floor - Exit door at the northeast side of the building was not secure and the double doors at the north end of the building were not secure. The door to the therapy department that was under construction had an alarm that was disabled, the side door on the hallway that opened to the parking lot was under construction and was not secured, the doors to the 2 stairwells to the 2nd floor were not secured. b. 2nd floor - the doors to the 2 stairwells from the 1st floor to the 3rd floor were not secured, the door at the stairwell that led to the designated outside Smoking Area for residents opened without any difficulty. c. 3rd floor - the doors to the 2 stairwells from the 2nd and 4th floor were not secure. d. 4th floor - the 2 doors to the stairwells from the 3rd floor were not secured. e. The stairwells on the 2nd, 3rd, and 4th floors on the northeast side of the building that led to the 1st floor exit door that was unlatched and led to the employee parking lot. During an interview on 5/12/2022 at 6:02 PM, the DON stated, .We did find discrepancies in the resident wander/elopement risk assessments . When asked what the discrepancies were, who had them, and how many residents were involved, she stated, .don't know who had them and how many . When asked for the documentation of what was done to address the discrepancies, she stated, .We didn't document what we did about it . When asked if there were interventions implemented to address the discrepancies and if the effectiveness of the interventions were evaluated, she stated, .No .I see what you mean . During an interview on 5/12/2022 at 6:02 PM, the Administrator confirmed education was not provided to all staff including agency personnel. She stated, .No, we didn't do it . The Administrator confirmed she did not provide specific education to the receptionist staff about wandering and elopement residents and their responsibility about the front door and the Wander Guard system doors. She stated, .No, we didn't do it . The Administrator confirmed she did not evaluate if any interventions were implemented on 3/2022 or 4/2022 and to see if the interventions were evaluated to determine if they were effective. She stated, .No, we didn't . The Administrator confirmed the wandering/elopement books were not accurate. She stated, .No, did not realize it until was brought to our attention . (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 5/13/2022 at 11:28 AM, LPN #1 was asked about the elopement. LPN #1 stated the resident came to the 3rd floor desk wearing new clothes and just giggled when asked where he was going. LPN #1 stated she left the facility about 7:30 PM, was at a traffic light, and saw Resident #1 crossing 6 lanes of traffic. LPN #1 tried to locate him but was unsuccessful and called the facility but was told no resident was missing. A nurse called about an hour later and stated Resident #1 was missing. During an interview on 5/13/2022 at 5:55 PM, the Administrator was asked if the elopement notebooks were accurate. The Administrator stated, .No, I did not realize it until it was brought our attention . During a telephone interview on 5/16/2022 at 11:08 AM, a family member of Resident #1 was asked what interventions the facility implemented to prevent another elopement (after the elopement), the family member stated, .They put a thing [Wanderguard] on his leg .I told them I can't come every week . During an interview on 5/16/2022 at 12:38 PM, LPN #8 was asked if there was a list of residents at risk to wander or elope. LPN #8 stated, .If have a Wanderguard they are a risk. I don't know about those that wander. I don't know who they are. LPN #8 had no knowledge of a notebook with a listing of residents at risk of elopement and wandering. During a telephone interview on 5/17/2022 at 11:36 AM Registered Nurse (RN) #1 stated she was at the receptionist's desk while the receptionist took the residents out to smoke at 7:00 PM. It was extremely busy answering the telephone and visitors signing in. Resident #1 came to the desk, placed some money on the desk, but then left and RN #1 did not see him again. Review of the Safe Smoking Screen dated 2/21/2022, revealed Resident #1 needed to use a smoking apron and required direct supervision while smoking. Observation on 5/10/2022 at 12:09 PM, revealed Resident #1 seated outside the building on the Front Patio smoking a cigarette. Three other residents were also on the patio. There was no staff member present. During an interview on 5/10/2022 at 12:13 PM, Receptionist #1 was asked if Resident #1 was allowed on the Front Patio. Receptionist #1 stated, .I didn't know he was out there. When asked if the Wanderguard alarm on the door had sounded, she stated, .It is busy here .I don't know how that happened . Observation on 5/10/2022 at 12:16 PM, revealed RN #2 asked Resident #1 if he had a lighter. He shook his head to answer No. RN #2 stated, I'm going to let him smoke that cigarette because he will get agitated if I try to take it. I'll see about the lighter . Review of a Nurses' Note dated 5/15/2022, revealed the nurse had walked past Resident #1's room and smelled smoke, entered the room, and observed Resident #1 tossing something out of the open window. The Resident became upset and approached the nurse in a threatening manner. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/16/2022 at 12:21 PM, LPN #2 was asked if Resident #1 had been found smoking in his room, LPN #2 stated, .I was walking down the hall and the sitter was outside his door. The door was closed .I smelled smoke and I knew that the smell was cigarette smoke. I opened the door. It was smokey, very smokey. He tossed something out the window. I searched the room. He wouldn't let me pat him down . During an interview on 5/17/2022 at 1:35 PM, the Central Supply Manager was asked if a lighter was found in Resident #1's room. The Central Supply Manager stated the lighter was in the zippered pocket of his sweatpants. The lighter was found on the resident on 5/16/2022, after he was found smoking unsupervised on 5/15/2022. Review of Resident #3's Nurses' Notes dated 4/28/2022, revealed a CNA saw Resident #3 hitting Resident #2 in the head with a Bible. Review of Resident #3's Nurse's Notes dated 4/28/2022 at 6:40 PM, revealed, .This nurse enter [entered] resident room an ask [asked] what happen [happened], resident stated He [Resident #2] enter [entered] my room an [and] I try [tried] to get him out. This nurse ask [asked] resident if she allegedly hit resident, resident stated No . During an interview on 5/11/2022 at 12:00 PM, the DON was asked what behaviors Resident #2 was exhibiting prior to the resident-to-resident altercation. She stated, .I don't know . When asked if staff were interviewed about the resident's behaviors prior to the altercation. She stated, .No . Review of Resident #4's Nurses' Notes dated 5/5/2022 at 1:11 PM, revealed, Resident #4 stated Resident #2 came into her room while she was sleeping. She was sleeping on her right side facing the window, she felt the mattress moving and a knee was on her leg. She told him he was in the wrong room and pushed him out of her bed and he fell on to the floor. Review of Resident #4's Nurses' Notes dated 5/8/2022 at 6:31 AM, revealed that Resident #4 called stating Resident #2 had entered her room. She was upset and stated it was the second time this had happened, and they had told her he would be watched. The nurse assured Resident #2 he would be watched and would not return to her room. During an interview on 5/10/2022 at 3:57 PM, RN #2 was asked what interventions were implemented after the 4/28/2022 altercation between Resident #2 and Resident #3. RN #2 stated they did hourly safety checks. When RN #2 was shown the documentation of the date the hourly safety checks were done was 3/3/2022, she stated, .Oh I see nothing new . When she was asked what interventions were implemented after the 5/5/2022 altercation of Resident #2 with Resident #4, she stated, .continue hourly safety checks .supposed to have close supervision .to be honest we failed to supervise him . During an interview on 5/11/2022 at 12:00 PM, the DON was asked what behaviors Resident #2 exhibited prior to the resident-to-resident altercation. She stated, .I don't know . When asked if staff were interviewed about the resident's behaviors prior to the altercation. She stated, .No . Review of Resident #5's Nurses' Notes dated 11/29/2021 at 10:05 PM, revealed a CNA reported to the nurse that Resident #5 was drinking liquor in his room. An empty bottle of Vodka was confiscated from his shoebox. Resident #5 denied drinking, but the nurse observed the resident's behavior as being loud, using inappropriate language, and had an unsteady gait. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. On 5/14/2022 the Nursing Home Administrator was educated on the role of Administrator, the job description, tools, and resources available to effectively administer a nursing facility operation by the Regional Director of Clinical Services. This was confirmed by review of education sign-in sheet and interview. 5. The Nursing Home Administrator was educated on Abuse, Neglect, and Exploitation on 5/14/2022 by the Regional Director of Clinical Services. This was confirmed by review of the education sign-in-sheet and interview on. 6. Quality Assurance Performance Improvement (QAPI) meetings will occur weekly for four weeks to monitor progress and then monthly thereafter. This was confirmed by review of sign in sheet and interview. 7. The DON, Nurse Supervisor, or Staff Development Coordinator will conduct abuse and neglect audits and smoking audits. The audits will include identifying residents with exit seeking behavior, unsafe or unsupervised smoking daily for four (4) weeks, then three times per week for four (4) weeks, then two (2) times week for four (4) weeks, then weekly ongoing. This was confirmed by review of audit sheets and interviews. 8. Regional Director of Operations or Regional Director of Clinical will provide oversight of facility administration with a weekly 1:1 interaction reviewing the completed audits and QA findings. The Plan of Correction will be reviewed weekly to ensure all the audits are completed and concerns are identified for 4 weeks and/or until substantial compliance is achieved. Monthly QAPI meetings will be conducted and attended by Regional Director of Operations and Regional Director of Clinical for a period of three months to ensure compliance is sustained. This was confirmed by review of audit tools and interviews. 9. Results of all audits will be brought to the QAPI Committee. The members include Committee Chairperson - Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director for 4 months for further suggestions and/or follow up as needed. The DON, Assistant Director of Nursing (ADON), Multi Data Set Nurse, Nurse Supervisor, or Staff Development Coordinator will review the outcome of the abuse and neglect audit monthly and ongoing. Any aberrancies will be addressed, interventions developed, and corrective actions taken. This was confirmed by review of the revised QAPI tool and interviews with QAPI members. The facility's noncompliance of F-835 continues at a scope and severity of E for monitoring of the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction.

