STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445237	A. Building B. Wing	07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Church Hill Post-Acute and Rehabilitation Center	701 West Main Blvd Church Hill, TN 37642

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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** 40105 Based on facility policy review, medical record review, observation, and interview, the facility failed to prevent and protect 2 residents (Resident #65 and #45) from abuse of 16 residents reviewed for abuse. The facility's failure to ensure interventions were implemented to prevent continued wandering of Resident #30 in and out of other residents' rooms and the failure of a Certified Nursing Assistant (CNA) to separate Resident #30 and Resident #65 when she overheard them arguing in the hallway, with Resident #30 hitting Resident #65 in the head, resulted in psychosocial harm to Resident #65. Resident #30 continued to wander throughout the facility, in and out of other residents' rooms, then entered Resident #45's room, attempted to choke her, and stated she would kill her. The facility's failure to prevent abuse by Resident #30 placed Resident #65 and Resident #45 in Immediate Jeopardy (a situation in which the provider's non-compliance with one or more requirements for participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident). The facility's failure to implement interventions to address Resident #30's wandering and aggressive behaviors had the potential to affect all residents in the facility. The Administrator was informed of the Immediate Jeopardy (IJ) in the conference room on 7/10/2021 at 12:50 PM. The facility was cited F-600 at a scope and severity of L which constitutes Substandard Quality of Care. The Immediate Jeopardy was removed onsite 7/12/2021 and was effective 5/3/2021-7/11/2021. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 7/12/2021 at 8:40 AM and the corrective actions were validated onsite by the surveyors on 7/12/2021 and 7/13/2021. The findings include: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the facility's policy titled, Freedom of Abuse, Neglect and Exploitation Standard, revised 11/2019, showed .The purpose of this written Freedom of Abuse, Neglect, Exploitation Standard is to outline the prevention and action steps taken to reduce the potential for abuse, mistreatment and neglect of residents . and to review practices and omissions which if allowed to go unchecked, could lead to abuse .The scope of this program shall apply to the prevention of an abuse committed by anyone including .Residents .This facility shall not condone any acts of resident mistreatment .physical and/or mental abuse .by any .other residents .preventative steps will be taken to reduce the potential for such occurrences .Appropriate interventions to deal with aggressive reactions of residents .How CMS [Centers for Medicare and Medicaid Services] defines abuse .Identifying what constitutes abuse .Recognizing signs of abuse .Dementia Management .Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect such as .Aggressive and/or catastrophic reactions of residents .Wandering or elopement-type behaviors .Outburst or yelling out .Identifying, correcting and intervening in situations in which abuse .is more likely to occur .assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms .The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict .Train staff in appropriate interventions to deal with aggressive and/or catastrophic reactions by residents .Observe resident behaviors and their reaction to other residents .React to all allegations or questions of abuse by residents .Take appropriate actions when abuse .is suspected .Assess, monitor and develop appropriate plans of care for residents with needs and behaviors which might lead to conflict .such as residents with a history of aggressive behaviors, residents who have behaviors such as entering other resident's rooms . Medical record review showed Resident #30 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Dementia with Behavioral Disturbance, Type 2 Diabetes Mellitus, Anxiety Disorder, Major Depressive Disorder, Insomnia, and Delusional Disorders. Review of Resident #30's comprehensive care plan dated 4/13/2021, showed .elopement risk/wanderer AEB [as evidenced by] History of attempts to leave facility unattended, she refuses to wear socks and shoes, she becomes aggressive/combative with other residents at times, she goes in and out of residents rooms, needs frequent redirection .Distract her from wandering by offering pleasant diversions, structured activities, food, conversation, television, book .Monitor location every shift. Document wandering behavior and attempted diversional interventions in behavior log . Review of Resident #30's Plan of Care Progress Note dated 4/14/2021, showed .Patient has been going in and out of other resident rooms .difficult to get vital signs, redirection . Review of Resident #30's Respiratory Evaluation Progress Note dated 4/15/2021, showed .Resident is currently experiencing unwanted behavior(s). Chronic disruptive behavior noted. Chronic wandering behavior noted. Resident wanders at night . Review of Resident #30's admission Minimum Data Set (MDS) dated [DATE], showed the resident had severe cognitive impairment and had wandered 1-3 days during the assessment period. Resident #30 required supervision to walk in the room and hallways with no use of mobility devices. Review of Resident #30's Care Plan showed an update on 4/21/2021, .Requires assistance to participate in activities .we will continue to invite to activities & [and] 1'1 [one on one activities] as needed . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #30's QAPI (Quality Assurance and Performance Improvement)/Risk Meeting Progress Note dated 5/3/2021 at 1:52 PM, showed .Resident remains a wandering risk with behaviors present. Close monitoring provided by staff. IDT [Interdisciplinary Team] will continue to monitor for effective/appropriateness of interventions and intervene accordingly . Review of Resident #30's Physician Notification Progress Note dated 5/3/2021 at 5:16 PM, showed .Staff reported to this nurse an Resident to resident altercation. [Resident #30] who was hitting [Resident #65] on the head and pulling her wheelchair back, [Resident #65] was screaming for Help . Review of Resident #30's Medication Administration Progress Note dated 5/3/2021 at 9:05 PM, showed Resident #30 was sent to the hospital for evaluation after the incident .resident out of facility to hospital . Review of Resident #30's hospital documentation dated 5/3/2021, showed .PT [patient] SENT FROM [name of facility] AFTER HITTING A RESIDENT. PT SENT HER [here] FOR A MENTAL EVALUATION AND HAS A DX [diagnosis] OF DEMENTIA .sent here for mental eval [evaluation] as she apparently hit another resident at the nursing home today . Review of Resident #30's Risk Meeting Progress Note dated 5/4/2021, showed .IDT will continue to monitor for effective/appropriateness of interventions and intervene accordingly. IDT met, reviewed, discussed, and in agreement . Review showed no additional interventions were implemented after the resident-to-resident abuse on 5/3/2021. Review of Resident #30's Plan of Care Progress Note dated 5/4/2021 at 11:14 AM, showed .Resident returned to facility at 0630 [6:30 AM] via [by] stretcher with no new orders received . Review of Resident #30's Risk Meeting Note dated 5/4/2021, showed .Resident to Resident [altercation] occurred on 05.03.21 @ [at] 1659 [4:59 PM]. This is Resident [Resident #30] and the aggressor - [Resident #30] was in a central location of hallway holding resident [Resident #65's] wheelchair and pulling the w/c [wheelchair] backwards with [Resident #65's] foot in the wheel of the chair. [Resident #30] hit [Resident #65] on top of the head several times. [Resident #65] started screaming for help. [Resident #30] was redirected successfully. [Resident #30] was unable to give description. [Resident #65] stated 'I was just sitting in my chair when all of a sudden [Resident #30] started hitting me on top of the head and pulling my w/c [wheelchair] backwards'. Called the psych [psychiatric] NP [Nurse Practitioner] and new orders received to send [Resident #30] to .ER [emergency room] for psychiatric evaluation and treatment .Monitor resident's location and activity q [every] 15 minutes and document x [for] 72 hours. Maintain personal space of comfort for other residents x 72 hours and then re-evaluate . Review of Resident #30's Physician's Progress Note dated 5/4/2021, showed .This person [Resident #30] began hitting the other resident [Resident #65] on her head and pulling .wheelchair back .The other resident was screaming for help .Mental health nurse practitioner was notified and responded with an order to send the patient [Resident #30] to the emergency department for evaluation . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #30's Psychiatric Evaluation dated 5/4/2021, showed .Evaluating mood and behaviors-patient having increased agitation, restlessness, aggression. Was sent out to ER for emergency eval [evaluation] and was returned without medication changes. Patient having increased psychosis and delusions, reasonable to add Seroquel [an anti-psychotic medication] to target symptoms .Agitation: Physical aggression .Combativeness .Severe restlessness .Recommendations: seroquel 25 mg [milligrams] bid [twice daily] delusions . Review of Resident #30's Behavior Note/Anxiety Progress Note dated 5/5/2021, showed .Resident wandering through out facility this shift. Entering residents' room and nurses' station. Becomes agitated with redirection, but generally will redirect . Review of Resident #30's Room Change Progress Note dated 5/5/2021, showed Resident #30 was involved in a .a resident to resident altercation . and the facility moved Resident #30 to a room on a different hall. Review of Resident #30's Behavior Note/Anxiety Progress Note dated 5/5/2021, showed .Resident continues to wander facility .Resident continues 15 minute checks . Review of Resident #30's Psychological Diagnostic Interview dated 5/6/2021, showed Resident #30 was referred by the Medical Director (MD) on 5/6/2021 to be seen by the Psychologist .Patient was shut down and even appeared angry .walked directly into another patient's room after leaving this area . patient is dismissive, has poor contract and seems angry . Review of Resident #30's Behavior Note/Anxiety Progress Note dated 5/20/2021, showed .Resident frequently walks throughout the building and goes into offices and just sits down. She tells other residents what to do. She shakes her head and gets upset when things don't go her way .Psych to be notified immediately per SS [social services] due to increased behaviors . Review of Resident #30's Behavior Note/Anxiety Progress Note dated 5/20/2021, showed .Resident wonders [wanders] the halls. Resident frequently goes into other Resident's [residents'] rooms and takes belonging, drinks, food, etc. Resident has been involved in a couple of verbal arguments with other residents . Review of Resident #30's Social Service Progress Note dated 5/20/2021, showed the Director of Social Services (DSS) documented .Resident exhibiting inappropriate behaviors .Discussed in team meeting this a. m. called and left a message with psych NP to assess for any needed medications . Further review showed no further recommendations or interventions were implemented. Review of Resident #30's Behavior Note/Anxiety Progress Note dated 5/21/2021, showed .entering other Residents [residents'] rooms taking items, food, etc. that doesn't belong to her. Resident tried to take a drink away from another Resident because she thought it was hers . Review of Resident #30's Medication Administration Record (MAR) dated 5/1/2021-5/31/2021, showed an order dated 5/4/2021 to monitor the resident's location and activity every 15 minutes for 72 hours. Review of Resident #30's medical record showed no documentation the resident's location and activity had been monitored every 15 minutes for the dates of 5/4/2021-5/7/2021. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #30's Behavior Note/Anxiety Progress Note dated 6/4/2021, showed .Resident continues to wander the halls, but is increasingly more intrusive into other Resident rooms. Resident enters every room and takes items and hides them. Resident upsets other Residents with her actions. Resident also pushes other Residents in their wheelchair around the halls. Resident takes a quite a bit of time to manage . Review of Resident #30's Social Service Progress Note dated 6/8/2021, showed .Resident displaying inappropriate behaviors, shopping in rooms, grabbing things out of residents hands, hard to redirect . Contacted psych NP to assess for any medication changes . Further review showed no additional recommendations or interventions were implemented. Review of Resident #30's Behavior Note/Anxiety Progress Note dated 6/30/2021, showed .Resident continues to wander this shift. Resident wandering into other resident rooms, causing distress to other residents. Resident also taking things from nurses [nurses'] station, and other residents .Attempts to redirect unsuccessful . Review of Resident #30's Behavioral Note/Anxiety Progress Note dated 7/5/2021, showed .Resident continues to wander this shift. Resident wandering into other resident rooms causing distress to other residents. Resident is also taking things from nurses [nurses'] station, med carts, and other residents rooms. PRN's [as needed medications] unsuccessful. Attempts to redirect are unsuccessful . Medical record review showed Resident #65 was admitted to the facility on [DATE] with diagnoses including Bipolar Disorder, Dementia Without Behavioral Disturbance, Difficulty Walking, Anxiety Disorder, Insomnia, and Acquired Absence of Right Leg Below Knee. Review of Resident #65's comprehensive care plan dated 11/20/2020, showed .behavior problem .has attention seeking behaviors as evidenced by often becoming tearful for no particular reason .states she has a 'hole in her head' .intervene as necessary to protect the rights and safety of others .Divert Attention. Remove from situation and take to alternate location as needed . Review of Resident #65's quarterly MDS dated [DATE], showed Resident #65 had moderately impaired cognitive status, the resident was independent for locomotion on the unit, and used a wheelchair for mobility. No behaviors were documented, and no wandering was documented. Review of Resident #65's Physician's Notification Progress Note dated 5/3/2021, showed .Resident to Resident altercation. This is [Resident #65] sitting in wheelchair while [Resident #30] was pushing wheelchair back and hitting [Resident #65] on top of head. Residents redirected with success . Review of Resident #65's Psychiatric Evaluation dated 5/4/2021, showed .Evaluating mood and behaviors-patient was involved in an incident with another resident since that time she had increased anxiety and delusions. Increasing distress reasonable to restart as needed Valium [a medication used for anxiety] as well as increase prn to target delusions . Review of Resident #65's Physician's Telephone Order dated 5/4/2021, showed .increase Seroquel 25 mg [milligrams] po [by mouth] BID [twice daily] .Valium 2 mg po BID PRN x [for] 14 days for anxiety . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #65's Physician's Progress Note dated 5/4/2021, showed .The patient was a victim of the resident on the resident violence [with Resident #30] earlier in the week .The patient's been very anxious since that time .The patient reports the other individual [Resident #30] came up from behind her and grabbed and hit her right parietal [top of head] and temporal [side of head] area .This incident unfortunately set off exacerbation of patient's underlying anxiety disorder To become increasingly anxious and avoids individuals when moving about the community in her wheelchair . Review of Resident #65's Medication Administration Progress Note dated 5/4/2021, showed the resident had received a dose of Valium 2mg .Resident in hall crying, repeatedly saying 'I'm not going up there' referring to her room . Review of Resident #65's Behavior Note/Anxiety Progress Note dated 5/5/2021, showed .Earlier in shift, crying, stating 'I'm not going up there' pointing towards room. I'm scared'. Resident reassured, but still expressed some concern. PRN anti-anxiety administered, and resident transferred to room on another hall and is resting in bed with eyes closed . Review of Resident #65's MAR dated 5/1/2021-5/31/2021, showed an order for Valium 2 mg to be given twice daily as needed with a start date of 5/4/2021. The Valium was administered 2 times on 5/4/2021 and 1 time on 5/5/2021. Review of Resident #65's Psychotherapy Progress Note dated 5/6/2021, showed .The patient was quite distressed. She was hit recently by another patient [Resident #30] and her room was moved. The patient approached the clinician stating she was distressed, and she asked if she could be sent to a psychiatric unit . the patient stating she is having hallucinations was significant this time, and having them directly after a significant stressor (being attacked by another patient) is highly consistent with the literature on psychosis, as opposed to a manipulative quality. The patient was crying, and insistent on being considered for evaluation outside of the facility. The clinician discussed this with the staff, who stated that they would send her in the morning as resources would be more supportive . Review of Resident #65's Progress Note dated 5/7/2021, showed .Resident at [name of hospital] for screening before going to [name of hospital] for psych eval . Review of Resident #65's Admission Summary Progress Note dated 5/10/2021, showed .Resident readmitted . Observation on 7/6/2021 at 12:15 PM, showed Resident #30 entered room [ROOM NUMBER]. A CNA was in the room setting up a lunch tray and redirected the resident out of the room and she wandered down the hallway. Observation on 7/6/2021 at 2:46 PM, showed Resident #30 entering room [ROOM NUMBER] (another resident's room) while a CNA was in the room. The CNA redirected the resident to exit the room. During an interview on 7/6/2021 at 2:55 PM, CNA #1 stated Resident #30 did wander frequently and did go into other residents' rooms. She stated Resident #30 would take other residents' water pitchers. CNA #1 stated if Resident #30 was noticed in another room, the staff would cue her to come out of the room. She stated .there's not much we can do .I have suggested putting up stop signs on the doors but we would have to put them on every door because you never know which room she will go in . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Observation on 7/6/2021 at 2:59 PM, showed Resident #30 wandering in the 400 hallway. She attempted to open the door to room [ROOM NUMBER] (another resident's room) but did not go in. She then went to the 100 hallway and attempted to open the double doors. Resident #30 then wandered to the nurse's station, walked past a nurse seated at the nurse's station, opened the door to the Unit Secretary's office, and entered the office. She picked up a notebook from the Unit Secretary's desk, walked past the nurse seated at the nurse's station, and went down the 300 hallway. During an interview on 7/7/2021 at 2:07 PM, the Director of Social Services (DSS) stated Resident #30 had been in a resident-to-resident altercation with Resident #65. She stated Resident #30 had been moved to a different room. She stated that Resident #65 had .psych issues . and .doesn't like to be touched . She stated after the incident on 5/3/2021, Resident #65 .became fearful .crying . The DSS stated Resident #30 goes in and out of resident rooms and .that's a problem .there is only so much medication you can mess with .we pretty much let her wander and redirect her . She further stated the interventions the facility had in place to prevent Resident #30's wandering behavior was .redirecting and put stop signs on some residents' rooms that she has a fondness to go into .the residents that complain . The DSS confirmed Resident #30 would wander into resident rooms, offices, and nurse's stations, and she had been informed that some residents had stated they had belongings that were missing. Medical record review showed Resident #45 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Muscle Wasting, Chronic Obstructive Pulmonary Disease, Difficulty Walking, Presence of a Cardiac Pacemaker, Personal History of Other Mental and Behavioral Disorders, Bipolar Disorder, Syncope and Collapse, General Anxiety Disorder, Wheezing, and Dependence on Supplemental Oxygen. Review of Resident #45's comprehensive care plan dated 3/23/2021, showed Resident #45 had a potential for impaired cognitive function related to confusion, with an update on 7/9/2021 for .stop sign to doorway to prevent other residents from entering resident's room- Monitor Stop Sign every 15 minutes for placement . Review of Resident #45's 5-day MDS dated [DATE], showed the resident had moderate cognitive impairment, no behaviors noted, she was totally dependent on staff for bed mobility and transfers, did not walk, used a wheelchair for mobility, and used oxygen daily. Review of Resident #45's Plan of Care Progress Note dated 7/7/2021, showed .Resident is A&O [alert and oriented] x 3 [person, place, time]. speech clear and able to make needs known . Review of Resident #45's Physician Progress Note dated 7/8/2021, showed .Resident [Resident #30] supervised the patient [Resident #45] while she was lying on her left resting .Resident [Resident #30] placed her right hand on the left side of the patient's [Resident #45] neck and held it .The patient [Resident #45] stated she turned and tried to push the arm away but it was very stiff .Ultimately she got the hand removed . Event was unprovoked . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #30's Physician's Progress Note dated 7/8/2021, showed .Yesterday this patient went into another resident's room [Resident #45] and placed her hand about the residents [resident's] neck making the resident [Resident #45] think she was being choked .Patient [Resident #30] had wandered into the residents [resident's] room [Resident #45] .Frequently up and about the building, restless .Eventually the patient [Resident #45] is able to push the hand away from her neck .PLAN .Mental health consult . One-on-one observation if available . Review of a facility witness statement given by Certified Nursing Assistant (CNA) #5, undated, showed . [Resident #45] stated she was sleeping, and thought was one of us shaking her awake. But it was [Resident #30] standing over her. She claimed [Resident #30] had her hands around her neck and told her she would hurt her/die . The facility's video surveillance footage for 7/8/2021 beginning at 5:46 AM was reviewed on 7/13/2021 at 1:49 PM, with the Administrator and the Plant Operations Manager present. The footage of the 300 hallway on 7/8/2021 showed Resident #30 at the end of the 300 hallway at 5:46:14 AM, she went to the linen cart at 5:47:24 AM. CNA #4 exited the shower room with another resident at 5:47:44 AM. Resident #30 walked past the other resident in the hallway who just came out of the shower room, and CNA #4 walked toward the nurses station away from the resident. Resident #30 stood by the shower room for several seconds then entered room [ROOM NUMBER] at 5:48:00 AM, and came back out of room [ROOM NUMBER] at 5:48:27 AM. Resident #30 then entered Resident #45's room at 5:48:31 AM. CNA #4 exited another resident's room at 5:48:42 AM. Resident #30 exited Resident #45's room at 5:49:05 AM. Resident #30 then entered another resident's room at 5:49:41 AM. Resident #45's roommate was seen walking in the hallway toward her room at 5:51:17 AM and entered the room at 5:51:39 AM (she had not been in the room while Resident #30 was in the room with Resident #45). Observation on 7/8/2021 at 7:45 AM, showed Resident #30 wandering on the 200 hallway, she entered another resident's room at the end of the 200 hallway. During an interview on 7/8/21 at 8:11 AM, Resident #40 stated Resident #30 would often wander into her room .we [Resident #40 and Resident #43] are afraid she will come in the middle of the night with a knife and stab us .you never know what someone might do .she [Resident #30] has tried to get in my roommate's bed . Resident #40 stated she had reported it to all the nurses and her roommate had made a complaint. During an interview on 7/8/2021 at 8:27 AM, Licensed Practical Nurse (LPN) #2 confirmed she had been assigned to Resident #30 and Resident #65 on 5/3/2021, the day of the altercation between the 2 residents. A CNA had reported the altercation to her. LPN #2 stated Resident #65 .was distraught and upset .crying . tearful . LPN #2 stated she tried to console her. LPN #2 stated both residents (#30 and #65) had rooms on the 300 hallway, but Resident #30 had been moved to the 400 hall after the altercation. LPN #2 confirmed Resident #30 had wandered into other residents' rooms prior to the incident, the staff try to redirect her, and use stop signs on the doors of some residents, but she was unsure which residents were supposed to have stop signs. Observation on 7/8/2021 at 8:30 AM, showed Resident #30 continued to wander on the 200 hallway. She entered another resident's room. Observation on 7/8/2021 at 8:45 AM, showed Resident #30 wandering by the nurse's station and started down the 300 hallway carrying a folded tablecloth. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 7/8/2021 at 9:13 AM, Resident #43 stated .that crazy one [Resident #30] comes in my room . Resident #43 stated she finally .ran crying to a nurse and she helped me file a grievance . During observation on 7/8/2021 at 9:22 AM, there was not a stop sign on Resident #43's door. During an interview on 7/8/2021 at 9:32 AM, Registered Nurse (RN) #2 stated a few days after Resident #30 was admitted to the facility, she had approached Resident #65 in the hallway as if she had recognized her saying .there you are . Resident #65 had told Resident #30 to get away from her because there was a pandemic. On 5/4/2021, after Resident #30 hit Resident #65 on the head and pulled her in the wheelchair on 5/3/2021, RN #2 was in the 300 hallway by the medication cart. Resident #65 approached her and stated she needed to go to the bathroom but was afraid to go in her room alone. The RN assisted her to the bathroom, got her a few outfits, and let her sleep in a different room for the night. RN #2 stated Resident #65 just spent the night in the other room to .ease her anxiety . RN #2 confirmed Resident #30 would wander into other residents' rooms. RN #2 stated the facility had put stop signs up for the rooms .we find may be an issue . but she was not sure which residents were supposed to have stop signs on their doors. RN #2 stated the staff monitor Resident #30 and try to redirect her but was unaware of any other interventions the facility had implemented to prevent Resident #30 from wandering. During an interview on 7/8/2021 at 10:21 AM, CNA #2 stated that she had been at the nurse's station on 5/3/2021. Resident #30 was walking near Resident #65. Resident #65 did not want Resident #30 near her, and they had started to argue. CNA #2 then went to do .something . down the hallway without intervening. When she returned to the nurse's station, CNA #3 reported to her that Resident #30 had hit Resident #65. CNA #2 stated Resident #30 would wander into other residents' rooms and some residents did complain. CNA #2 stated Resident #65 had complained that Resident #30 would go into her room and go through her stuff. CNA #2 stated she had reported the complaints to a nurse, there .really wasn't anything we could do . CNA #2 stated the staff would redirect the resident but was not made aware of any other interventions to prevent Resident #30 from wandering into other residents' rooms. During an interview on 7/8/2021 at 10:33 AM, CNA #3 stated on 5/3/2021, she was in a room on the 300 hallway when she heard Resident #65 .screaming bloody murder . She came out into the hallway and saw Resident #30 and Resident #65 close to the nurse's station and Resident #30 was .tapping . Resident #65 on the head. CNA #3 stated she separated the residents and Resident #30 then .wandered off . CNA #3 stated Resident #65 .freaks out .says she has water on the brain and that could hurt her . CNA #3 stated Resident #30 would wander into other residents' rooms. She stated Resident #41 had complained about her being in his room and Resident #46 had a stop sign on her door to prevent Resident #30 from going into her room. CNA #3 stated she would provide redirection but was unaware of any other interventions, including diversional activities, the staff were to use to prevent wandering. During an interview on 7/8/2021 at 11:04 AM, Resident #41 stated he turns his call light on when other residents wander into his room so staff will come remove them. He stated on one occasion, a resident had wandered into the room during a window visit with his family member. The resident .grabbed my wheelchair and pulled me backwards . He stated he was unable to reach his call light on that day and he had to yell out for help to come. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Church Hill Post-Acute and Rehabilitation Center	701 West Main Blvd Church Hill, TN 37642

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 7/8/2021 at 11:10 AM, Resident #46 stated in the past, she has had a woman come into her room and woke her up. Resident #46 stated that she did not know her name but said .she walks around the place all of the time . Resident #46 stated it made her feel uneasy because .you never know what she will do . During an interview on 7/8/2021 at 1:31 PM, the Assistant Director of Nursing (ADON) stated the facility considers abuse to be a purposeful and willful physical act toward another such as punching, hitting, kicking, and the resident must have the comprehension and knowledge of what they are doing. She stated the IDT (Interdisciplinary Team) team reviews resident to resident altercations and reviews the resident's history of behaviors, diagnoses, and the causative factors. She stated the facility's standard is if a resident had Brief Interview for Mental Status (BIMS) score of 8 (a score of 8-12 indicates moderately impaired cognitive status, a score of 13-15 indicates cognitively intact) or above, that the residents know what is going on and can make their own decisions. The ADON stated each resident-to-resident altercation depended on what the situation was and whether it was abuse. She stated Resident #65 had been having behaviors on 5/3/2021 and had been going through the hallway .crying and screaming . She stated it had been reported to her that Resident #30 approached Resident #65 and .it was more of a tap . She further stated both residents were . very behavioral . and the altercation had not been determined to be abuse by the facility. The ADON stated the facility had provided close monitoring of Resident #30, but she had the right to wander because the facility was her home. The ADON stated allegations of abuse would be reviewed by the IDT team and a decision would be made as to whether it met abuse. She stated all resident-to-resident altercations would not be determined to be abuse. The ADON confirmed it was her expectation for a staff member to intervene if 2 residents were seen/heard arguing and she had not been aware of the argument between Resident #30 and Resident #65 on 5/3/2021 that CNA #2 had witnessed prior to the altercation. The ADON confirmed Resident #30 had made willful physical contact with Resident #65 on 5/3/2021. The ADON confirmed Resident #30's wandering had been discussed in IDT meetings. The ADON stated she had suggested Resident #30 may need placement in a locked unit, but the IDT had stated the facility was able to meet the resi [TRUNCATED]

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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** 40105 Based on facility policy review, medical record review, and interview, the facility failed to timely report to the State Survey Agency an allegation of abuse for 2 residents (Residents #65 and #45) and failed to timely report an allegation of abuse to Administration for 1 resident (Resident #45) of 16 residents reviewed for abuse. Resident #30 hit Resident #65 in the head. Resident #30 continued to display wandering and aggressive behavior and entered Resident #45's room and attempted to choke Resident #45. The facility's failure to ensure allegations of abuse were reported timely placed all residents in the facility in Immediate Jeopardy (a situation in which the provider's non-compliance with one or more requirements for participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident). The Administrator was informed of the Immediate Jeopardy (IJ) in the conference room on 7/10/2021 at 12:50 PM. The facility was cited F-609 at a scope and severity of L which constitutes Substandard Quality of Care. The Immediate Jeopardy was removed 7/12/2021 and was effective 5/3/2021 - 7/11/2021. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 7/12/2021 at 8:40 AM and the corrective actions were validated onsite by the surveyors on 7/12/2021 and 7/13/2021. The findings include: Review of the facility's policy titled, Freedom of Abuse, Neglect and Exploitation Standard, revised 11/2019, showed .All employees are required to immediately notify the administrative or nursing supervisory staff that is on duty of any complaint, allegation, observation or suspicion of resident abuse, mistreatment or neglect so that the resident's needs can be attended to immediately and investigation can be undertaken promptly . all violations involving abuse .are reported immediately, but not later than 2 hours after the allegation is made .The abuse coordinator will contact the State Agency and the local Ombudsman office to report the alleged abuse .Report the results of all investigations .to the State Survey Agency, within 5 working days of the incident . Medical record review showed Resident #30 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Dementia with Behavioral Disturbance, Type 2 Diabetes Mellitus, Anxiety Disorder, Major Depressive Disorder, Insomnia, and Delusional Disorders. Review of Resident #30's comprehensive care plan dated 4/13/2021, showed .elopement risk/wanderer AEB [as evidenced by] History of attempts to leave facility unattended .she becomes aggressive/combative with other residents at times, she goes in and out of residents rooms . Review of Resident #30's admission Minimum Data Set (MDS) dated [DATE], showed the resident had severe cognitive impairment and had wandered 1-3 days during the assessment period. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #30's Physician Notification Progress Note dated 5/3/2021 at 5:16 PM, showed Resident #30 had been in a resident to resident altercation with Resident #65 .This Resident .was hitting [Resident #65] on the head and pulling her wheelchair back, [Resident #65] was screaming for Help . Review of Resident #30's Physician's Progress Note dated 5/4/2021, showed .This person began hitting the other resident [Resident #65] on her head and pulling .wheelchair back .The other resident was screaming for help . Review of Resident #30's Psychiatric Evaluation dated 5/4/2021, showed .Evaluating mood and behaviors-patient having increased agitation, restlessness, aggression . Further review showed Resident #30 was having physical aggression and combativeness. Review of Resident #30's Behavior Note/Anxiety Progress Note dated 5/20/2021, showed .Resident frequently goes into other Resident's rooms and takes belonging, drinks, food, etc. Resident has been involved in a couple of verbal arguments with other residents . Review of Resident #30's Behavior Note/Anxiety Progress Note dated 6/4/2021, showed .Resident continues to wander the halls, but is increasingly more intrusive into other Resident rooms. Resident enters every room and takes items and hides them. Resident upsets other Residents with her actions. Resident also pushes other Residents in their wheelchair around the halls . Review of Resident #30's Behavioral Note/Anxiety Progress Note dated 7/5/2021, showed .Resident continues to wander this shift. Resident wandering into other resident rooms causing distress to other residents. Resident is also taking things from nurses station, med carts, and other residents rooms . Medical record review showed Resident #65 was admitted to the facility on [DATE] with diagnoses including Bipolar Disorder, Dementia Without Behavioral Disturbance, Difficulty Walking, Anxiety Disorder, Insomnia, and Acquired Absence of Right Leg Below Knee. Review of Resident #65's comprehensive care plan dated 11/20/2020, showed .often becoming tearful for no particular reason .states she has a 'hole in her head' .intervene as necessary to protect the rights and safety of others . Review of Resident #65's quarterly MDS dated [DATE], showed the resident had moderately impaired cognitive status, the resident was independent for locomotion on the unit, and used a wheelchair for mobility. Review of Resident #65's Physician's Notification Progress Note dated 5/3/2021, showed Resident #65 had been in a resident to resident altercation on 5/3/2021. Resident #30 was hitting Resident #65 in the head. Review of Resident #65's Psychiatric Evaluation dated 5/4/2021, showed .Evaluating mood and behaviors-patient was involved in an incident with [Resident #30] since that time she had increased anxiety and delusions . and the resident's medications had been increased. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #65's Physician's Progress Note dated 5/4/2021, showed .The patient was a victim of the resident on resident violence earlier in the week .The patient's been very anxious since that time .The patient reports the other individual came up from behind her and grabbed and hit her right parietal [top of head] and temporal [side of head] area .This incident unfortunately set off exacerbation of patient's underlying anxiety disorder To become increasingly anxious and avoids individuals when moving about the community in her wheelchair . Review of Resident #65's Behavior Note/Anxiety Progress Note dated 5/5/2021, showed the resident was crying and did not want to return to her room and stated she was scared. The nurse moved her to a different room for the night. Review of Resident #65's Psychotherapy Progress Note dated 5/6/2021, showed .The patient was quite distressed. She was hit recently by another patient and her room was moved. The patient approached the clinician stating she was distressed, and she asked if she could be sent to a psychiatric unit .the patient stating she is having hallucinations was significant this time, and having them directly after a significant stressor (being attacked by another patient) is highly consistent with the literature on psychosis, as opposed to a manipulative quality. The patient was crying, and insistent on being considered for evaluation outside of the facility . During an interview on 7/7/2021 at 2:34 PM, the Assistant Director of Nursing (ADON) confirmed the facility did not report resident to resident altercations to the State Survey Agency. She stated the facility would report allegations of abuse. The ADON stated the resident to resident altercation between Resident #30 and Resident #65 was considered to be behaviors and not abuse. During an interview on 7/7/2021 at 2:37 PM, the Administrator stated when a resident hits another resident, it would only be reported to the State Survey Agency depending on the situation. She stated the resident to resident altercation that occurred between Resident #30 and Resident #65 on 5/3/2021 was not considered to be abuse by the facility .those were behaviors . She stated both residents had a history of behaviors and the altercation was due to those behaviors. She stated the IDT (Interdisciplinary Team) would discuss any resident to resident altercation and decide if they should be investigated as an abuse allegation or reported to the State Survey Agency. Medical record review showed Resident #45 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Muscle Wasting, Chronic Obstructive Pulmonary Disease, Difficulty Walking, Presence of a Cardiac Pacemaker, Personal History of Other Mental and Behavioral Disorders, Bipolar Disorder, Syncope and Collapse, General Anxiety Disorder, Wheezing, and Dependence on Supplemental Oxygen. Review of Resident #45's 5 day MDS dated [DATE], showed the resident had moderate cognitive impairment. Review of Resident #45's Physician Progress Note dated 7/8/2021, showed .Resident [Resident #30] supervised the patient [Resident #45} while she was lying on her left resting .Resident [Resident #30] placed her right hand on the left side of the patient's [Resident #45] neck and held it .The patient [Resident #45] stated she turned and tried to push the arm away but it was very stiff .Ultimately she [Resident #45] got the hand removed .Event was unprovoked . (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #30's Physician's Progress Note dated 7/8/2021, showed .Yesterday this patient went into another resident's room [Resident #45] and placed her hand about the residents neck making the resident think she was being choked .Patient had wandered into the resident's room .Frequently up and about the building, restless .Eventually the patient is able to push the hand away from her neck .PLAN . Mental health consult .One-on-one observation if available . Review of a facility witness statement given by CNA #5, undated, showed .Resident [#45] stated she was sleeping, and thought was one of us shaking her awake. But it was [Resident #30] standing over her. She claimed [Resident #30] had her hands around her neck and told her she would hurt her/die . Review of facility documentation dated 7/8/2021, showed the resident to resident abuse between Resident #30 and Resident #45 that had been reported to the staff on 7/8/2021 at 6:00 AM, had not been reported to the State Survey Agency until 7/8/2021 at 12:01 PM (4 hours after the occurrence). During an interview on 7/8/2021 at 8:27 AM, Licensed Practical Nurse (LPN) #2 confirmed she had been assigned to Resident #30 and Resident #65 on the day of the altercation between the 2 residents on 5/3/2021. A CNA had reported the altercation to her. LPN #2 stated Resident #65 .was distraught and upset . crying .tearful . During an interview on 7/9/2021 at 1:40 PM, the Psychiatric (Psych) Nurse Practitioner (NP) stated she was aware of the resident to resident altercation between Resident #30 and Resident #65 that occurred on 5/3/2021. She confirmed she had added an antipsychotic medication for Resident #30 after the incident for delusions. She had also seen Resident #65 after the altercation and stated Resident #65 had delusions about the incident and thought the woman (Resident #30) was out to get her and out to kill her. The Psych NP confirmed the altercation did trigger some increased anxiety for Resident #65 which required medication changes. She confirmed the altercation did cause Resident #65 some significant distress and psychosocial harm. During an interview on 7/9/2021 at 2:19 PM, the Medical Director (MD) stated he was aware of Resident #30's wandering into other resident's rooms and stated .she has bumped into a few folks along the way . He stated the resident to resident altercation that occurred between Resident #30 and Resident #65 .really set off [Resident #65's] anxiety .caused a significant amount of anxiety . He further confirmed the incident had caused Resident #65 to have psychosocial harm and there was a continued risk to other residents due to Resident #30's continued wandering. Review of facility documentation dated 7/11/2021, showed the resident to resident abuse between Resident #30 and Resident #65 that occurred on 5/3/2021 was not reported to the State Survey Agency until 7/11/2021 (69 days after the occurrence). (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 7/13/2021 at 10:40 AM, the Physical Therapy Assistant (PTA) stated he had assisted Resident #45 to therapy in the mid-morning of 7/8/2021. He had asked her how her morning had been and Resident #45 stated her morning had .gotten off to a rough start . Resident #45 stated to the PTA that someone came into the room and she thought at first it was a nurse. She had felt a hand on her upper chest but when she looked up it was another resident, not the nurse. Resident #30 said to Resident #45 .I'll kill you . The PTA told Resident #45 he would report the incident and she told him she had already reported the incident to a nurse. The PTA stated he went to LPN #2 and reported the incident. LPN #2 told him she had not been made aware of the incident, but she would report it. The PTA stated he also reported the incident to his supervisor about 1-1 1/2 hours after he reported it to LPN #2. He stated his supervisor then immediately reported the incident to the ADON. During an interview on 7/13/2021 at 11:03 AM, LPN #2 stated the PTA had reported the incident between Resident #30 and Resident #45 to her on 7/8/2021 at about 10:00 AM. LPN #2 stated she reported the incident to her supervisor RN #1. LPN #2 stated the night shift staff had not reported the incident during shift report. During a telephone interview on 7/13/2021 at 11:30 AM, CNA #4 stated she had worked the night shift on 7/7/2021 into the morning of 7/8/2021. CNA #5 had worked the 300 hallway that night and CNA #4 had worked on all halls. CNA #5 reported to CNA #4 prior to them leaving their shift at 6:00 AM that Resident #45 (who resided on the 300 hallway) had reported the incident with Resident #30 to her. CNA #4 stated she did not report the incident because she assumed CNA #5 would report it. During an interview on 7/13/2021 at 1:11 PM, RN #1 stated she was the supervisor of the 300 hallway on 7/8/2021. LPN #2 reported to her at about 11:30 AM of an incident that occurred between Resident #30 and Resident #45. RN #1 went immediately to report to nurse management (RN #2) and was told by RN #2 that management was already aware. During an interview on 7/13/2021 at 1:27 PM, RN #2 confirmed she had been in the ADON's office on 7/8/2021 when the Rehabilitation Director had made her and the ADON aware of the resident to resident altercation between Resident #30 and Resident #45. She stated it was not long before lunch when they had been notified of the incident and they immediately reported it to the Administrator (approximately 4 1/2 hours after incident occurred). During an interview on 7/13/2021 at 2:11 PM, while reviewing the video surveillance footage from 7/8/2021, the Administrator confirmed Resident #30 had entered Resident #45's room for a period of 34 seconds from 5:48:31 AM to 5:49:05 AM. She confirmed she had no way of knowing what happened in the room other than taking Resident #45's word. The Administrator stated Resident #45's roommate had not been in the room when Resident #30 had entered. She confirmed CNA #5 had reported the altercation to CNA #4 prior to them leaving their shift at 6:00 AM on 7/8/2021, but neither CNA had reported the incident to nursing or administration. She confirmed the facility should have reported the incident by 8:00 AM on 7/8/2021 to the State Survey Agency and confirmed the facility had not reported to any other entity such as the Ombudsman's office or Adult Protective Services. The Administrator further confirmed the facility had not followed their policy for reporting alleged abuse. Refer to F- 600 (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received 7/12/2021 at 8:40 AM, and the corrective actions were validated on-site by the surveyors on 7/12/2021-7/13/2021 through review of documents, review of facility policies, and staff interviews. The Removal Plan presented to the survey team by the facility documented the following immediate corrective actions implemented. On 7/10/2021 the Regional Director of Operations provided training to the Administrator, Assistant Director of Nursing, Nursing Educator, Unit Manager, MDS Coordinator, Medical Records, Social Services, Director of Rehab, Dietary, Admissions Liaison, and Human Resources. The training included: 1. the Abuse policy 2. types and reporting and investigating and prevention of abuse 3. process of identifying, preventing, and reporting abuse 4. how to recognize a potential behavior that is escalating, and to intervene 5. who is the Abuse Coordinator 6. suspected or observed abuse, all types, reported to the Administrator immediately All staff not working on 7/10/2021 were called and in-serviced. On 7/10/2021 the Administrator was in-serviced by the Regional Director of Operations on how to identify, report, and investigate potential allegations of abuse. All residents with a diagnosis of Dementia/behaviors had their care plan reviewed and revised to reflect resident specific behavioral interventions. Interviewable residents were interviewed by the Social Service Director on any concerns related to abuse. Residents that were not interviewed had a skin assessment completed by the ADON and Unit Manager on 7/10/2021. The Regional Director of Clinical services reviewed the last 72 hours of nursing notes to identify any issues that needed to be investigated as an allegation with no issues identified. On 7/10/2021 the Nurse Educator, Director of Rehab, and Human Resources educated staff. The training included: 1. how to recognize potential behavior that is escalating and to intervene 2. who the abuse coordinator is- the Administrator 3. suspected or observed abuse 4. all types reported to the Administrator immediately All staff not working on 7/10/2021 were called and in-serviced. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 7/11/2021 all staff started competency tests on Hand-in-Hand Dementia module part 1 & 2, abuse prevention, reporting, and investigating. Audits will be performed by the DON/designee of progress notes to identify any potential new or exacerbations of behaviors 5 times per week for 4 weeks, 3 times per week for 4 weeks, and 2 times per week for 4 weeks. The Nurse Educator will perform behavior management training monthly for 6 months using Hand-in-Hand. The Kardex's will be printed from Point Click Care and updated to reflect the behavioral interventions that are resident specific, on 7/11/2021 by the ADON and Unit manager. The Regional Director of Clinical Services will monitor nursing notes written in the past 24 hours to identify any areas that potentially could be exacerbated behaviors 5 times per week for 4 weeks, 3 times per week for 4 weeks, and 2 times per week for 4 weeks. Changes to a behavior care plan or development by the IDT team will be reviewed by the Administrator to ensure it is resident specific as updates occur. The comprehensive care plan development is overseen by the MDS Coordinator with input from Social Services, Activities, Dietary, and Rehab. Revisions to the behavioral care plan is the responsibility of the Social Services. Nursing Care plan updates are the responsibility of Licensed Nurses, Unit Manager, ADON, and the DON. The QAPI committee will meet weekly to analyze all events that may require investigation and reporting. Weekly updates will be provided by responsible members on the progress. The Regional Director of Nursing and/or the Regional [NAME] President of Operations will attend QAPI meetings in person or by phone. This will include input and review of data collected for the meeting. The Regional Director of Nursing and/or Regional [NAME] President of Operations will do facility visits to monitor compliance at a minimum weekly until substantial compliance is achieved and maintained. On 7/12/2021, Surveyors reviewed the education and sign in sheets which validated the corrective action plans. The documentation showed all staff working on 7/12/2021 and 7/13/2021 had been provided the education on abuse, types of abuse, preventing, protecting, recognizing/identifying abuse/behaviors, reporting, and investigating abuse. The Administrator was educated on abuse by the corporate nurse. Residents affected by the wandering residents were assessed and interviewed to determine if psychosocial harm had occurred. Twenty-two resident records were reviewed randomly to ensure care plans had been updated and Dementia care had been added to those with Dementia and behaviors. The records had been updated to include interventions on the 22 resident records reviewed. The surveyors validated all staff working on 7/12/2021-7/13/2021 had been educated and were knowledgeable about the new procedures related to abuse/behavior, Dementia Care, and person-centered care planning. On 7/12/2021, Surveyors validated the corrective actions onsite through interviews with the Administrator, DON, Nurse Educator, MDS Coordinator, Social Service Director, 4 RNs, 2 LPN's, 8 CNA's, 2 nurse aides in training, 2 therapists and 2 housekeepers. The interviews showed the staff were educated on how to prevent abuse, what to do when abuse occurs, reporting of all allegations of abuse to the Administrator immediately, investigating all allegations of abuse, documentation and implementing person centered care plans for each resident with Dementia and behaviors. Staff verbalized knowledge of development of care plans for Dementia and behaviors and how to assess residents to determine person centered needs/interventions. Administrator interview confirmed all allegations of abuse would be reported to the state agency within 2 hours of the allegation. Noncompliance at F-609 continues at a scope and severity of F for monitoring of the effectiveness of the corrective actions to ensure sustained compliance. The facility is required to submit a plan of correction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Church Hill Post-Acute and Rehabilitation Center	701 West Main Blvd Church Hill, TN 37642

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40105 Based on facility policy review, medical record review, and interview, the facility failed to investigate an allegation of abuse for 2 residents (Resident #30 and #65) of 16 residents reviewed for abuse when a Certified Nursing Assistant (CNA) failed to separate Resident #30 and Resident #65 when she overheard them arguing in the hallway, which resulted in a resident to resident altercation when Resident #30 hit Resident #65 in the head. This resulted in psychosocial harm for Resident #65. Resident #30's continued wandering led to Resident #30 entering Resident #45's room and attempting to choke Resident #45 and stating she would kill Resident #45. The facility's failure to recognize and investigate resident to resident abuse that occurred between Resident #30 and Resident #65 placed Resident #65 and Resident #45 in Immediate Jeopardy (a situation in which the provider's non-compliance with one or more requirements for participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident). The facility's failure to investigate an allegation of abuse perpetrated by Resident #30, and implement interventions based on the investigation to prevent further instances of abuse, had the potential to affect all residents in the facility . The Administrator was informed of the Immediate Jeopardy (IJ) in the conference room on 7/10/2021 at 12:50 PM. The facility was cited F-610 at a scope and severity of L which constitutes Substandard Quality of Care. The Immediate Jeopardy was removed onsite 7/12/2021 and was effective 5/3/2021-7/11/2021. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 7/12/2021 at 8:40 AM and the corrective actions were validated onsite by the surveyors on 7/12/2021 and 7/13/2021. The findings include: Review of the facility's policy titled, Freedom Of Abuse, Neglect And Exploitation Standard, dated 11/2019, showed .The facility will consider factors indicating possible abuse .including .Resident, staff or family report of abuse .Physical abuse of a resident observed .The facility will implement policies and procedures to prevent and prohibit all types of abuse .When suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur, an investigation is immediately warranted .All alleged violations involving mistreatment, abuse or neglect will be thoroughly investigated by the facility under the direction of the Administrator and in accordance with state and federal law .The Administrator, or his/her designee, will ensue that the investigation is completed within 48 to 72 hours . Medical record review showed Resident #30 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Dementia with Behavioral Disturbance, Type 2 Diabetes Mellitus, Anxiety Disorder, Major Depressive Disorder, Insomnia, and Delusional Disorders. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #30's comprehensive care plan dated 4/13/2021, showed .she becomes aggressive/combative with other residents at times, she goes in and out of residents rooms, needs frequent redirection . Review of Resident #30's admission Minimum Data Set (MDS) dated [DATE], showed the resident had severe cognitive impairment and had wandered 1-3 days during the assessment period. Resident #30 required supervision to walk in the room and hallways with no use of mobility devices. Review of Resident #30's Respiratory Evaluation Progress Note dated 4/15/2021, showed .Chronic disruptive behavior noted. Chronic wandering behavior noted . Review of Resident #30's QAPI (Quality Assurance and Performance Improvement)/Risk Meeting Progress Note dated 5/3/2021 at 1:52 PM, showed Resident #30 was a wandering risk with behaviors noted. Review of Resident #30's Risk Meeting Note dated 5/4/2021, showed .Resident to Resident [altercation] occurred on 05.03.21 @ [at] 1659 [4:59 PM]. This is Resident A [Resident #30] and the aggressor [Resident #30] was in a central location of hallway holding [Resident #65's] wheelchair and pulling the w/c [wheelchair] backwards with her [Resident #65] foot in the wheel of the chair. [Resident #30] hit [Resident #65] on top of the head several times. [Resident #65] started screaming for help .[Resident #65] stated 'I was just sitting in my chair when all of a sudden [Resident #30] started hitting me on top of the head and pulling my w/c backwards'. Called the psych [psychiatric] NP [Nurse Practitioner] and new orders received to send [Resident #30] to .ER [emergency room] for psychiatric evaluation and treatment . Review of Resident #30's Physician's Progress Note dated 5/4/2021, showed Resident #30 .began hitting the other resident [Resident #65] on her head and pulling .wheelchair back .The other resident was screaming for help . Further review showed the Mental Health Nurse Practitioner (NP) was notified and had responded with an order to send Resident #30 to the emergency department for evaluation. Review of Resident #30's Behavior Note/Anxiety Progress Note dated 5/20/2021, showed Resident #30 would frequently wander into other resident rooms and take their belongings and had verbal arguments with other residents. Review of Resident #30's Behavior Note/Anxiety Progress Note dated 6/4/2021, showed Resident #30 continued to wander .but is increasingly more intrusive into other Resident rooms. Resident enters every room and takes items and hides them. Resident upsets other Residents with her actions. Resident also pushes other Residents in their wheelchair around the halls . Review of Resident #30's Social Service Progress Note dated 6/8/2021, showed Resident #30 had inappropriate behaviors and had been .shopping in rooms, grabbing things out of residents hands, hard to redirect . Review of a Behavior Note/Anxiety Progress Note dated 7/4/2021, showed .Resident wandering into other resident rooms, causing distress to other residents .taking things from .other residents rooms .Attempts to redirect unsuccessful . (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #30's Physician's Progress Note dated 7/8/2021, showed .Yesterday this patient went into another resident's room [Resident #45] and placed her hand about the resident's neck making the resident think she was being choked . Eventually the patient is able to push the hand away from her neck . One-on-one observation if available . Medical record review showed Resident #65 was admitted to the facility on [DATE] with diagnoses including Bipolar Disorder, Dementia Without Behavioral Disturbance, Difficulty Walking, Anxiety Disorder, Insomnia, and Acquired Absence of Right Leg Below Knee. Review of Resident #65's comprehensive care plan dated 11/20/2020, showed Resident #65 had a behavioral problem and often would become tearful for no particular reason. Further review showed .states she has a 'hole in her head' . Review of Resident #65's quarterly MDS dated [DATE], showed the resident had moderately impaired cognitive status with no behaviors documented. Review of Resident #65's Physician's Notification Progress Note dated 5/3/2021, showed Resident #65 was involved in a resident to resident altercation with Resident #30. Resident #65 had been sitting in a wheelchair while Resident #30 was pushing the wheelchair back and hitting resident #65 on top of the head. Review of Resident #65's Psychiatric Evaluation dated 5/4/2021, showed .patient was involved in an incident with another resident since that time she had increased anxiety and delusions. Increasing distress reasonable to restart as needed Valium [a medication used for anxiety] as well as increase Seroquel [an anti-psychotic medication] to target delusions . Review of Resident #65's Physician's Progress Note dated 5/4/2021, showed .The patient was a victim of the resident on the resident violence earlier in the week .The patient's been very anxious since that time . Further review showed Resident #30 had come up behind Resident #65 and hit her on the top and side of the head .This incident unfortunately set off exacerbation of patient's underlying anxiety disorder To become increasingly anxious and avoids individuals when moving about the community in her wheelchair . Review of Resident #65's Medication Administration Progress Note dated 5/4/2021, showed the resident was crying and stating I'm not going up there referring to her room. The resident was administered a dose of Valium 2mg. Review of Resident #65's Psychotherapy Progress Note dated 5/6/2021, showed Resident #65 was quite distressed. She had been hit by another resident .stating she was distressed, and she asked if she could be sent to a psychiatric unit .the patient stating she is having hallucinations was significant this time, and having them directly after a significant stressor (being attacked by another patient) is highly consistent with the literature on psychosis, as opposed to a manipulative quality. The patient was crying, and insistent on being considered for evaluation outside of the facility . Further review showed her request was discussed with the staff and the resident was to be sent out for evaluation the next morning. Review of Resident #65's medical record showed she was sent out to a hospital on 5/7/2021 and returned to the facility on [DATE]. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Medical record review showed Resident #45 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Muscle Wasting, Chronic Obstructive Pulmonary Disease, Difficulty Walking, Presence of a Cardiac Pacemaker, Personal History of Other Mental and Behavioral Disorders, Bipolar Disorder, Syncope and Collapse, General Anxiety Disorder, Wheezing, and Dependence on Supplemental Oxygen. Review of Resident #45's 5 day MDS dated [DATE], showed the resident had moderate cognitive impairment with no behaviors noted. Review of Resident #45's Physician Progress Note dated 7/8/2021, showed Resident #30 entered her room . Resident [Resident #30] placed her right hand on the left side of the patient's [Resident #45] neck and held it . The patient [Resident #45] stated she turned and tried to push the arm away but it was very stiff .Ultimately she got the hand removed .Event was unprovoked . During an interview on 7/7/2021 at 2:34 PM, the Assistant Director of Nursing (ADON) confirmed there had been no investigation completed related to the resident to resident altercation between Resident #30 and Resident #65 that occurred on 5/3/2021. During an interview on 7/7/2021 at 2:37 PM, the Administrator stated the resident to resident altercation that occurred between Resident #30 and Resident #65 on 5/3/2021 was not considered to be abuse by the facility .those were behaviors . She stated both residents had a history of behaviors and the altercation was due to those behaviors. She stated the IDT (Interdisciplinary Team) discusses any resident to resident altercations and decides if they should be investigated as an abuse allegation. She confirmed the facility felt this was not abuse but just a behavior and it had not been investigated. The Administrator stated the facility would only do a full abuse investigation if they decided it was abuse and not a behavior. During an interview on 7/8/2021 at 10:21 AM, CNA #2 stated she had been at the nurse's station on 5/3/2021. Resident #30 was walking near Resident #65 and they had started to argue. CNA #2 then went to do .something . down the hallway without intervening. When she returned to the nurse's station, CNA #3 reported to her that Resident #30 had hit Resident #65. During an interview on 7/8/2021 at 10:33 AM, CNA #3 stated on 5/3/2021 she was in a room on the 300 hallway when she heard Resident #65 .screaming bloody murder . She came out into the hallway and saw Resident #30 and Resident #65 close to the nurse's station and Resident #30 was .tapping . Resident #65 on the head. CNA #3 stated she separated the residents and Resident #30 then .wandered off . CNA #3 stated Resident #65 .freaks out .says she has water on the brain and that could hurt her . (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 7/8/2021 at 1:31 PM, the ADON stated the facility considers abuse to be a purposeful and willful physical act toward another such as punching, hitting, kicking, and the resident must have the comprehension and knowledge of what they are doing. She stated the IDT team reviews resident to resident altercations and reviews the resident's history of behaviors, diagnoses, and the causative factors. She stated the facility's standard is if a resident had Brief Interview for Mental Status (BIMS) score of 8 (a score of 8-12 indicates moderately impaired cognitive status, a score of 13-15 indicates cognitively intact) or above, that they know what is going on and are able to make their own decisions. The ADON stated each resident to resident altercation depended on what the situation was and whether an incident would be investigated as abuse. The ADON stated staff are trained to report all incidents and then the IDT team would complete an Incident and Accident (I&A) report. The I&A report would be reviewed by the IDT team and a decision would be made as to whether an abuse investigation needed to be completed. She confirmed all resident to resident altercations would not be investigated as potential abuse. She stated Resident #65 had been having behaviors on 5/3/2021 and had been going through the hallway .crying and screaming . She stated it had been reported to her that Resident #30 approached Resident #65 and .it was more of a tap . She further stated both residents were .very behavioral . and the altercation had not been investigated as an allegation of abuse. The ADON confirmed Resident #30 had made willful physical contact with Resident #65 on 5/3/2021. During an interview on 7/9/2021 at 1:40 PM, the Psychiatric NP stated she was aware of the resident to resident altercation between Resident #30 and Resident #65 that occurred on 5/3/2021. The Psych NP confirmed the altercation did trigger some increased anxiety for Resident #65 and psychosocial harm. During an interview on 7/9/2021 at 2:19 PM, the Medical Director (MD) stated he was aware of Resident #30's wandering into other resident's rooms and stated .she has bumped into a few folks along the way . The MD confirmed Resident #30's continued wandering did increase the risk of another resident to resident altercation. He stated the resident to resident altercation that occurred between Resident #30 and Resident #65 .really set off [Resident #65's] anxiety .caused a significant amount of anxiety . He further confirmed the incident had caused Resident #65 to have psychosocial harm and there was a continued risk to other residents due to Resident #30's continued wandering. Refer to F-600 An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received 7/12/2021 at 8:40 AM, and the corrective actions were validated on-site by the surveyors on 7/12/2021-7/13/2021 through review of documents, review of facility policies, and staff interviews. The Removal Plan presented to the survey team by the facility documented the following immediate corrective actions implemented. On 7/10/2021 the Regional Director of Operations provided training to the Administrator, Assistant Director of Nursing, Nursing Educator, Unit Manager, MDS Coordinator, Medical Records, Social Services, Director of Rehab, Dietary, Admissions Liaison, and Human Resources. The training included: 1. the Abuse policy 2. types and reporting and investigating and prevention of abuse (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	3. process of identifying, preventing, and reporting abuse 4. how to recognize a potential behavior that is escalating, and to intervene 5. who is the Abuse Coordinator 6. suspected or observed abuse, all types, reported to the Administrator immediately All staff not working on 7/10/2021 were called and in-serviced. On 7/10/2021 the Administrator was in-serviced by the Regional Director of Operations on how to identify, report, and investigate potential allegations of abuse. All residents with a diagnosis of Dementia/behaviors had their care plan reviewed and revised to reflect resident specific behavioral interventions. Interviewable residents were interviewed by the Social Service Director on any concerns related to abuse. Residents that were not interviewed had a skin assessment completed by the ADON and Unit Manager on 7/10/2021. The Regional Director of Clinical services reviewed the last 72 hours of nursing notes to identify any issues that needed to be investigated as an allegation with no issues identified. On 7/10/2021 the Nurse Educator, Director of Rehab, and Human Resources educated staff. The training included: 1. how to recognize potential behavior that is escalating and to intervene 2. who the abuse coordinator is- the Administrator 3. suspected or observed abuse 4. all types reported to the Administrator immediately All staff not working on 7/10/2021 were called and in-serviced. On 7/11/2021 all staff started competency tests on Hand-in-Hand Dementia module part 1 & 2, abuse prevention, reporting, and investigating test. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Audits will be conducted by the Administrator and Director of Nursing (DON) of nursing notes for the past 24 hours to identify any potential reportable events. These audits will be performed 5 times per week for 4 weeks, 3 times per week for 4 weeks, and 2 times per week for 4 weeks. Five random residents will be interviewed daily to ensure no resident to resident and no incidents of other residents wandering into their rooms by Social Services. A Licensed Nurse will do 5 skin sweeps 5 times per week for 4 weeks, 3 times per week for 4 weeks, and 2 times per week for 4 weeks on residents who are not interviewable. The Regional Director of Clinical Services will monitor nursing notes written in the past 24 hours to identify any areas that potentially could be a reportable event 5 times per week for 4 weeks, 3 times per week for 4 weeks, and 2 times per week for 4 weeks. The Nurse Educator will track the interviews and skin sweeps, a reportable event log will be maintained in the Administrators office. Residents with behaviors/Dementia care plans were reviewed and updated on 7/10/2021 by the MDS Nurse and Social Services to reflect resident specific interventions for behaviors. Nursing staff were interviewed by the ADON and the Unit Manager to identify any new behaviors observed and/or exacerbations on 7/10/2021, no issues were identified. The Regional Director of Nursing reviewed the past 72 hours of nursing documentation for new and/or exacerbations of behaviors on 7/10/2021, no issues identified. On 7/10/2021 the Regional Director of Nursing Services in-serviced the ADON, Unit Manager, Social Services, MDS Coordinator, and Activities Director on behavioral management policy including: 1. Making resident care plans specific to their behaviors with interventions 2. how to recognize potential behaviors that is escalating and to intervene On 7/10/2021 the Regional Director of Clinical Services in-serviced the Administrator, ADON, Nursing Educator, Unit Manager, MDS Coordinator, Medical Records, Social Services, Director of Rehab, Dietary, Admission Liaison, and Human Resources on behavior management including: how to recognize a potential behavior that is escalating and to intervene All staff not present on 7/10/2021 were called and in-serviced by the Nurse Educator. No employee will work prior to being trained. Future employees will be educated on hire regarding behavioral management and care plan revisions as it relates to resident specific interventions and including how to recognize a potential behavior that is escalating and to intervene. Audits will be performed by the DON/designee of progress notes to identify any potential new or exacerbations of behaviors 5 times per week for 4 weeks, 3 times per week for 4 weeks, and 2 times per week for 4 weeks. The Nurse Educator will perform behavior management training monthly for 6 months using Hand-in-Hand. The Kardex's will be printed from Point Click Care and updated to reflect the behavioral interventions that are resident specific, on 7/11/2021 by the ADON and Unit manager. The Regional Director of Clinical Services will monitor nursing notes written in the past 24 hours to identify any areas that potentially could be exacerbated behaviors 5 times per week for 4 weeks, 3 times per week for 4 weeks, and 2 times per week for 4 weeks. Changes to a behavior care plan or development by the IDT team will be reviewed by the Administrator to ensure it is resident specific as updates occur. The comprehensive care plan development is overseen by the MDS Coordinator with input from Social Services, Activities, Dietary, and Rehab. Revisions to the behavioral care plan is the responsibility of the Social Services. Nursing Care plan updates are the responsibility of Licensed Nurses, Unit Manager, ADON, and the DON. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The QAPI committee will meet weekly to analyze all events that may require investigation and reporting. Weekly updates will be provided by responsible members on the progress of each citation. The Regional Director of Nursing and/or the Regional [NAME] President of Operations will attend QAPI meetings in person or by phone. This will include input and review of data collected for the meeting. The Regional Director of Nursing and/or Regional [NAME] President of Operations will do facility visits to monitor compliance at a minimum weekly until substantial compliance is achieved and maintained. On 7/12/2021, Surveyors reviewed the abuse policy which included investigating and reporting of abuse. The surveyors reviewed education and sign in sheets which validated the corrective action plans onsite which was provided by the Administrator. The documentation showed all staff working on 7/12/2021 and 7/13/2021 had been provided the education on abuse, types of abuse, preventing, protecting, recognizing/identifying abuse/behaviors, reporting, and investigating abuse. The Administrator was educated on abuse by the corporate nurse. Residents affected by the wandering residents were assessed and interviewed to determine if psychosocial harm had occurred. Twenty-two resident records were reviewed randomly to ensure care plans had been updated and Dementia care had been added to those with Dementia and behaviors. The records had been updated to include interventions on the 22 resident records reviewed. The surveyors validated all staff working on 7/12/2021-7/13/2021 had been educated and were knowledgeable about the new procedures related to abuse/behavior, Dementia Care, and person-centered care planning. On 7/12/2021, Surveyors validated the corrective actions onsite through interviews with the Administrator, DON, Nurse Educator, MDS Coordinator, Social Service Director, 4 RNs, 2 LPN's, 8 CNA's, 2 nurse aides in training, 2 therapists and 2 housekeepers. The interviews showed the staff were educated on how to prevent abuse, what to do when abuse occurs, reporting of abuse to the administrator immediately, investigating all allegations of abuse, documentation, and implementing person centered care plans for each resident with Dementia and behaviors. Staff verbalized knowledge of development of care plans for Dementia and behaviors and how to assess residents to determine person centered needs/interventions. Interview with the Administrator confirmed she would initiate and oversee the abuse investigations. Noncompliance at F-610 continues at a scope and severity of F for monitoring of the effectiveness of the corrective actions to ensure sustained compliance. The facility is required to submit a plan of correction.