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 29706 Based on policy review, job description review, Quality Assurance Performance Improvement (QAPI) report, medical record review, observation, and interview, the QAPI committee failed to ensure systems and processes were in place that involved tracking/trending, quantitative and qualitative data analysis, evaluation/reevaluation of interventions, data, and trends to address quality concerns related to wandering and elopement behaviors, resident to resident abuse, and safe smoking practices. The QAPI committee failed to ensure a thorough investigation of a resident elopement and a thorough investigation of resident-to-resident abuse, failed to provide safe smoking practices and supervision of residents that smoked, failed to identify quality deficiencies and effective interventions, failed to monitor the effectiveness of the interventions, and failed to assess staff knowledge of the care of residents with wandering/elopement behaviors in order to identify deviations and adverse events when a resident exited the facility without staff knowledge, and failed to ensure a safe environment for Resident #1, #2, #3, #4 and #5 that demonstrated resident to resident altercations. The facility's failure resulted in Immediate Jeopardy (IJ) when Resident #1, a cognitively impaired resident assessed as a risk for wandering/elopement and a high fall risk left the facility unsupervised and was missing for approximately 14 hours, and there were three incidents of resident-to-resident abuse when Resident #3 hit Resident #2 in the head with a book, Resident #4 willfully pushed Resident #2 to the floor, and Resident #5 willfully pushed Resident #1 to the floor hitting his head which had the likelihood to cause serious injury. Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Regional Director of Clinical Services, Administrator, and Director of Nursing (DON) were notified of the Immediate Jeopardy on 5/13/2022 at 6:30 PM, in the Chapel. The facility was cited Immediate Jeopardy (IJ) at F-600, F-610, F-689, F-835, and F-867. The facility was cited F-600 at a scope and severity of J, which is Substandard Quality of Care. The facility was cited F-610 and F-689 at a scope and severity of K, which is Substandard Quality of Care. The Immediate Jeopardy existed from 2/20/2022 through 5/16/2022. An acceptable Removal Plan, which removed the immediacy of jeopardy, was received on 5/14/2022 at 1:44 PM, and the corrective actions were validated onsite by surveyors on 5/17/2022 through review of in-service sign-in sheets, review of audits, meeting minutes, and staff interviews. The findings include: (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's undated policy titled, Quality Assurance & Performance Improvement (QAPI) Plan for [Named] Healthcare Management, revealed .QAPI focuses on systems and processes .the emphasis is on identifying system gaps rather than on blaming individuals. Our organization makes decisions based on data . The QAPI program at [Named] Healthcare Management will aim for safety and high quality .while emphasizing autonomy and choice in daily life for residents, by ensuring our data collection tools and monitoring systems are in place and are consistent for a proactive analysis .The QAPI plan will guide your facility's performance improvement efforts. This is a living document that you will continue to refine and revisit .The governing body assures adequate resources exist to conduct QAPI efforts. This includes designating one or more persons to be accountable for QAPI; developing leadership and facility-wide training on QAPI; and ensuring staff time, equipment and technical training as needed .governing body is ultimately responsible for overseeing the QAPI Committee .The QAPI Committee, which includes the medical director, is ultimately responsible for assuring compliance with federal and state requirements and continuous improvement in quality of care and customer satisfaction .[Named] Healthcare Management facilities will put in place systems to monitor care and services .It will include using performance indicators to monitor a wide range of care processes and outcomes, and reviewing findings against benchmarks .It also includes tracking, investigating, and monitoring adverse events/medical errors every time they occur, and action plans implemented through the Plan Do Study Act (PDSA) and Root Cause Analysis to prevent recurrences .The QAPI team will review our sources of information to determine if gaps or patterns exist in our systems of care that could result in quality problems . Review of the facility's Administrator Job Description dated 12/2018, revealed .Lead and direct the overall operations of the facility in accordance with customer needs, government regulations and Company policies . Monitor company identified Key Performance Indicators and address issues that affect performance of the facility .Oversee regular rounds to monitor delivery of nursing care, operation of support departments . Responsible for the QA [Quality Assurance] program. Maintain a working knowledge of and confirm compliance with all governmental regulations . Review of the facility's Director of Nursing Job Description updated 12/2011, revealed .to manage the overall operations of the Nursing Department .Identify and participate in process improvement initiatives that improve the customer experience, enhance work floor, and/or improve the work environment .Participate in . Quality Assessment and Assurance Committee Meetings, In-service Education .Complete investigative analysis as required .Schedule daily rounds to observe residents and to determine if nursing needs are being met in accordance with the resident's request .Study .Resident Incident Reports for corrective action. Keep Administrator informed on a daily basis of nursing department functions, recommending changes in techniques or procedures for a more efficient operation .Confirm accurate completion of forms/reports . Review Quality Indicator reports and submit to [NAME] President of Clinical Services on monthly basis . Participate in monthly QA [Quality Assurance] .Along with the Administrator engage the medical director in all department activity . Review of Resident #1's medical record, revealed Resident #1 exited the facility unsupervised and without staff knowledge on 2/20/2022 at approximately 7:00 PM, was out of the facility approximately 14 hours, and returned on 2/21/2022 at approximately 9:30 AM, when he was found by a family member in a neighborhood that was known for drug deals. Review of the QAPI meeting sign-in sheet dated 2/23/2022, revealed the Medical Director did not attend. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the QAPI folder dated 2/23/2022 on 5/12/2022 at 5:30 PM, revealed there was no documentation of quantitative or qualitative data obtained from the audit of records for wandering/elopement risk assessments, if there were any interventions implemented as a result of the data obtained, and if there was an assessment of the effectiveness of any interventions implemented. Review of the education sign-in sheets dated 2/21/2022 and 2/22/2022 revealed all staff were not educated on the topic of elopement and wandering. Only the staff working on the day of the elopement had any education provided and there was no documented plan to educate all staff including the agency staff. There was no documentation of quantitative or qualitative data obtained as a result of monitoring the door closure or the Wander Guard (a sensor alarm system worn by residents to alert staff if a resident attempts to exit through monitored exit doors) system or if any interventions were implemented and assessed for effectiveness. There was no documentation of an elopement drill completed for 2021 and no plans documented to conduct an elopement drill in 2022. There was no documentation of completion of a root cause analysis to identify or better understand the problems as stated in the facility's QAPI policy. During an interview on 5/12/2022 at 6:02 PM, the DON stated, .We did find discrepancies in the resident wander/elopement risk assessments . When asked what the discrepancies were, who had them and how many, she stated, .don't know who had them and how many . When asked for the documentation of what was done, she stated, .We didn't document what we did about it . When asked what the quantitative and qualitative data revealed, what interventions were implemented, and if the interventions were evaluated for effectiveness. She stated, .No .I see what you mean . During an interview on 5/12/2022 at 6:02 PM, the Administrator confirmed education was not provided to all staff including agency personnel. She stated, .No, we didn't do it . The Administrator confirmed there was no specific education provided the receptionist staff regarding residents that had wandering and elopement behaviors and the receptionist responsibility regarding monitoring the front door and being aware of the Wanderguard system doors. She stated, .No, we didn't do it . The Administrator confirmed they did not evaluate if any interventions were implemented on 3/2022 or 4/2022 and there was no process to determine if the interventions implemented were effective. She stated, .No, we didn't . The Administrator confirmed the wandering/elopement books were not accurate. She stated, .No, did not realize it until was brought to our attention . The Administrator confirmed they did not do a root cause analysis as stated in the facility's QAPI policy. She stated, .No, we did not do a root cause analysis .I see what you mean . During a telephone interview on 5/16/2022 at 8:17 AM, the Medical Director stated, .A couple of days later after the elopement I was notified that it happened .that he [Resident #1] got out and that was it .I had no input about it and they didn't ask for my input . During an interview on 5/16/2022 at 11:16 AM, the Administrator stated, .I am just going to be honest with you the Medical Director did not attend and was not called for the ad hoc meeting . Review of the Safe Smoking Screen dated 2/21/2022, revealed Resident #1 needed to use a smoking apron and required direct supervision while smoking. Observation on 5/10/2022 at 12:09 PM, revealed Resident #1 was seated outside on the Front Patio smoking a cigarette. Three other residents were also on the patio. There was no staff present. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/10/2022 at 12:13 PM, Receptionist #1 was asked if Resident #1 was allowed on the Front Patio. Receptionist #1 stated, .I didn't know he was out there. When asked if the Wander Guard alarm on the door had sounded, she stated, .It is busy here .I don't know how that happened . Review of a Nurses' Note dated 5/15/2022, revealed .This writer walked pass [past] [room number] [Resident #1's room] and smelled smoke .upon entering the room I could smell smoke and observed the resident [Resident #1] standing by the window tossing something out of the open window .Resident became visible [visibly] upset and walked towards this writer with fist balled up in a threatening attempt to fight . Review of Resident #3's Nurses' Notes dated 4/28/2022, revealed a Certified Nursing Assistant (CNA) saw Resident #3 hitting Resident #2 in the head with Bible. Review of Resident #3's Nurses' Notes dated 4/28/2022 at 6:40 PM, revealed .This nurse enter [entered] resident room an ask [asked] what happen [happened], resident stated He [Resident #2] enter [entered] my room an [and] I try [tried] to get him out. This nurse ask [asked] resident if she allegedly hit resident, resident stated No . During an interview on 5/11/2022 at 12:00 PM, the DON was asked what behaviors Resident #2 exhibited prior to the resident-to-resident altercation. She stated, .I don't know . When asked if staff were interviewed about the resident's behaviors prior to the altercation. She stated, .No . Review of Resident #4's Nurses' Notes dated 5/5/2022 at 1:11 PM, revealed, Resident #4 stated Resident #2 came into her room while she was sleeping during the night. She was sleeping on her right side facing the window, felt the mattress moving, and a knee was on her leg. She told him he was in the wrong room and pushed him out her bed and he fell on to the floor. Review of Resident #4's Nurses' Note dated 5/8/2022 at 6:31 AM, revealed Resident #4 called on the unit phone stating Resident #2 had entered her room. She was upset and stated this is the second time this has happened, and they said he would be watched. The nurse ensured the resident that Resident #2 would be watched and would not return to her room. During an interview on 5/10/2022 at 3:57 PM, Registered Nurse (RN) #2 was asked what interventions were implemented after the 4/28/2022 altercation of Resident #2 with Resident #3. She stated, .we did hourly safety checks . When RN #2 was shown the date of onset for hourly safety checks was 3/3/2022, she stated, .Oh I see nothing new . When she was asked what interventions were implemented after the 5/5/2022 altercation of Resident #2 with Resident #4, she stated, .continue hourly safety checks .supposed to have close supervision .to be honest we failed to supervise him . During an interview on 5/11/2022 at 12:00 PM, the DON was asked what behaviors Resident #2 exhibited prior to the resident-to-resident altercation. She stated, .I don't know . When asked if staff were interviewed about the resident's behaviors prior to the altercation. She stated, .No . Review of Resident #5's Nurses' Notes dated 11/29/2021 at 10:05 PM, revealed a CNA reported to the nurse that Resident #5 was drinking liquor in his room. An empty bottle of Vodka was confiscated from his shoebox. Resident #5 denied drinking, but the nurse observed the resident exhibited behavior of being loud, using inappropriate language, and had an unsteady gait. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Incident Report and Nurses' Notes dated 2/9/2022, revealed Resident #5 initiated physical and verbal aggression against Resident #1 in the Lobby of the Nurses' Station. Resident #5 got out of his wheelchair talking loudly and accusing Resident #1 of stealing from him and then forcibly pushed Resident #1 to the floor near the window causing Resident #1 to hit his head against the wall. During a telephone interview on 5/13/2022 at 2:57 PM, Licensed Practical Nurse (LPN) #4 stated, .I reported him [Resident #5] drinking to the Administrator and the Director of Nursing back in November 2021. I told them about the empty Vodka bottle, and he may have been under the influence. Loud and talking a lot and a shift in his behavior . During an interview on 5/13/2022 at 3:35 PM, the Administrator was asked about the 11/29/2021 incident of finding an empty bottle of alcohol in Resident #5's room and the behaviors he exhibited and were documented in a Nurses' Note dated 11/29/2021. When asked if the incident was investigated, the Administrator stated, .No, it was never brought to my attention .No, we never investigated it . Refer to F-600, F-610, F-689 and F-835. The surveyors verified the Removal Plan by: 1. Resident #1 was placed on 15-minute checks until 10:00 PM on 5/13/2022, then hourly checks ongoing. A staff member was placed outside Resident #1's room to monitor the resident's location. Staff will escort residents out to smoke. Resident #1's BIMS was reassessed on 5/13/2022. The Family Nurse Practitioner reevaluated Resident #1 on 5/13/2022. Preadmission evaluation will be updated to reflect Resident #1's status. The Care Plan was updated with new interventions. Resident #2 was discharged on [DATE]. This was confirmed by observations, record review, and interviews. 