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40606 Based on facility policy review, medical record review, observation, and interview, the facility failed to ensure staff had the knowledge and skill set required to develop appropriate behavior health care plans and provide care to meet the behavioral health needs of 2 residents (#30 and #65) of 4 residents reviewed for behaviors. The facility's failure to have competent staff to implement appropriate behavioral interventions resulted in an altercation between Resident #30 and Resident #65 where Resident #65 suffered psychosocial harm. Resident #30's continued wandering behavior led to Resident #30 wandering into Resident #45's room and placing her hands-on Resident #45's neck and attempting to choke her. The facility's failure to ensure staff were knowledgeable and competent to provide services for residents with behavior care needs placed Resident #30 and Resident #65, and Resident #45 in Immediate Jeopardy (a situation in which the providers non-compliance with one or more requirements for participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident) and had the potential to place all residents in Immediate Jeopardy. The Administrator was informed of the Immediate Jeopardy (IJ) in the conference room on 7/10/2021 at 12:50 PM. The Immediate Jeopardy was removed onsite 7/12/2021 and was effective 5/3/2021 - 7/11/2021. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 7/12/2021 at 8:40 AM and the corrective actions were validated onsite by the surveyors on 7/12/2021 and 7/13/2021. The findings include: Review of the facility policy titled, Resident Centered Care Plans, dated 3/2019, showed .Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for caring [carrying] out the interventions, initially and when changes are made . Review of the facility policy titled, Behavior Management, dated 9/2019 revealed .the facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skill sets to provide .services to assure resident safety .maintain the highest practicable physical, mental, and psychosocial well-being of each resident .Planning and implementing appropriate interventions into the resident's plan of care and evaluating the effectiveness of pharmacological and non-pharmacological interventions .Providing meaningful activities which promote engagement .between resident and staff . Meaningful activities are those that address the resident's customary routines, interests, preferences .and enhance the resident's well-being .Purpose to implement the most desirable and effective interventions that meet .needs of the residents, to change, modify, decrease or eliminate behaviors that are distressing to the resident and/or are decreasing or impacting on the resident's quality of life . (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Medical record review showed Resident #30 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Dementia with Behavioral Disturbance, Anxiety Disorder, Major Depressive Disorder, Insomnia, and Delusional Disorders. Review of Resident #30's comprehensive care plan dated 4/13/2021, showed .elopement risk/wanderer AEB [as evidenced by] History of attempts to leave facility unattended .she becomes aggressive/combative with other residents at times, she goes in and out of residents rooms, needs frequent redirection .Distract her from wandering by offering pleasant diversions, structured activities, food, conversation, television, book . Document wandering behavior and attempted diversional interventions in behavior log . Review of Resident #30's Plan of Care Progress Note dated 4/14/2021, showed .Patient has been going in and out of other resident rooms .difficult to get vital signs .redirection . Review of Resident #30's admission Minimum Data Set (MDS) dated [DATE], showed the resident had severe cognitive impairment and had wandered 1-3 days during the assessment period. Resident #30 required supervision to walk in the room and hallways with no use of mobility devices. Review of Resident #30's care plan showed an update on 4/21/2021, .Requires assistance to participate in activities .we will continue to invite to activities & [and] 1'1 [one on one activities] as needed . The care plan had no individualized interventions for behaviors. Review of Resident #30's Physician Notification Progress Note dated 5/3/2021 at 5:16 PM, showed .Staff reported to this nurse a Resident to resident altercation. This Resident is [Resident #30], who was hitting [Resident #65] on the head and pulling her wheelchair back, [Resident #65] was screaming for Help . Review of Resident #30's Behavior Note/Anxiety Progress Note dated 5/5/2021, showed .Resident wandering through out facility this shift. Entering resident's room and nurse's station. Becomes agitated with redirection . Further review revealed no documentation of staff inventions to address the wandering behaviors. Review of Resident #30's Behavior Note/Anxiety Progress Note dated 5/20/2021, showed .Resident wanders the halls. Resident frequently goes into other Resident's rooms and takes belonging, drinks, food, etc. Resident had been involved in a couple of verbal arguments with other residents . Further review revealed staff had provided redirection out of the room and there was no documentation of staff inventions to address the wandering behaviors. Review of Resident #30's Social Service Progress Note dated 5/20/2021, showed .Resident exhibiting inappropriate behaviors .Discussed in team meeting this a.m. called and left a message with psych [psychiatric] NP [Nurse Practitioner] to assess for any needed medications . Further review revealed no documentation of staff inventions to address the wandering behaviors. Review of Resident #30's Social Service Progress Note dated 6/8/2021, showed .Resident displaying inappropriate behaviors, shopping in rooms, grabbing things out of residents hands, hard to redirect . Contacted psych NP to assess for any medication changes . Further review revealed no documentation of any non-pharmacological interventions attempted to distract the resident. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #30's Behavior Note/Anxiety Progress Note dated 6/20/2021, showed .Resident continues to wander this shift. Resident wandering into other resident rooms and causing distress to other residents. Attempts to redirect are unsuccessful. Further review revealed no documentation of staff inventions to address the wandering behaviors. Medical record review showed Resident #65 was admitted to the facility on [DATE] with diagnoses including Bipolar Disorder, Dementia Without Behavioral Disturbance, Anxiety Disorder, and Insomnia. Review of Resident #65's comprehensive care plan dated 11/20/2020, showed .behavior problem .has attention seeking behaviors as evidenced by often becoming tearful for no particular reason .states she has a 'hole in her head' .intervene as necessary to protect the rights and safety of others .Divert Attention. Remove from situation and take to alternate location as needed . Further review showed no documentation of interventions to address crying and tearful behaviors. Review of Resident #65's quarterly MDS dated [DATE], showed the resident had moderately impaired cognitive status, the resident was independent for locomotion on the unit, and used a wheelchair for mobility. No behaviors were documented, and no wandering was documented. Review of Resident #65's Physician's Notification Progress Note dated 5/3/2021, showed .Resident to Resident altercation. This is [Resident #65] sitting in wheelchair while resident [Resident #30] was pushing wheelchair back and hitting [Resident #65] on top of head . Review of Resident #65's Psychotherapy Progress Note dated 5/6/2021, showed .The patient was quite distressed. She was hit recently by another patient and her room was moved. The patient approached the clinician stating she was distressed, and she asked if she could be sent to a psychiatric unit .the patient stating she is having hallucinations was significant this time, and having them directly after a significant stressor (being attacked by another patient) is highly consistent with the literature on psychosis, as opposed to a manipulative quality. The patient was crying, and insistent on being considered for evaluation outside of the facility. The clinician discussed this with the staff, who stated that they would send her in the morning . Review of Resident #65's medical record showed she was sent to the hospital for psychiatric evaluation on 5/7/2021 and returned to the facility on [DATE]. Observation on 7/6/2021 at 12:15 PM, showed Resident #30 entered room [ROOM NUMBER]. A Certified Nursing Assistant (CNA) was in the room setting up a lunch tray and redirected the resident out of the room. No other intervention to address Resident #30's wandering was attempted. Observation on 7/6/2021 at 2:46 PM, showed Resident #30 entering room [ROOM NUMBER] while a CNA was in the room. The CNA redirected the resident to exit the room and no other intervention to address Resident #30's wandering was attempted. During an interview on 7/6/2021 at 2:55 PM, CNA #1 stated Resident #30 did wander frequently and did wander into other residents' rooms. She stated Resident #30 would take other residents' water pitchers. CNA #1 stated .there's not much we can do . CNA #1 stated she did not attempt any diversional activities or other interventions to address Resident #30's wandering. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Observation on 7/6/2021 at 2:59 PM, showed Resident #30 wandering in the 400 hallway. She attempted to open the door to room [ROOM NUMBER] but did not go in. She then went to the 100 hallway and attempted to open the double doors into the hallway which is under construction. There was a cart blocking the door and she was unable to get onto the 100 hallway. She then wandered to the nurse's station, walked past a nurse seated at the nurse's station, opened the door to the Unit Secretary's office, and entered the office. She picked up a notebook from the Unit Secretary's desk, walked past the nurse seated at the nurse's station, and went down the 300 hallway. A staff member walked up to Resident #30 and took the notebook from her. No other intervention to address Resident #30's wandering was attempted. During an interview on 7/7/2021 at 2:07 PM, the Director of Social Services (DSS) stated Resident #30 had been in a resident-to-resident altercation with Resident #65. She stated Resident #30 used to work in a nursing facility and that Resident #65 had .psych issues . and .doesn't like to be touched . She stated after the altercation between Resident #30 and Resident #65, .became fearful .crying . The DSS stated Resident #30 goes in and out of resident rooms and .that's a problem .we pretty much let her wander and redirect her . She further stated the interventions staff took to prevent Resident #30's wandering behavior was .redirecting and put stop signs on some residents' rooms that she has a fondness to go into .the residents that complain . Further interview confirmed she was unaware of any other behavioral interventions, other than medication and redirection, to prevent Resident #30 from wandering into other residents' rooms. Medical record review showed Resident #45 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Muscle Wasting, Chronic Obstructive Pulmonary Disease, Difficulty Walking, Presence of a Cardiac Pacemaker, Personal History of Other Mental and Behavioral Disorders, Bipolar Disorder, Syncope and Collapse, General Anxiety Disorder, Wheezing, and Dependence on Supplemental Oxygen. Review of Resident #45's comprehensive care plan dated 3/23/2021, showed Resident #45 had a potential for impaired cognitive function related to confusion with an update on 7/9/2021 for .stop sign to doorway to prevent other residents from entering resident's room- Monitor Stop Sign every 15 minutes for placement . Review of Resident #45's 5-day MDS dated [DATE], showed the resident had moderate cognitive impairment, no behaviors noted, she was total dependence for bed mobility and transfers, did not walk, used a wheelchair for mobility, and used oxygen daily. Review of Resident #45's Physician Progress Note dated 7/8/2021, showed .Resident [Resident #30] supervised the patient [Resident #45] while she was lying on her left resting .Resident [Resident #30] placed her right hand on the left side of the patient's [Resident #45] neck and held it .The patient [Resident #45] stated she turned and tried to push the arm [Resident #30's arm] away but it was very stiff .Ultimately she got the hand removed .Event was unprovoked . (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a telephone interview on 7/8/2021 at 7:41 AM, Licensed Practical Nurse (LPN) #1 stated Resident #30 would wander frequently, and would wander into other resident's rooms. Resident #30's wandering .gets them [other residents] upset . The LPN stated at times Resident #30 would enter other resident rooms and the other residents would scream at her to get out. The LPN confirmed Resident #30 would pick up other resident's belongings from their rooms such as socks, toothbrushes, and decorations. LPN #1 stated when the staff hear the residents screaming, they go redirect her, but she is not easily redirectable. The LPN stated Resident #30 would often remove the stop signs placed on other residents' rooms and they would . disappear .we don't realize they are gone .we may find them on another hall or another nurses station . LPN #1 stated staff were unable to watch wandering residents at all times. During an interview on 7/8/2021 at 8:27 AM, LPN #2 confirmed Resident #30 had wandered into other residents' rooms, the staff try to redirect her and use stop signs on the doors of some residents, but she was unsure which residents were supposed to have stop signs. LPN #2 was not aware of any diversional activities to offer Resident #30 when she was wandering into other residents' rooms. During an interview on 7/8/2021 at 8:39 AM, Registered Nurse (RN) #1 stated Resident #30 would wander into other residents' rooms and would take things. RN #1 confirmed it was often difficult and required multiple attempts to redirect Resident #30, and she was unaware of any other interventions to prevent Resident #30 from wandering into other residents' rooms. During an interview on 7/8/2021 at 8:46 AM, the DSS confirmed the facility .would divert the resident as best they could .with demented patients [wandering] would occur . The DSS stated the stop signs on some resident doors had been attempted, but had been taken down, and they were effective at times. The DSS was unaware of which residents required stop signs and was unaware of how to obtain that information. She stated stop sign placement was determined when a resident had made a complaint about a wandering resident. During an interview on 7/8/2021 at 9:23 AM, LPN #3 stated Resident #30 would wander in and out of other residents' rooms, would take items from the other residents' rooms, and would drink everybody's drinks. LPN #3 stated the facility had placed stop signs on some of the resident's doors but Resident #30 would take them down and carry them around. LPN #3 stated Resident #30 is redirectable most of the time. She was unaware of any other interventions to prevent Resident #30 from wandering, including diversional activities. During an interview on 7/8/2021 at 9:32 AM, RN #2 confirmed Resident #30 would wander into other residents' rooms. RN #2 stated the facility had put stop signs up for the rooms .we find may be an issue . but she was not sure which residents were supposed to have stop signs on their doors. RN #2 stated the staff monitor Resident #30, and try to redirect, but was unaware of any other interventions to prevent Resident #30 from wandering, including diversional activities. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 7/8/2021 at 10:21 AM, CNA #2 stated that she had been at the nurse's station on 5/3/2021. Resident #30 was walking near Resident #65. Resident #65 did not want Resident #30 near her, and they had started to argue. CNA #2 then went to do .something . down the hallway without intervening. When she returned to the nurse's station, she was told Resident #30 had hit Resident #65. CNA #2 stated Resident #30 would wander into other residents' rooms and some residents did complain. CNA #2 stated Resident #65 had complained that Resident #30 would go into her room and go through her stuff. CNA #2 stated Resident #30 would wander into other residents' rooms and some residents did complain. CNA #2 stated there .really wasn't anything we could do . CNA #2 stated the staff would redirect the resident but was not aware of any other interventions, including diversional activities, to prevent wandering. During an interview on 7/8/2021 at 10:33 AM, CNA #3 stated Resident #30 would wander into other residents' rooms. CNA #3 stated she would provide redirection but no other interventions, including diversional activities, were used to prevent wandering. During a telephone interview on 7/8/2021 at 12:47 PM, RN #3 stated Resident #30 would wander .nonstop . into any room that was not locked, in and out of other residents' rooms, and would move/take other residents' belongings. RN #3 had witnessed Resident #30 remove a stop sign from a resident's door and had tried to explain to Resident #30 that she could not enter those rooms, but she was unable to understand. RN #3 was unsure which residents wanted a stop sign on their door and stated the information was passed on in shift report but not documented in the chart. RN #3 had reported Resident #30's wandering behavior to the Assistant Director of Nursing (ADON) and had been instructed to document the behaviors in the resident's chart, but no other interventions were utilized by staff. During an interview on 7/8/2021 at 1:31 PM, the ADON stated the facility had provided close monitoring of Resident #30, but she had the right to wander because the facility was her home. The ADON stated Resident #30's wandering had been discussed in IDT meetings. The ADON stated she had suggested Resident #30 may need placement in a locked unit, but the IDT had stated the facility was able to meet the resident's needs. During an interview on 7/9/2021 at 9:09 AM, the Activity Director stated she had not had a conversation with Resident #30's family to obtain her likes or interests, and the resident could not answer questions for the activity assessment. She stated .I went by what people told me to put down . The Activity Director stated she was aware of the resident's past occupation of working in a health care facility, then confirmed she had not taken that information into consideration when developing the resident's activity care plan. The Activity Director confirmed she was not aware of what person-centered care planning meant and was not aware that a care plan needed to be individualized to the resident's likes and interests. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 7/9/2021 at 10:10 AM, the MDS Coordinator stated Resident #30 had behaviors and had been seen grabbing stuffed animals from other residents and being aggressive. The MDS Coordinator was aware of the resident-to-resident abuse when Resident #30 hit Resident #65. She confirmed Resident #30 had gotten physically aggressive with residents. She stated Resident #30's wandering had been discussed with Administration, IDT (interdisciplinary team) team meetings, as well as in morning meetings. The MDS Coordinator stated after Resident #30 hit Resident #65, some members of the IDT had suggested Resident #30 needed one on one supervision, but Nursing Administration did not approve this. She confirmed Resident #30 had diversional activities listed on the care plan but was unsure how the facility had determined those activities and unsure of the effectiveness of the diversional activities. She stated she thought staff just get to know the residents and know what diversional activities she needs. She confirmed she had not had a conversation with the resident's family to obtain her likes or dislikes. She confirmed the facility had not developed diversional activities or interventions for behaviors for Resident #30. During an interview on 7/9/2021 at 12:51 PM, The DSS stated she had not developed any interventions for Resident #30's behaviors, including her wandering. She further stated she thought the MDS Coordinator had been adding behavioral interventions. She stated she had been aware of Resident #30 wandering into other residents' rooms from discussions in the facility's morning meetings. She stated Resident #30 needed interventions of redirection and medications for her behaviors .we can't tie her down .you can't restrict her in any manner . She stated Resident #30 had a wander guard (device used to alert staff when a resident is attempting to exit a door) placed on admission, but she had not assessed the resident for her wandering behaviors. She further stated Resident #30 had not been easily redirectable and had been more irritated lately. She stated she had not used the resident's past occupation to determine individualized interventions. She further stated Resident #65 had behaviors .she is tearful a lot .she has a history of abuse . She confirmed Resident #65 had a history of abuse and believed she had a hole in her head, making her more susceptible to a negative outcome from someone hitting her in the head, as occurred with Resident #30 on 5/3/2021. The DSS confirmed she was not aware of any intervention the staff had taken to address Resident #65's crying and tearful behaviors. During an interview on 7/9/2021 at 2:19 PM, the Medical Director stated that Resident #30 would wander into residents' rooms and take things. He confirmed the diversional activities the facility had attempted were not successful. He stated the resident-to-resident altercation that occurred between Resident #30 and Resident #65 .really set off [Resident #65's] anxiety .caused a significant amount of anxiety . He further confirmed the incident had caused Resident #65 to have psychosocial harm and there was a continued risk to other residents due to Resident #30's continued wandering. During an interview on 7/9/2021 at 3:20 PM, the Assistant Director of Nursing (ADON) confirmed Resident #30 exhibited aimless wandering. She stated the interventions used to prevent the wandering had been, close monitoring, a wander guard, psychological services, and activities. She confirmed Resident #30 needed closer monitoring and would not participate in activities. The ADON further confirmed the interventions the staff implemented had not been individualized and had been ineffective and Resident #30 had continued to wander into other resident's rooms. Refer to F-600, F-744 (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received 7/12/2021 at 8:40 AM, and the corrective actions were validated on-site by the surveyors on 7/12/2021 - 7/13/2021 through review of documents, review of facility policies, and staff interviews. The Removal Plan presented to the survey team by the facility documented the following immediate corrective actions implemented. On 7/10/2021 the Regional Director of Operations provided training to the Administrator, Assistant Director of Nursing, Nursing Educator, Unit Manager, MDS Coordinator, Medical Records, Social Services, Director of Rehab, Dietary, Admissions Liaison, and Human Resources. The training included: 1. the Abuse policy 2. types and reporting and investigating and prevention 3. process of identifying, preventing, and reporting abuse 4. how to recognize a potential behavior that is escalating, and to intervene 5. who is the Abuse Coordinator 6. suspected or observed abuse, all types, reported to the Administrator immediately All staff not working on 7/10/2021 were called and in-serviced. All residents with a diagnosis of Dementia/behaviors had their care plan reviewed and revised to reflect resident specific behavioral interventions. Interviewable residents were interviewed by the Social Service Director on any concerns related to abuse. Residents that were not interviewed had a skin assessment completed by the ADON and Unit Manager on 7/10/2021. The Regional Director of Clinical services reviewed the last 72 hours of nursing notes to identify any issues that needed to be investigated as an allegation with no issues identified. On 7/10/2021 the Nurse Educator, Director of Rehab, and Human Resources educated staff. The training included: 1. how to recognize potential behavior that is escalating and to intervene 2. who the abuse coordinator is- the Administrator 3. suspected or observed abuse 4. all types reported to the Administrator immediately All staff not working on 7/10/2021 were called and in-serviced. On 7/11/2021 all staff started competency tests on Hand-in-Hand Dementia module part 1 & 2, abuse prevention, reporting, and investigating test. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Audits will be conducted by the Administrator and Director of Nursing (DON) of nursing notes for the past 24 hours to identify any potential reportable events. These audits will be performed 5 times per week for 4 weeks, 3 times per week for 4 weeks, and 2 times per week for 4 weeks. Five random residents will be interviewed daily to ensure no resident to resident and no incidents of other residents wandering into their rooms by Social Services. A Licensed Nurse will do 5 skin sweeps 5 times per week for 4 weeks, 3 times per week for 4 weeks, and 2 times per week for 4 weeks on residents who are not interviewable. The Regional Director of Clinical Services will monitor nursing notes written in the past 24 hours to identify any areas that potentially could be a reportable event 5 times per week for 4 weeks, 3 times per week for 4 weeks, and 2 times per week for 4 weeks. The Nurse Educator will track the interviews and skin sweeps, a reportable event log will be maintained in the Administrators office. Residents with behaviors/Dementia care plans were reviewed and updated on 7/10/2021 by the MDS Nurse and Social Services to reflect resident specific interventions for behaviors. Nursing staff were interviewed by the ADON and the Unit Manager to identify any new behaviors observed and/or exacerbations on 7/10/2021, no issues were identified. The Regional Director of Nursing reviewed the past 72 hours of nursing documentation for new and/or exacerbations of behaviors on 7/10/2021, no issues identified. On 7/10/2021 the Regional Director of Nursing Services re-inserviced the ADON, Unit Manager, Social Services, MDS Coordinator, and Activities Director on behavioral management policy including: 1.Making resident care plans specific to their behaviors with interventions 2. how to recognize potential behaviors that is escalating and to intervene On 7/10/2021 the Regional Director of Clinical Services re-inserviced the Administrator, ADON, Nursing Educator, Unit Manager, MDS Coordinator, Medical Records, Social Services, Director of Rehab, Dietary, Admission Liaison, and Human Resources on behavior management including : how to recognize a potential behavior that is escalating and to intervene All staff not present on 7/10/2021 were called and in-serviced by the Nurse Educator. No employee will work prior to being trained. Future employees will be educated on hire regarding behavioral management and care plan revisions as it relates to resident specific interventions and including how to recognize a potential behavior that is escalating and to intervene. Audits will be performed by the DON / designee of progress notes to identify any potential new or exacerbations of behaviors 5 times per week for 4 weeks, 3 times per week for 4 weeks, and 2 times per week for 4 weeks. The Nurse Educator will perform behavior management training monthly for 6 months using Hand-in-Hand. The Kardex's will be printed from Point Click Care and updated to reflect the behavioral interventions that are resident specific, on 7/11/2021 by the ADON and Unit manager. The Regional Director of Clinical Services will monitor nursing notes written in the past 24 hours to identify any areas that potentially could be exacerbated behaviors 5 times per week for 4 weeks, 3 times per week for 4 weeks, and 2 times per week for 4 weeks. Changes to a behavior care plan or development by the IDT team will be reviewed by the Administrator to ensure it is resident specific as updates occur. The comprehensive care plan development is overseen by the MDS Coordinator with input from Social Services, Activities, Dietary, and Rehab. Revisions to the behavioral care plan is the responsibility of the Social Services. Nursing Care plan updates are the responsibility of Licensed Nurses, Unit Manager, ADON, and the DON. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The QAPI committee will meet weekly to analyze all events that may require investigation and reporting. Weekly updates will be provided by responsible members on the progress of each citation. The Regional Director of Nursing and /or the Regional [NAME] President of Operations will attend QAPI meetings in person or by phone. This will include input and review of data collected for the meeting. The Regional Director of Nursing and/or Regional [NAME] President of Operations will do facility visits to monitor compliance at a minimum weekly until substantial compliance is achieved and maintained. On 7/12/2021, Surveyors reviewed abuse policy, behavioral management policy, person-centered care plan policy. The Surveyors reviewed the education and sign in sheets which validated the corrective action plans onsite which was provided by the Administrator. The documentation showed all staff working on 7/12/2021 and 7/13/2021 had been provided the education on abuse, types of abuse, preventing, protecting, recognizing/identifying abuse/behaviors, reporting, and investigating abuse. The administrator was educated on abuse by the corporate nurse. Residents affected by the wandering residents were assessed and interviewed to determine if psychosocial harm had occurred. Twenty-two resident records were reviewed randomly to ensure care plans had been updated and Dementia care had been added to those with Dementia and behaviors. The records had been updated to include interventions on the 22 resident records reviewed. The surveyors validated all staff working on 7/12/2021 - 7/13/2021 had been educated and were knowledgeable about the new procedures related to abuse/behavior, Dementia Care, and person-centered care planning. On 7/12/2021, Surveyors validated the corrective actions onsite through interviews with the Administrator, DON, Nurse Educator, MDS Coordinator, Social Service Director, 4 RNs, 2 LPN's, 8 CNA's, 2 nurse aides in training, 2 therapists and 2 housekeepers. The interviews showed the staff were educated on how to prevent abuse, what to do when abuse occurs, reporting of abuse, investigating abuse, documentation and implementing person centered care plans for each resident with Dementia and behaviors. Staff verbalized knowledge of development of care plans for Dementia and behaviors and how to assess residents to determine person centered needs/interventions. The MDS Coordinator was provided education on person-centered care plans to address behaviors and how to update the care plans. The DSS had received education on behavioral interventions and updating the care plan for behavioral management interventions individualized to each resident. The Activity Director was educated on person centered care planning and updating the care plans with person centered interventions. Noncompliance at F-741 continues at a scope and severity of F for monitoring of the effectiveness of the corrective actions to ensure sustained compliance. The facility is required to submit a plan of correction. <b [TRUNCATED]

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41725 Based on facility policy review, medical record review, observation, and interview, the facility failed to develop and implement individualized care plan interventions to include and support each resident's Dementia care needs for 5 residents (Residents #30, #65, #41, #43, and #46) of 7 residents reviewed for Dementia care. The facility's failure to develop, implement and maintain individualized care plans for Dementia care needs resulted in a resident to resident altercation between Resident #30 and Resident #65 with Resident #30 hitting Resident #65 in the head resulting in psychosocial harm for Resident #65. Resident #30's continued wandering led to Resident #30 entering Resident #45's room, attempting to choke her, and stating she would kill her. The facility's failure to develop, implement and maintain an individualized, resident-centered care plan for Residents' #30, #65, #41, #43, and #46 placed Residents #30, #65, and #45 in Immediate Jeopardy (a situation in which the provider's non-compliance with one or more requirements for participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident) and had the potential to effect all residents with dementia care needs. The Administrator was informed of the Immediate Jeopardy (IJ) in the conference room on 7/10/2021 at 12:50 PM. The facility was cited F-744 at a scope and severity of L which constitutes Substandard Quality of Care. The Immediate Jeopardy was removed onsite 7/12/2021 and was effective 5/3/2021-7/11/2021. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 7/12/2021 at 8:40 AM and the corrective actions were validated onsite by the surveyors on 7/12/2021 and 7/13/2021. The findings include: Review of the facility policy titled, Dementia - Clinical Protocol, dated 11/2018, showed .For the individual with confirmed dementia, the IDT [Interdisciplinary Team] will identify a resident-centered care plan to maximize remaining function and quality of life .The IDT will adjust interventions and the overall plan depending on the individual's responses to those interventions, progression of dementia, development of new acute medical conditions or complications . Review of the facility's policy titled, Resident Centered Care Planning, dated 3/2019, showed .It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident .to meet a resident's medical, nursing, and mental and psychosocial needs .'Person-centered care' means to focus on the resident as the locus of control .The care planning process will include an assessment of the resident's strengths and needs .The comprehensive care plan will describe .services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .The comprehensive care plan will be prepared by an interdisciplinary team that includes, but is not limited to . attending physician .registered nurse with responsibility for the resident .nurse aide with responsibility for the resident .The resident and the resident's representative . (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the facility's policy titled, Behavior Management, dated 9/2019, revealed .the facility must have . staff who provide direct services to residents with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident determined by resident assessments and individual plans of care .Implementing non-pharmacological interventions .Planning and implementing appropriate interventions into the resident's plan of care and Evaluating the effectiveness of Pharmacological and non-pharmacological interventions .Providing meaningful activities which promote engagement and positive meaningful relationships between resident and staff, families, other residents and the community. Meaningful activities are those that address the resident's customary routines, interests, preferences, etc .and enhance the resident's well- being .Purpose to implement the most desirable and effective interventions that meet . needs of the residents, to change, modify, decrease or eliminate behaviors that are distressing to the resident and/or are decreasing or impacting on the resident's quality of life . Medical record review showed Resident #30 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Dementia with Behavioral Disturbance, Anxiety Disorder, Major Depressive Disorder, Insomnia, and Delusional Disorders. Review of Resident #30's comprehensive care plan dated 4/13/2021 showed, .elopement risk/wanderer AEB [as evidenced by] History of attempts to leave facility unattended .she becomes aggressive/combative with other residents at times, she goes in and out of residents rooms, needs frequent redirection .Distract her from wandering by offering pleasant diversions, structured activities, food, conversation, television, book . Monitor location every shift. Document wandering behavior and attempted diversional interventions in behavior log . Review of Resident #30's Activity assessment dated [DATE], showed the resident had been interviewed to determine her interests. The review showed .Attention span .easily distracted . and it was not very important for the resident to have books, music, go outside, do things with groups of people, or attend religious services. The section titled, Previous Leisure Areas of Interest was not answered. The resident's activity goals were to .attend 1 out of room leisure activity 3-5 x's [times] per week for 3 months . Further review showed there was no documentation of her previous leisure areas of interest being assessed and there was no family involvement in completing the assessment. Review of Resident #30's Plan of Care Progress Note dated 4/14/2021, showed .going in and out of other resident rooms . and was difficult to redirect. Review of Resident #30's Respiratory Evaluation Progress Note dated 4/15/2021, showed Resident #30 was .experiencing unwanted behavior(s) .Chronic disruptive behavior noted. Chronic wandering behavior noted . Further review showed Resident #30 would wander at night. Review of Resident #30's admission Minimum Data Set (MDS) dated [DATE], showed the resident had severe cognitive impairment and had wandered 1-3 days during the assessment period. Her preferences for customary routine and activities showed having snacks between meals was very important and having pets was somewhat important to her. Books, music, going outside, and religious services were not important to her. Resident #30 required supervision to walk in the room and hallways with no use of mobility devices. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #30's comprehensive care plan showed an update on 4/21/2021, .Requires assistance to participate in activities .we will continue to invite to activities & [and] 1'1 [one on one activities] as needed . The care plan did not include individualized, person-centered interventions to address the resident's dementia-related behaviors. Review of Resident #30's QAPI/Risk Meeting Progress Note dated 5/3/2021 at 1:52 PM, showed the resident remained a wandering risk with behaviors present, and staff were to provide close monitoring. The IDT (Interdisciplinary Team) would continue to monitor the interventions for .effective/appropriateness and intervene accordingly . Review of Resident #30's Physician Notification Progress Note dated 5/3/2021 at 5:16 PM, showed a resident to resident altercation between Resident #30 and Resident #65 had occurred. Resident #30 was hitting Resident #65 on the head and pulling her wheelchair back as Resident #65 was screaming for help. Review of Resident #30's Behavior Note dated 5/4/2021, showed .Resident to Resident occurred on 05.03. 21 @ [at] 1659 [4:59 PM] .Monitor resident's location and activity q [every] 15 minutes and document x [for] 72 hours. Maintain personal space of comfort for other residents x 72 hours and then re-evaluate . Review of Resident #30's medical record showed no documentation the resident's location and activity had been monitored every 15 minutes for the dates of 5/4/2021-5/7/2021. Further review showed the resident's behaviors had not been documented every shift. Review of Resident #30's Risk Meeting Progress Note dated 5/4/2021, showed the IDT team would continue to monitor for effective/appropriateness of interventions .and intervene accordingly. IDT met, reviewed, discussed, and in agreement . Review revealed no individualized behavior interventions were implemented after the resident to resident abuse on 5/3/2021. Review of Resident #30's Psychiatric Evaluation dated 5/4/2021, showed .Evaluating mood and behaviors-patient having increased agitation, restlessness, aggression .Patient having increased psychosis and delusions, reasonable to add Seroquel [an anti-psychotic medication] to target symptoms .Agitation: Physical aggression .Combativeness .Severe restlessness .Recommendations: seroquel 25 mg [milligrams] bid [twice daily] delusions . Further review showed no non-pharmacological behavioral interventions were recommended. Review of Resident #30's Behavior Note/Anxiety Progress Note dated 5/5/2021, showed .Resident wandering through out facility .Entering resident's room and nurses station. Becomes agitated with redirection . Review of Resident #30's Psychological Diagnostic Interview dated 5/6/2021, showed .Patient was shut down .appeared angry .walked directly into another patient's room after leaving this area .THIS PATIENT IS NOT A CANDIDATE FOR PSYCHOTHERAPY . Review of Resident #30's Behavior Note/Anxiety Progress Note dated 5/20/2021, showed .Resident frequently walks throughout the building .She tells other residents what to do. She shakes her head and gets upset when things don't go her way . Further review showed the Psychiatric NP would be notified due to increased behaviors. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #30's Behavior Note/Anxiety Progress Note dated 5/20/2021, showed Resident #30 frequently wandered into other resident's rooms and would take their belongings. Further review showed . Resident has been involved in a couple of verbal arguments with other residents . Review of Resident #30's Social Service Progress Note dated 5/20/2021, showed .Resident exhibiting inappropriate behaviors . Further review showed the Psychiatric NP would assess the resident for needed medications. There was no documentation of any non-pharmacological behavioral interventions attempted. Review of Resident #30's Behavior Note/Anxiety Progress Note dated 5/21/2021, showed .entering other Residents rooms taking items, food, etc. that doesn't belong to her. Resident tried to take a drink away from another Resident because she thought it was hers . Review of Resident #30's Behavior Note/Anxiety Progress Note dated 6/4/2021, showed Resident #30 continued to wander .is increasingly more intrusive into other Resident rooms. Resident enters every room and takes items and hides them. Resident upsets other Residents with her actions. Resident also pushes other Residents in their wheelchair around the halls . Review of Resident #30's Social Service Progress Note dated 6/8/2021, showed Resident #30 was . displaying inappropriate behaviors, shopping in rooms, grabbing things out of residents hands . Continued review showed Resident #30 was hard to redirect and the Psychiatric NP would be notified to assess for medication changes. There was no documentation of any new non-pharmacological behavioral interventions to be attempted. Review of Resident #30's Behavior Note/Anxiety Progress Note dated 6/20/2021, showed the resident was . wandering into other resident rooms, causing distress to other residents . Resident was attempting to push other residents in their wheelchair and taking things from nurse's station and other residents. Staff were unable to redirect the resident. Documentation showed the Plan of Care would be continued. Review of Resident #30's Behavior Note/Anxiety Progress Note dated 6/30/2021, showed Resident #30 was wandering into other residents' rooms, causing distress to other residents. Resident was also taking things from nurse's station, and other residents. Attempts to redirect Resident #30 were unsuccessful. Review of Resident #30's Behavioral Note/Anxiety Progress Note dated 7/5/2021, showed the resident was wandering into other resident rooms causing distress to other residents. Resident #30 was taking things from the nurse's station, med carts, and other residents' rooms. Further review showed, .PRN's [as needed medications] unsuccessful. Attempts to redirect are unsuccessful . (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the facility's video surveillance footage dated 7/8/2021 from the 300 hallway, reviewed on 7/13/2021 at 1:49 PM, with the Administrator and the Plant Operations Manager present. The video showed Resident #30 at the end of the 300 hallway at 5:46:14 AM, she went to the linen cart at 5:47:24 AM. CNA #4 exited the shower room with another resident at 5:47:44 AM. Resident #30 walked past the other resident in the hallway, who just came out of the shower room, and CNA #4 walked toward the nurses station away from the resident. Resident #30 stood by the shower room for several seconds then entered room [ROOM NUMBER] at 5:48:00 AM, and came back out of room [ROOM NUMBER] at 5:48:27 AM. Resident #30 then entered Resident #45's room at 5:48:31 AM. CNA #4 exited another resident's room at 5:48:42 AM. Resident #30 exited Resident #45's room at 5:49:05 AM. Resident #30 then entered another resident's room at 5:49:41 AM. Medical record review showed Resident #65 was admitted to the facility on [DATE] with diagnoses including Bipolar Disorder, Dementia Without Behavioral Disturbance, Anxiety Disorder, and Insomnia. Review of Resident #65's comprehensive care plan dated 11/20/2020, showed the resident had attention seeking behaviors as evidenced by often becoming tearful for no particular reason. She would state she had a hole in her head. Interventions in place included, .intervene as necessary to protect the rights and safety of others .Divert Attention. Remove from situation and take to alternate location as needed . Further review showed no individualized, resident-centered care plan with individualized interventions for dementia care had been developed for Resident #65. Review of Resident #65's quarterly MDS dated [DATE], showed the resident had moderately impaired cognitive status, the resident was independent for locomotion on the unit, and used a wheelchair for mobility. No behaviors were documented, and no wandering was documented. Review of Resident #65's Physician's Notification Progress Note dated 5/3/2021, showed a resident to resident altercation had occurred between Resident #30 and Resident #65. Resident #65 was sitting in her wheelchair while Resident #30 was pushing the wheelchair back and hitting Resident #65 on top of the head. Review of Resident #65's Psychiatric Evaluation dated 5/4/2021, showed Resident #65 was evaluated for mood and behaviors after the resident to resident abuse on 5/3/2021. Following the incident, Resident #65 had .increased anxiety and delusions . Further review showed Resident #65's Valium (anxiety medication) was restarted for her increasing distress and Seroquel (antipsychotic medication) was increased to target her delusions. Further review revealed no non-pharmacological interventions were recommended. Review of Resident #65's Physician Progress Note dated 5/4/2021, showed the resident had been involved in a resident to resident altercation earlier in the week and had been very anxious since that time. The patient reported the other individual (Resident #30) .came up from behind her and grabbed and hit her right parietal [top of head] and temporal area [side of head] .The patient's been very anxious since that time .This incident unfortunately set off exacerbation of patient's underlying anxiety disorder . Further review showed she had become increasingly anxious and was avoiding individuals when moving about in her wheelchair. Review of Resident #65's Medication Administration Progress Note dated 5/4/2021, showed .Resident in hall crying, repeatedly saying 'I'm not going up there' referring to her room . Further review showed Resident #65 was administered an as needed (PRN) dose of Valium. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #65's Behavior Note/Anxiety Progress Note dated 5/5/2021, showed Resident #65 continued to not want to go into her room after the resident to resident abuse .crying, stating 'I'm not going up there' pointing towards room. 'I'm scared'. Resident reassured, but still expressed some concern . Further review showed Resident #65 required a PRN dose of Valium to be administered and was transferred to another room for the night. Review of Resident #65's Psychotherapy Progress Note dated 5/6/2021, showed the resident was hit recently by another patient and thereafter relocated to a different room. The patient informed the clinician she was distressed and requested to be sent out to a psychiatric unit. Resident #65 stated she was having hallucinations. The clinician documented .having them [hallucinations] directly after a significant stressor (being attacked by another patient) is highly consistent with the literature on psychosis, as opposed to a manipulative quality . Further review showed Resident #65 was crying, and insistent on being considered for evaluation outside of the facility. Review of Resident #65's medical record showed she was sent to the hospital for psychiatric evaluation on 5/7/2021 and returned to the facility on [DATE]. There was no individualized Dementia or behavioral plan developed after the resident's return from the hospital. Observation on 7/6/2021 at 12:15 PM, showed Resident #30 entered room [ROOM NUMBER]. A Certified Nursing Assistant (CNA) was in the room setting up a lunch tray and redirected the resident out of the room. No diversional activity was offered. Observation on 7/6/2021 at 2:46 PM, showed Resident #30 entering room [ROOM NUMBER] while a CNA was in the room. The CNA redirected the resident to exit the room with no diversional activity offered. During an interview on 7/6/2021 at 2:55 PM, CNA #1 stated Resident #30 did wander frequently and did go into other resident's rooms. She stated Resident #30 would take other residents' water pitchers. CNA #1 stated redirection was provided, and .there's not much we can do .I have suggested putting up stop signs on the doors but we would have to put them on every door because you never know which room she will go in . CNA #1 was unaware of any diversional activities that Resident #30 was to be offered. Observation on 7/6/2021 at 2:59 PM, showed Resident #30 wandering in the 400 hallway. She attempted to open the door to room [ROOM NUMBER] but did not go in. She then went to the 100 hallway and attempted to open the double doors. She then wandered to the nurse's station, walked past a nurse seated at the nurse's station, opened the door to the Unit Secretary's office, and entered the office. She picked up a notebook from the Unit Secretary's desk, walked past the nurse seated at the nurse's station, and went down the 300 hallway. A staff member walked up to Resident #30 and took the notebook from her. No diversional activity was offered. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 7/7/2021 at 2:07 PM, the Director of Social Services (DSS) stated Resident #30 had been in a resident to resident altercation with Resident #65. She stated Resident #30 had been moved to a different room. She stated Resident #30 used to work in a nursing facility and that Resident #65 had .psych issues . and .doesn't like to be touched . She stated after the incident, Resident #65 .became fearful .crying . The DSS confirmed Resident #30 wandered into other residents' rooms and .that's a problem .there is only so much medication you can mess with . we pretty much let her wander and redirect her . She further stated the interventions the facility had in place to prevent Resident #30's wandering behavior was .redirecting and put stop signs on some residents' rooms that she has a fondness to go into .the residents that complain . During a telephone interview on 7/8/2021 at 7:41 AM, Licensed Practical Nurse (LPN) #1 stated Resident #30 would wander frequently, and would wander into other residents' rooms. Resident #30's wandering .gets them [other residents] upset . The LPN stated at times Resident #30 would enter other resident rooms and the other residents would scream at her to get out. The LPN confirmed Resident #30 would pick up other resident's belongings from their rooms such as socks, toothbrushes, and decorations. LPN #1 stated when the staff hear the residents screaming, they go redirect her but she is not easily redirectable. Resident #30 is sometimes .a little mouthy . and does not want to come out of other residents' rooms. The LPN stated Resident #30 would often remove the stop signs placed on other residents' rooms and they would .disappear .we don't realize they are gone .we may find them on another hall or another nurses station . LPN #1 stated Resident #30's wandering and the complaints by other residents about her wandering had been reported by letter to the DSS and verbally to the dayshift nurse. LPN #1 stated staff were unable to watch wandering residents at all times. LPN #1 stated no new behavioral interventions had been communicated by the facility in regard to Resident #30's continued wandering into other residents' rooms. Observation on 7/8/2021 at 7:45 AM, showed Resident #30 wandering on the 200 hallway, she entered another resident's room at the end of the 200 hallway, a staff member redirected her back into the hallway without any diversional activities offered. During an interview on 7/8/2021 at 8:27 AM, LPN #2 confirmed Resident #30 had hit Resident #65 on the head during a resident to resident altercation, which caused Resident #65 to be upset and tearful. Resident #30 had been moved to another hallway after the altercation, but continued to wander throughout the facility, in and out of other residents' rooms. LPN #2 confirmed the staff try to redirect Resident #30 and use stop signs on the doors of some residents, but she was unsure which residents were supposed to have them. LPN #2 was not aware of any diversional activities the staff were to offer Resident #30 when she wandered into other residents' rooms. Observation on 7/8/2021 at 8:30 AM, showed Resident #30 continued to wander on the 200 hallway. She entered another resident's room and a staff member redirected her back into the hallway without any diversional activities offered. During an interview on 7/8/2021 at 8:39 AM, RN #1 stated Resident #30 would wander into other residents' rooms and would take things. RN #1 confirmed it was often difficult and required multiple attempts to redirect Resident #30, and she was unaware of any other interventions the facility had implemented to prevent Resident #30 from wandering into other residents' rooms. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Observation on 7/8/2021 at 8:45 AM, showed Resident #30 wandering by the nurse's station and started down the 300 hallway carrying a folded tablecloth. A staff member took the tablecloth from her without offering any diversional activities. During an interview on 7/8/2021 at 8:46 AM, the DSS confirmed the facility .would divert the resident as best they could .with demented patients [wandering] would occur . The DSS stated the stop signs on some resident doors had been attempted but had been taken down and are effective at times. The DSS was unaware of which residents required stop signs and was unaware of how to obtain that information. She stated stop sign placement was determined when a resident had made a complaint about a wandering resident. During an interview on 7/8/2021 at 9:23 AM, LPN #3 stated Resident #30 would wander in and out of other residents' rooms, would take items from the other residents' rooms, and would drink everybody's drinks. LPN #3 stated the facility had placed stop signs on some of the residents' doors, but Resident #30 would take them down and carry them around. LPN #3 stated she had witnessed Resident #30 take the stop sign off other residents' doors. LPN #3 stated Resident #30 is redirectable .at times . but was unaware of any other interventions the facility had implemented to prevent Resident #30 from wandering, including diversional activities. During an interview on 7/8/2021 at 9:32 AM, RN #2 confirmed Resident #30 would wander into other residents' rooms. RN #2 stated the facility had put stop signs up for the rooms .we find may be an issue . but she was not sure which residents were supposed to have stop signs on their doors. RN #2 stated the staff monitor Resident #30 and try to redirect, but was unaware of any other interventions the facility had implemented to prevent Resident #30 from wandering, including diversional activities. During an interview on 7/8/2021 at 10:21 AM, CNA #2 stated Resident #30 would wander into other residents' rooms and some residents did complain. CNA #2 stated Resident #65 had complained that Resident #30 would go into her room and go through her stuff. CNA #2 stated she had reported the complaints to a nurse, there .really wasn't anything we could do . CNA #2 stated the staff would redirect the resident but was not made aware of any other interventions, including diversional activities, to prevent wandering. During an interview on 7/8/2021 at 10:33 AM, CNA #3 stated Resident #30 would wander into other residents' rooms and some residents had complained. CNA #3 stated she would provide redirection but was unaware of any other interventions, including diversional activities the staff were to use to prevent wandering. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a telephone interview on 7/8/2021 at 12:47 PM, RN #3 stated Resident #30 would wander .nonstop . into any room that was not locked, in and out of other residents' rooms, and would move/take other residents' belongings. RN #3 stated Resident #30 would get into the nurse's bags and once drank a nurse's drink. RN #3 stated the staff would look for other residents' belongings in her room and would sometimes find other residents' glasses, but most items she took were never located. RN #3 stated most residents were .not happy . with Resident #30 wandering into their rooms. RN #3 had witnessed Resident #30 remove a stop sign from a resident's door and had tried to explain to Resident #30 that she could not enter those rooms, but the resident was unable to understand. RN #3 was unsure which residents wanted a stop sign on their door and stated the information was passed on in shift report, but not documented in the chart. RN #3 had reported Resident #30's wandering behavior to the Assistant Director of Nursing (ADON) and had been instructed to document the behaviors in the resident's chart, but no further non-pharmacological behavioral interventions had been communicated. During an interview on 7/8/2021 at 1:31 PM, the ADON stated Resident #65 had been having behaviors on 5/3/2021 and had been going through the hallway .crying and screaming . She stated it had been reported to her that Resident #30 approached Resident #65 and .it was more of a tap . She further stated both residents were .very behavioral . The ADON stated the facility had provided close monitoring of Resident #30, but she had the right to wander because the facility was .her home . The ADON had been aware of another resident's complaint of Resident #30 wandering into her room. The ADON confirmed Resident #30's wandering behaviors had been discussed in the IDT meetings. The ADON confirmed Resident #30's medications were monitored by the Psychiatric NP and the facility staff monitor her wandering. No other interventions had been attempted. During an interview on 7/9/2021 at 12:51 PM, the DSS stated she had not developed any care plan interventions for Resident #30's behaviors, including her wandering. She further stated she thought the MDS Coordinator had been adding behavioral interventions into the care plans during the care plan meetings. She stated she had been aware of Resident #30 wandering into other residents' rooms from discussions in the facility's morning meetings. She stated Resident #30 needed interventions of redirection and medications for her behaviors .we can't tie her down .you can't restrict her in any manner . She was unaware of any other non-pharmacological behavioral interventions that had been developed for Resident #30's wandering behaviors. She stated Resident #30 had a wander guard (device used to alert staff when a resident is attempting to exit a door) placed on admission but she had not assessed the resident for her wandering behaviors. She further confirmed Resident #30 had not been easily redirectable and had been more irritated lately. She stated she had not incorporated the resident's past occupation in her care plan to determine individualized interventions. The DSS stated she believed she had been aware Resident #30 had been taking items from other residents. She stated she did feel the wandering into other residents' rooms and taking other residents' belongings did increase the susceptibility of Resident #30 to be involved in another resident to resident altercation. She further stated Resident #65 had behaviors .she is tearful a lot .she has a history of abuse . She stated Resident #65 believed she had a hole in her head and confirmed Resident #65's history of abuse and belief she had a hole in her head would have made her more susceptible to a negative outcome from someone hitting her in the head. The DSS confirmed she was not aware of any intervention the facility had taken to address Resident #65's behaviors. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 7/9/2021 at 1:40 PM, the Psychiatric NP stated she had evaluated Resident #30 and Resident #65 after the resident to resident altercation that occurred on 5/3/2021. She confirmed she had added an antipsychotic medication for Resident #30 after the incident for delusions. She confirmed Resident #65 had delusions about the incident and thought the woman (Resident #30) was out to get her and out to kill her. The Psychiatric NP confirmed the altercation triggered increased anxiety for Resident #65 which required medication changes and a hospitalization . She confirmed the altercation did cause Resident #65 some significant distress and psychosocial harm. The Psychiatric NP stated she would only provide medication recommendations to the facility and had not provided any recommendations of behavioral interventions. During an interview on 7/9/2021 at 2:19 PM, the Medical Director (MD) stated he was aware of Resident #30's wandering into other residents' rooms and stated .she has bumped into a few folks along the way . The MD stated that other residents had told him Resident #30 would wander into their rooms and would take things. He stated he had tried to encourage the other residents to not .take it personally . He confirmed the diversional activities the facility had attempted had been unsuccessful and a memory care unit might be more appropriate for Resident #30. The MD stated he had communicated informally with the facility staff, but he did not state if he made any recommendations to the facility to address the continued wandering. He stated the resident to resident altercation that occurred between Resident #30 and Resident #65 caused Resident #65 .a significant amount of anxiety . and caused Resident #65 to have psychosocial harm. The MD confirmed Resident #30's continued wandering did increase the risk of another resident to resident altercation. During an interview on 7/9/2021 at 3:20 PM, the ADON confirmed Resident #30 exhibited aimless wandering and was recently placed on one-on-one supervision. She confirmed [TRUNCATED]

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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** 40639 Based on review of facility policy, medical record review, and interview, the facility's Quality Assurance Performance Improvement (QAPI) program failed to identify a quality deficiency and implement interventions to address the root causes of a resident to resident altercation when Resident #30 hit Resident #65 in the head, which led to psychosocial harm to Resident #65.The facility's failure to investigate an instance of resident to resident abuse and to implement individualized, person-centered behavior interventions for Resident #30's continued wandering throughout the facility resulted in Resident #30 later entering Resident #45's room and placing her hands on the resident's neck and attempting to choke Resident #45. The facility's QAPI program's failure to identify, develop, and implement interventions to protect all residents from Resident #30's continued wandering and potential abuse placed all residents in Immediate Jeopardy (a situation in which the provider's non-compliance with one or more requirements for participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident). The Administrator was informed of the Immediate Jeopardy (IJ) in the conference room on 7/10/2021 at 12:50 PM. The Immediate Jeopardy was removed onsite 7/12/2021 and was effective 5/3/2021 - 7/11/2021. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 7/12/2021 at 8:40 AM and the corrective actions were validated onsite by the surveyors on 7/12/2021 and 7/13/2021. The findings include: Review of the facility policy titled Quality Assurance and Performance Improvement (QAPI) dated 9/2019, revealed .Policy Explanation and Compliance Guidelines .Develop and implement appropriate plans of action to correct identified quality deficiencies. The facility will utilize Root Cause Analysis (RCA) and the Plan, Do, Study, Act (PDSA) cycle of improvement to improve existing processes. Chosen actions for change will be linked to the root causes and will be designed to effect change at the systems level . Medical record review showed Resident #30 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Dementia with Behavioral Disturbance, Anxiety Disorder, Major Depressive Disorder, Insomnia, and Delusional Disorders. Review of Resident #30's admission Minimum Data Set (MDS) dated [DATE], showed the resident had severe cognitive impairment, and had wandered 1-3 days during the assessment period. Continued review showed Resident #30 required supervision to walk in the room and hallways with no use of mobility devices. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #30's Physician Notification Progress Note dated 5/3/2021, revealed .Staff reported to this nurse an [a] Resident to resident altercation. This resident [Resident #30] who was hitting [Resident #65] on the head and pulling her wheelchair back .order to send to [local hospital] emergency room for psych eval [mental health evaluation] and treatment . Review of Resident #30's QAPI/Risk Meeting Progress Note dated 5/3/2021 at 1:52 PM, showed .Resident remains a wandering risk with behaviors present. Close monitoring provided by staff. IDT [Interdisciplinary Team] will continue to monitor for effective/appropriateness of interventions and intervene accordingly . Review of Resident #30's Risk Meeting Progress Note dated 5/4/2021, showed .IDT will continue to monitor for effective/appropriateness of interventions and intervene accordingly. IDT met, reviewed, discussed, and in agreement . Review showed no additional interventions were implemented after the resident-to-resident abuse on 5/3/2021. Medical record review of progress notes from 5/4/2021 - 7/5/2021 revealed Resident #30 wandered the facility daily, in and out of other resident rooms, and was frequently aggressive and combative with others. Review of Resident #30's Behavior Note/Anxiety Progress Note dated 7/5/2021 showed .Resident continues to wander this shift. Resident wandering into other resident rooms causing distress to other residents . Medical record review showed Resident #65 was admitted to the facility on [DATE] with diagnoses including Bipolar Disorder, Dementia Without Behavioral Disturbance, Difficulty Walking, Anxiety Disorder, Insomnia, and Acquired Absence of Right Leg Below Knee. Review of Resident #65's quarterly MDS dated [DATE], showed the resident had moderately impaired cognitive status, the resident was independent for locomotion on the unit, and used a wheelchair for mobility. No behaviors were documented, and no wandering was documented. Review of Resident #65's Physician's Progress Note dated 5/4/2021, showed .The patient was a victim of the resident on the resident violence earlier in the week .The patient's been very anxious since that time .The patient reports the other individual came up from behind her and grabbed and hit her right parietal and temporal area .This incident unfortunately set off exacerbation of patient's underlying anxiety disorder To become increasingly anxious and avoids individuals when moving about the community in her wheelchair . Medical record review showed Resident #65 experienced increased anxiety after the abuse by Resident #30 requiring medications to alleviate anxiety and an in-patient psychiatric stay from 5/7/2021 - 5/10/2021 to stabilize the resident. Medical record review showed Resident #45 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Muscle Wasting, Chronic Obstructive Pulmonary Disease, Difficulty Walking, Presence of a Cardiac Pacemaker, Personal History of Other Mental and Behavioral Disorders, Bipolar Disorder, Syncope and Collapse, General Anxiety Disorder, Wheezing, and Dependence on Supplemental Oxygen. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Medical record review of Resident #45's 5-day MDS dated [DATE], showed the resident had moderate cognitive impairment with no behaviors noted. She was total dependence for bed mobility and transfers, did not ambulate, used a wheelchair for mobility, and used oxygen daily. Review of Resident #45's Physician Progress Note dated 7/8/2021, showed .Resident [Resident #30] supervised the patient [Resident #45] while she was lying on her left resting .Resident [Resident #30] placed her right hand on the left side of the patient's [Resident #45] neck and held it .The patient [Resident #45] stated she turned and tried to push the arm [Resident 30's arm] away but it was very stiff .Ultimately she got the hand removed .Event was unprovoked . Review of a facility witness statement given by Certified Nursing Assistant (CNA) #5, undated, showed . Resident stated she was sleeping, and thought was one of us shaking her awake. But it was [Resident #30] standing over her. She claimed [Resident #30] had her hands around her neck and told her she would hurt her/die . During an interview on 7/8/2021 at 2:11 PM, the Administrator stated the facility had not investigated the altercation between Resident #30 and Resident #65 as an abuse allegation. The Administrator stated she was unaware of the nurse's notes stating Resident #30 had wandered into other residents' rooms and caused distress to those residents. She further stated Resident #30 had .never harmed anyone .just wanders in the hallway . During an interview on 7/9/2021 at 5:12 PM, the Administrator stated the Interdisciplinary Team (IDT) reviewed the resident-to-resident altercation between Resident #30 and Resident #65 and stated the facility did not identify the altercation as abuse. She stated the resident-to-resident altercation was considered behaviors due to both residents' history and condition. She stated, I think we need more Dementia care training. The Administrator confirmed the resident-to-resident altercation was not identified as abuse, was not investigated as abuse, and was not reported to the State Agency. The Administrator stated there had been no other resident to resident altercations. The Administrator did not divulge any details for the incident of Resident #30 choking Resident #45. The QAPI committee had not identified the issue of resident wandering and how that led to the incidents of resident-to-resident abuse. Refer to F-600, F-609, F-610, F-741, and F-744 An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received 7/12/2021 at 8:40 AM, and the corrective actions were validated on-site by the surveyors on 7/12/2021-7/13/2021 through review of documents, review of facility policies, and staff interviews. The Removal Plan presented to the survey team by the facility documented the following immediate corrective actions implemented. On 7/10/2021 the Regional Director of Operations provided training to the Administrator, Assistant Director of Nursing, Nursing Educator, Unit Manager, MDS Coordinator, Medical Records, Social Services, Director of Rehab, Dietary, Admissions Liaison, and Human Resources. The training included: 1. the Abuse policy 2. types and reporting and investigating and prevention (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 7/10/2021 the Regional Director of Nursing Services re-inserviced the ADON, Unit Manager, Social Services, MDS Coordinator, and Activities Director on behavioral management policy including: 1.Making resident care plans specific to their behaviors with interventions 2. how to recognize potential behaviors that is escalating and to intervene On 7/10/2021 the Regional Director of Clinical Services re-inserviced the Administrator, ADON, Nursing Educator, Unit Manager, MDS Coordinator, Medical Records, Social Services, Director of Rehab, Dietary, Admission Liaison, and Human Resources on behavior management including : how to recognize a potential behavior that is escalating and to intervene All staff not present on 7/10/2021 were called and in-serviced by the Nurse Educator. No employee will work prior to being trained. Future employees will be educated on hire regarding behavioral management and care plan revisions as it relates to resident specific interventions and including how to recognize a potential behavior that is escalating and to intervene. Audits will be performed by the DON / designee of progress notes to identify any potential new or exacerbations of behaviors 5x/week x 4 weeks, 3xweek x4 weeks, and 2xweek x 4 weeks. The Nurse Educator will perform behavior management training monthly for 6 months using Hand-in-Hand. The Kardex's will be printed from Point Click Care and updated to reflect the behavioral interventions that are resident specific, on 7/11/2021 by the ADON and Unit manager. The Regional Director of Clinical Services will monitor nursing notes written in the past 24 hours to identify any areas that potentially could be exacerbated behaviors 5x/week x 4 weeks, 3xweek x4 weeks, and 2xweek x 4 weeks. Changes to a behavior care plan or development by the IDT team will be reviewed by the Administrator to ensure it is resident specific as updates occur. The comprehensive care plan development is overseen by the MDS Coordinator with input from Social Services, Activities, Dietary, and Rehab. Revisions to the behavioral care plan is the responsibility of the Social Services. Nursing Care plan updates are the responsibility of Licensed Nurses, Unit Manager, ADON, and the DON. The QAPI committee will meet weekly to analyze all events that may require investigation and reporting. Weekly updates will be provided by responsible members on the progress of each citation. The Regional Director of Nursing and /or the Regional [NAME] President of Operations will attend QAPI meetings in person or by phone. This will include input and review of data collected for the meeting. The Regional Director of Nursing and/or Regional [NAME] President of Operations will do facility visits to monitor compliance at a minimum weekly until substantial compliance is achieved and maintained. (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 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 7/12/2021, Surveyors reviewed the education and sign in sheets which validated the corrective action plans onsite which was provided by the Administrator. The documentation showed all staff working on 7/12/2021 and 7/13/2021 had been provided the education on abuse, types of abuse, preventing, protecting, recognizing/identifying abuse/behaviors, reporting, and investigating abuse. The administrator was educated on abuse by the corporate nurse. Residents affected by the wandering residents were assessed and interviewed to determine if psychosocial harm had occurred. 22 resident records were reviewed randomly to ensure care plans had been updated and Dementia care had been added to those with Dementia and behaviors. The records had been updated to include interventions on the 22 resident records reviewed. The surveyors validated all staff working on 7/12/2021-7/13/2021 had been educated and were knowledgeable about the new procedures related to abuse/behavior, Dementia Care, and person-centered care planning. On 7/12/2021, Surveyors validated the corrective actions onsite through interviews with the Administrator, DON, Nurse Educator, MDS Coordinator, Social Service Director, 4 RNs, 2 LPN's, 8 CNA's, 2 nurse aides in training, 2 therapists and 2 housekeepers. The interviews showed the staff were educated on how to prevent abuse, what to do when abuse occurs, reporting of abuse, investigating abuse, documentation and implementing person centered care plans for each resident with Dementia and behaviors. Staff verbalized knowledge of development of care plans for Dementia and behaviors and how to assess residents to determine person centered needs/interventions. Noncompliance at F-867 continues at a scope and severity of L for monitoring of the effectiveness of the corrective actions to ensure sustained compliance. The facility is required to submit a plan of correction.