2. Residents with Brief Interview for Mental status (BIMS) scores of 8 or above will be interviewed for abuse or potential for abuse. Residents with a BIMS below 8 will have a skin assessment conducted. Smoking assessments were conducted on 100 percent (%) of residents 5/14/2022. This was confirmed by record review, audit tool review, and interviews. 3. On 5/14/2022 the Nursing Home Administrator and DON were educated by the Regional Director of Clinical Services on the QAPI process, to include systems review, and performance improvement process. This was confirmed by review of the education sign-in sheet and interviews. 4. 100% of staff will be in-serviced by the DON, Nurse Supervisor, Staff Development Coordinator or department head on the abuse and elopement policy, prevention and reporting, and smoking policy. Abuse and neglect, smoking policy and elopement policy were reviewed. Staff not at work will be called and re-educated via phone. Staff that were not able to be educated will be educated prior to returning to work. In the event of any future resident exiting, the resident will be placed on 1 on 1 (1:1) supervision until primary care, nursing and psychiatric evaluations can be completed. Outcomes of these evaluations will result in continued 1:1 supervision or the initiation of discharge planning to a facility with a focus on behavior management. During smoke break, 2 staff will supervise smoking break when there are more than 6 residents present. This was confirmed by review of revised smoking policy, review of the education sign-in sheets, and interviews on all shifts. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445139	A. Building B. Wing	05/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midtown Center for Health and Rehabilitation	141 N McLean Blvd Memphis, TN 38104

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

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	5. On 5/14/2022 the Nursing Home Administrator was educated on the role, job description, tools, and resources available to effectively administer nursing facility operations by the Regional Director of Clinical Services. This was confirmed by review of education sign-in sheets and interviews. 6. Nursing Home Administrator was educated on Abuse, Neglect, and Exploitation on 5/14/2022 by the Regional Director of Clinical Services. This was confirmed by review of the education sign-in sheet and interview. 7. The DON, nurse supervisor, or staff development coordinator will conduct abuse and neglect audits and smoking audits. The audits will include identifying residents with exit seeking behaviors and unsafe or unsupervised smoking daily x four (4) weeks, then three times per week x four (4) weeks, then two (2) x week x four (4) weeks, then weekly ongoing. This was confirmed by review of audit sheets and interviews on 5/17/2022. 8. Quality Assurance Performance Improvement (QAPI) meetings will occur weekly for four weeks to monitor progress and then monthly thereafter. This was confirmed by interviews. 9. The Regional Director of Operations or Regional Director of Clinical will provide oversight of facility administration with a weekly 1:1 interaction reviewing the completed audits and QA findings. The Plan of Correction will be reviewed weekly to ensure all the audits are completed and issues are identified for 4 weeks and/or until substantial compliance is achieved. Monthly QAPI meetings will be conducted and attended by Regional Director of Operations and Regional Director of Clinical for a period of three months to ensure compliance is sustained. This was confirmed by review of audit tools and interviews. 10. Results of all audits will be brought to the QAPI Committee members which include Committee Chairperson - Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director for 4 months for further suggestions and/or follow up as needed. The DON, Assistant Director of Nursing (ADON), Multi Data Set Nurse, Nurse Supervisor, or Staff Development Coordinator will review the outcome of the abuse and neglect audit monthly and ongoing. Any aberrancies will be addressed, interventions developed, and corrective actions taken. This was confirmed by review of the revised QAPI tool and interviews. The facility's noncompliance of F-867 continues at a scope and severity of E for monitoring the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction.

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure staff are vaccinated for COVID-19 29706 Based on Centers for Medicare and Medicaid Services (CMS) guidelines, policy review, record review, and interview, the facility failed to document and track staff vaccinations for COVID-19 (an infectious disease caused by SARS-CoV-2 virus) according to the current guidelines to prevent the potential spread of COVID-19 for 5 of 215 employees (Certified Nursing Assistant (CNA) #1, #2, #3, and #5, and Contracted Environmental Service employee #1). This had the potential to affect the 161 residents residing in the facility. The facility has not had COVID-19 positive residents. The findings include: Review of the CMS Center for Clinical Standards and Quality/Quality, Safety & Oversight Group (QSO-22-07-ALL) memorandum dated 12/28/2021, revealed .Medicare and Medicaid-certified facilities are expected to comply with all regulatory requirements . Review of the QSO-22-07-ALL Long-Term Care and Skilled Nursing Facility Attachment A dated 12/28/2021, revealed .The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19 .Process for tracking staff vaccine status .The facility must track and securely document .each staff member's vaccination status .this should include the specific vaccine received, and the dates of each dose received, or the date of the next scheduled dose for a multi-dose vaccine .any staff member who has obtained any booster doses .this should include the specific vaccine booster received and the date of the administration of the booster .staff who have been granted an exemption from vaccination . this should include the type of exemption and supporting documentation .requirements by the facility .staff for whom COVID-19 vaccination must be temporarily delayed. For temporary delays, facilities should track when the identified staff can safely resume their vaccination .facilities' tracking mechanism should clearly identify each staff's role, assigned work are, and how they interact with residents. This includes staff who are contracted, volunteers, or students . Review of the facility's policy titled, Employee COVID-19 Vaccinations revised 1/27/2022, revealed .It is the policy of this facility to ensure that all eligible employees are vaccinated against COVID-19 as per applicable Federal, State and local guidelines .The facility will ensure that all eligible employees are fully vaccinated against COVID-19, unless religious or medical exemptions are granted .The facility will ensure that all eligible employees .have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents .The facility will track and securely document the vaccination status of each staff member (current and as new employees are onboarded) on the Healthcare Personnel COVID-19 Vaccination Tracking Worksheet . The facility was unable to provide second dose tracking documentation of COVID-19 vaccination status of Certified Nursing Assistant (CNA) #1 and CNA #3. CNA #1 was hired on 12/6/2021 and received 1 dose of Pfizer on 4/10/2021. CNA #3 was hired on 1/9/2019 and received 1 dose of Pfizer on 3/26/2022. CNA #1 and #3 continued to work as of 5/12/2022. (continued on next page)

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/12/2022 at 12:33 PM, Staff Development Coordinator confirmed there was no documentation of a second dose of Pfizer vaccine for CNA #1 or #3. She stated, .We don't have a process to follow up .to make sure get the second vaccine timely and if the employee is in compliance . The Director of Nursing (DON) stated, .We don't have a process to follow up . Review of the employee list dated 5/8/2022, revealed CNA #2, hired 6/12/2019, and CNA #5, (hire date unknown), had no documentation of vaccination status or exemption status. During an interview on 5/11/2022 at 2:20 PM, when asked if the facility had a record of exemptions for the vaccination, the DON stated, .I guess we don't have a log of the exemptions. I don't know. During an interview on 5/12/2022 at 12:33 PM, the DON stated, .I don't have anything [vaccination or exemption status] for them . Review of the employee list dated 5/8/2022, revealed Contracted Environmental Service employee #1, hired 1/3/2022 and last day worked of 4/9/2022, had a medical exemption form not completed or signed by a Physician or Practitioner. During an interview on 5/12/2022 at 12:33 PM, the Regional Director of Clinical Services confirmed the form with Contracted Environmental Service employee #1's name on it was not completed or signed by a Physician or Practitioner. During an interview on 5/12/2022 at 12:33 PM, the Administrator confirmed the facility could not provide complete documentation of tracking of staff COVID-19 vaccination that included all the elements required per the current CMS guidance. She stated, .We don't have a thorough process of keeping up with employees or agency staff vaccination status or exemption status .We need to do that . During an interview on 5/13/2022 at 11:00 AM, the Regional Director of Clinical Services stated, .No one here knew about those vaccines, to keep up with and follow through, and it was not given to a person to be responsible for .