STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45732 Based on observation, interview and record review the facility failed to protect the resident's right to be free from abuse and neglect for 8 (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #9, and Resident #10) of 8 residents reviewed for abuse and neglect. 1. The facility failed to ensure Hall 100/Unit 1 (male secured locked unit) had sufficient staffing to prevent Resident #6, a resident with known history of stealing food of wrong texture, from a choking episode that led to hospitalization . 2. The facility failed to prevent Resident #5 from abusing Resident #2 on Hall 200/Unit 2 (male secured locked unit) that led to hospitalization of Resident #2 and Resident #5. 3. The facility failed to prevent Resident #4 from abusing Resident #1 on Hall 200/Unit 2 (male secured locked unit) that led to hospitalization of Resident #4 and Resident #1. 4. The facility failed to prevent Resident #3 from abusing Resident #1 on Hall 200/Unit2 (male secured locked unit) that led to an injury of Resident #1. 5. The facility failed to prevent Resident #9 from abusing Resident #1 on Hall 200/Unit2 (male secured locked unit). 6. The facility failed to protect Resident #10 from abusing Resident #1 that led to a fracture for Resident #1. An Immediate Jeopardy (IJ) situation was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of pattern with actual harm that is not immediate, due to the facility's need to evaluate the effectiveness of their corrective systems. These failures could place residents at risk for choking, resident-to-resident altercations, serious harm in the event of an emergency, hospitalization s, and even death. 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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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility assessment dated [DATE] Part 3 titled Facility Resourced Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies revealed: Staff: Licensed nurses: Station 2: LVN/RN Days: 2 and Nights: 2 Direct Care Staff/CNAs: Station 2: Days 8, Evenings 8, Nights 5. Resident #6 Record review of Resident #6's electronic face sheet, accessed on [DATE], revealed an [AGE] year-old male admitted on [DATE] to Hall 100/Unit 1 (male secured locked unit) with diagnoses which included: bipolar disorder, dementia, difficulty swallowing, and depression. Record review of Resident #6's Quarterly MDS, dated [DATE], revealed a BIMS score interview was not performed. Further review of the MDS, revealed: Section E: Behavior: E0100. Potential Indicators of Psychosis: B. Delusions. E0200. Behavioral Symptoms: A. Physical behavioral symptoms directed towards others occurred 1 to 3 days. B. Verbal behavioral symptoms directed towards others occurred 1 to 3 days. Section G: Functional Status: G0110. Activities of Daily Living Assistance: H. Eating:1. Self-Performance Supervision. 2. Support: One-person physical assist. Section K: Swallowing/Nutrition Status: K0100. Swallowing Disorder: A. Loss of liquids/solids from mouth when eating or drinking. K0510: Nutritional Approaches: C. Mechanically altered diet. D. Therapeutic Diet. Record review of Resident's #6's Care Plan, dated [DATE], revealed: Problem: Nutritional Status Diet. Goal: Maintain Stable Weight. Approach: Diet as ordered: Dysphagia advanced pureed, carbohydrate consistent, and Report problems to charge nurse. Further review of the Care Plan revealed no evidence of interventions to prevent resident choking or stealing food. Record review of Provider Investigation Report, dated [DATE], revealed on [DATE] at approximately 07:30 PM, [Resident #6] was found unresponsive with no pulse and no reparations. Staff immediately started CPR. [Resident #6] responsive at time of transport. [Resident #6] expelled a portion of food. [Resident #6] is on a pureed diet. [Resident #6] was sent to the emergency room after staff performed CPR. [Resident #6] did respond to paramedics that arrived shortly after the 911 call was placed. During a random observation on [DATE] at 12:40 PM on Hall 100/Unit 1 (male secured locked unit) revealed 9 residents sitting in the dining room. TNA M assisted unsampled resident with eating lunch. CNA G assisted unsampled resident with eating lunch. No nurse was observed in the dining room. Resident #6 sat next to CNA G and was redirected continuously not to grab food from other residents' plates. During an interview attempt on [DATE] at 12:45 PM Resident #6 was unable to answer any questions due to his level of cognitive impairment. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 11:00 AM, the DON stated Station 2 had 6 wings: Hall 100/Unit 1 (male secured locked unit), Hall 200/Unit 2 (male secured locked unit), Hall 300, Hall 400, Hall 500, and Hall 600/Unit 3 (female secured locked unit). The DON stated Station 2 always had 2 CNAs on each of the 3 secured locked units. She stated the facility tried to keep the same staff on the same units for continuity of care. The DON stated station 2 was to be staffed with 2 nurses at night and day, 8 CNAs for days and evenings, and 5 CNAs at night. She stated licensed nurses' shifts were: Day shift 6:00 AM to 6:00 PM and night shift 6:00 PM to 6:00 AM. She stated CNA shifts were: Day shift 6:00 AM to 2:00 PM, Evening shift 2:00 PM to 10:00 PM, and Night shift 10:00 PM to 06:00 AM. During an interview on [DATE] at 5:00 PM, TNA J stated she was CPR and Heimlich maneuver certified but most of the other TNAs were not. She stated worked Hall 100/unit 1 (male secured locked unit) on [DATE] when Resident #6 choked. TNA J stated LVN B was on the unit at the time of the incident. She stated generally the nurse was at the nurse's station and not easily accessible. She stated the nurse working Hall 100/Unit1 (male secured locked unit) was available and started CPR. TNA J stated there had been times when she was the only staff on Hall 100/Unit1 (male secured locked unit) but she could not state the exact dates and if an emergency occurred, she would not be able to get help. She stated she would have scream until someone heard her. She stated the nurse would be at the nurses' station located off Hall 100/Unit1 (male secured locked unit) passed the locked doors and she would not be able to get help. She stated if a TNA that was not CPR and Heimlich maneuver certified and was alone on Hall 100/Unit1 (male secured locked unit) it would be a very unsafe environment. She stated Hall 100/Unit1 (male secured locked unit) was often staffed with only 1 TNA. TNA J stated she believed failure occurred because the facility did not have enough staff to prevent Resident #6 to get the food from the other resident's room. TNA J stated she was not aware that Resident #6 had a history of stealing food and required enhanced supervision around food. TNA J stated she had not done or received any training at all. She stated she was not trained on abuse and neglect. During an interview on [DATE] at 12:45 PM, CNA G stated the facility was never staffed with 2 CNAs per unit. She stated she worked units' alone multiple shifts, but she could not state the exact dates. She stated Resident #6 had always tried to steal food and he had to be constantly monitored during mealtimes. She did not state if she reported this to DON or Administrator. CNA G stated she had been trained on abuse and neglect. She stated she would report abuse to the Administrator. During an interview on [DATE] at 12:55 PM, TNA M stated she had been a TNA since [DATE]. She stated she was not CPR certified and had not received any training regarding resident's behaviors or abuse and neglect. She stated she worked alone on units almost every shift but could not state the exact dates. She stated Hall 100/Unit 1 (male secured lock unit) had 2 (unsampled) residents that required feeding assistance and one resident who stole food. She stated she would assist one resident eating and the other resident waited until she was done before she could assist him with eating. She stated she also had to redirect Resident #6 continuously while assisting residents with eating. She stated nurses were never on the units during mealtimes. She stated multiple residents had voiced concerns about their care and safety but could not state exactly which resident voiced or when. She did not state if she reported this to DON or Administrator. Record review of grievance log revealed no evidence of residents complaining about their concerns for their care and safety. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 10:00 AM, CNA H stated she worked the units/halls alone multiple times but could not state the exact dates. She stated the facility kept putting staff on Hall 100/Unit 1 (male secured locked unit) that did not know the residents. She stated that Hall 100/Unit 1 (male secured locked unit) had 2 residents that required assistance with meals. She stated Resident #6 had always tried to steal food and it was worse after he started a pureed diet. She did not state if she reported this to DON or Administrator. She stated she had been trained on abuse and neglect. She stated she would report abuse to the Administrator. During an interview on [DATE] at 10:10 AM, CNA I stated she was an agency aide and had worked every hall in the facility. She stated she never received any training regarding behaviors or abuse and neglect. She stated she did not know that Resident #6 needed to be monitored for stealing food and was to be monitored at mealtimes. Record review of the facility employee timecards for [DATE] at 7:30 PM revealed Station 2 had 2 LVNs, 2 CNAs (1 of the 2 was Agency), and 5 TNAs working with a census of 111. Record review of the facility daily staff schedule, dated [DATE], revealed there were 2 TNAs assigned to Hall 100/Unit 1 (male secured locked unit) without the supervision of a CNA and census of 12 residents with known behaviors. Resident #5 Record review of Resident #5's electronic face sheet, accessed on [DATE], revealed an [AGE] year-old male admitted to the facility on [DATE] to Hall 200/Unit2 (male secured locked unit) with diagnoses which included Schizophrenia, Bipolar disorder, and dementia. Record review of Resident #5's Discharge MDS, dated [DATE], revealed a BIMS score of 07, which indicated severe cognitive impairment. The MDS revealed: Section E: Behavior: E0200. Behavioral Symptoms: A. Physical behavioral symptoms directed towards others occurred 1 to 3 days. B. Verbal behavioral symptoms directed towards others occurred 1 to 3 days. C. Other behavioral symptoms not directed towards others occurred 4 to 6 days. E0800. Rejection of Care: Occurred 1 to 3 days. E0900 Wandering: occurred 1 to 3 days. Section N: Medications: Number of days received in the last 7 days. A. Antipsychotic 7. Record review of Resident's #5's Care Plan, dated [DATE], revealed the objectives that lacked the ability to be evaluated or quantified were: Problem: Mood State Goal: Resident will express/exhibit satisfaction. Approach: Assess, monitor, and document mood, Be reassuring and listen to concerns, Meds as ordered. Problem: Behavioral Symptoms. Goals: I will have fewer episode of physical aggression. Approach: Staff will redirect as needed. Staff will notify physician with any increase in behaviors. Problem: Psychotropic Drug Use. Goal: Benefit without side effects. Approach: Refer to Social Services if needed, Gradual dose reduction, Monitor for side effects, Monitor target behaviors. Record review of Resident #5's electronic progress note, dated [DATE] at 4:54 PM by the ADON, revealed Resident #5 was placed on one-on-one monitoring to which Administrator did while removing Resident to his office to deescalate the situation. Resident #2 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #2's electronic face sheet, accessed on [DATE], revealed an [AGE] year-old male admitted on [DATE] to Hall 200/Unit2 (male secured locked unit) with diagnoses which included Schizoaffective disorder, Bipolar, dementia, and depression. Record review of Resident #2's Discharge MDS, dated [DATE], for Resident # 2 revealed a BIMS interview was not performed. The MDS revealed: Section E: Behavior: E0200. Behavioral Symptoms: A. Physical behavioral symptoms directed towards others occurred 1 to 3 days. B. Verbal behavioral symptoms directed towards others occurred 1 to 3 days. Section N: Medications: Number of days received in the last 7 days. C. Antidepressant 7. Record review of Resident's #2's Care Plan, dated [DATE], revealed the objectives lacked the ability to be evaluated or quantified were: Problem: Psychotropic Drug Use. Goal: Benefit without side effects. Approach: Refer to Social Services if needed, Gradual dose reduction, Monitor for side effects, Monitor target behaviors. Problem: Psychosocial Well-Being Goal: Resident will express/exhibit satisfaction Approach: Allow to express feelings, Listen carefully and be non-judgmental, Keep topics of conversation light and cheerful, Customary routines adhered to: (specify). Problem: Mood State Goal: Resident will express/exhibit satisfaction. Approach: Assess, monitor, and document mood, Be reassuring and listen to concerns, Meds as ordered. Resident #4 Record review of Resident #4's electronic face sheet, accessed on [DATE], revealed a [AGE] year-old male admitted to the facility on [DATE] to Hall 200/Unit2 (male secured locked unit) with diagnoses which included: Dementia, Bipolar disorder, major depression, and anxiety. Record review of Resident #4's Discharge MDS, dated [DATE], revealed a BIMS score of 08, which indicated moderate cognition impairment. The MDS revealed: Section E: Behavior: E0200. Behavioral Symptoms: A. Physical behavioral symptoms directed towards others occurred 1 to 3 days. B. Verbal behavioral symptoms directed towards others occurred 1 to 3 days. E0900 Wandering: occurred 1 to 3 days. Section N: Medications: Number of days received in the last 7 days. A. Antipsychotic 7 C. Antidepressant 7. Record review of Resident's #4's Care Plan, dated [DATE], revealed: Problem: Resident exhibits wandering. Goal: Resident will wander safely within specified boundaries over the next 90 days. Approach: Remove resident from other resident's rooms and unsafe situations, Assess resident for placement in a specially designed therapeutic unit, and Avoid over-stimulation. Problem: Behavioral Symptoms [DATE] aggression towards others and impulsiveness Goal: Resident will have less than 3 episodes of Verbal and/or physical aggression towards others over the next 90 days. Approach: Remove from public area when behavior is unacceptable, Keep environment calm and relaxed, Encourage diversional activities, Redirect me when I am in the day room around others if they get to close to me, and staff will assist me to a quiet area if I become inappropriate with others. Record review of progress note dated [DATE] at 3:42 pm by LVN-A revealed: Resident left facility by way of of facility van. Resident alert, apprehensive to leave facility. Took no belongings to [local psychiatric hospital.] Resident #3 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #3's electronic face sheet, accessed on [DATE], revealed a [AGE] year-old male admitted [DATE] to Hall 200/Unit 2 (male secured locked unit) with diagnoses which included diabetes, dementia, depression, and stroke. Record review of Resident #3's Quarterly MDS, dated [DATE], revealed a BIMS interview was not performed. The MDS revealed: Section E: Behavior: E0200. Behavioral Symptoms: A. Physical behavioral symptoms directed towards others occurred 1 to 3 days. Section N: Medications: Number of days received in the last 7 days. A. Antipsychotic 7 B. Antianxiety 7 C. Antidepressant. Record review of Resident #3's Care Plan, dated [DATE], revealed: Problem: I was exhibiting physically aggressive behavior towards others. Goal: I will have less than 2 physical altercations over the next 90 days. Approach: Assist me to a quiet area when I become agitated to reduce stimuli and monitor for pain, injuries. Resident #9 Record review of Resident #9's electronic face sheet, accessed on [DATE], revealed a [AGE] year-old male admitted on [DATE] to Hall 200/Unit 2 (male secured locked unit) with diagnoses which included anxiety, Alzheimer's, dementia, and depression. Record review of Resident #9's Discharge MDS, dated [DATE], revealed a BIMS interview was not performed. The MDS revealed: Section N: Medications: Number of days received in the last 7 days. A. Antipsychotic 7 C. Antidepressant 7. Record review of Resident #9's Care Plan, dated [DATE], revealed: Problem: Mood remains agitated and anxious. Goal: Resident will express/exhibit less anxiousness and agitation. Approach: Assess, monitor, and document mood, Be reassuring and listen to concerns, Encourage group activities, and Meds as ordered. Resident #10 Record review of Resident #10's electronic face sheet, accessed on [DATE], revealed a [AGE] year-old male admitted on [DATE] to Hall 200/Unit 2 (male secured locked unit) with diagnoses which included heart failure, dementia, stroke, and high blood pressure. Record review of Resident #10's Quarterly MDS, dated [DATE], revealed a BIMS score of 07, which indicated moderate cognitive impairment. The MDS revealed: Section E: Behavior: E0200 Behavior Symptoms: B. Verbal behavior symptoms directed towards others occurred 1 to 3 days. Section N: Medications: Number of days received in the last 7 days. C. Antidepressant 7. Record review of Resident #10's Care Plan, dated [DATE], revealed: Problem: Behavioral Symptoms Goal: Resident will have fewer episodes of wandering. Approach: Always ask for help if resident becomes abusive/resistive, Encourage diversional activities, and Remove from public area when behavior is unacceptable. Resident #1 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's electronic face sheet, accessed on [DATE], revealed a [AGE] year-old male admitted on [DATE] on Hall 200/Unit2 (male secured locked unit) with diagnoses which included: seizures, dementia, fractured lumbar, and depression. Record review of Resident #1's Discharge MDS, dated [DATE], for Resident #1 revealed a BIMS score of 03, which indicated severe cognitive impairment. The MDS revealed: Section E: Behavior: E0200. Behavioral Symptoms: A. Physical behavioral symptoms directed towards others occurred 1 to 3 days. B. Verbal behavioral symptoms directed towards others occurred 1 to 3 days. E0900 Wandering: occurred 1 to 3 days. Section N: Medications: Number of days received in the last 7 days. C. Antidepressant 7. Record review of Resident's #1's Care Plan, dated [DATE], revealed: Problem: Resident exhibits wandering as evidence by resident went out the side gate to the front door Goal: Resident will wander safely within specified boundaries. Approach: Place resident in a secure environment, Remove resident from other resident's rooms and unsafe situations, and Avoid over-stimulation. Record review of the Provider Investigation Report, dated [DATE], revealed on [DATE], at 2:00 PM, [Resident #5] was leaning against the door frame with arms crossed and an agitated expression on his face arguing with a nurse stating. 'Get him out of my room.' ADON got closer and was able to see why they were unable to move [Resident #2]. [Resident #2] was sent to the emergency room for a suspected fracture of the hip. [Resident #5] stated, 'He was eating my snacks, so he told him to get out. When [Resident # 2] did not leave, I pushed him' room. [Resident #2] was assessed and 911 called. Resident went to the hospital and was later admitted for delirium with no fracture noted. Record review of the facility employee timecards for [DATE] at 2:35 PM revealed Station 2 had 2 LVNs, 6 CNAs (5 agency and 1 TNA) working with a census of 110. Record review of facility staff schedule, dated [DATE], revealed there was 1 agency CNA working Hall 200/Unit 2 (male secured locked unit), which had a census of 18 residents which included Resident #2 and Resident #5. Record review of the Provider Investigation Report, dated [DATE], revealed on [DATE] at 7:00 PM agency [CNA C] reporter she was sitting at the desk in the day room (CNA E was helping the residents come in from smoking) when she heard [Resident #4] yelling 'get the hell out of my room'. [CNA C] entered room [ROOM NUMBER]. [Resident #1] was lying on the floor in the room. [Resident #4] was pulling [Resident #1] by his legs. [CNA C] separated the residents. [Resident #1] started kicking at [CNA C] so that he could proceed to have further contact with [Resident #4.] [Resident #4] pushed [CNA C] out of the way to get back to physical contact with [Resident #1] again. [Resident #4] made second contact with [Resident #1]. Per [CNA C's] statement [Resident #4] pulled at [Resident #1's] arm and face. [CNA C] stepped in between residents to separate the residents again. Nurse was called and assessment begun. 911 was called for [Resident #1]. All appropriate notifications made. Resident was sent out with EMS to the hospital. [Resident #4] received increase in supervision until he was sent to a behavior health hospital on [DATE] early morning. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the Provider Investigation Report, dated [DATE], revealed on [DATE] at 5:45 PM, CNA reported she heard a commotion and saw [Resident #3] sitting in a dining room chair with [Resident #1] standing over him. Both residents were immediately separated. [Resident #1] sustained red marks to the nose and left cheek and a nosebleed. [Resident #3] assessment showed 1.5 x 1.5 bump/bruise to left eye, 2. 5 cm x 2 cm bruise/redness to right side of neck, and no other injuries. [Resident #1] upper lip appeared slightly swollen. An abrasion to the right side of the neck. [Resident #1] was placed on 15-minute checks with increased supervision while out in the common area. Record review of the facility employee timecards for [DATE] at 5:45 PM revealed Station 2 had 2 LVNs, 4 CNAs (1 agency and 4 TNAs) working with a census of 108. Record review of facility staff schedule, dated [DATE], revealed there was 1 agency CNA working Hall 200/Unit 2 (male secured locked unit), which had a census of 18 residents with known aggressive behaviors. Record review of the Provider Investigation Report, dated [DATE], revealed on [DATE] at 3:15 PM, CNA reported [Resident #9] hit [Resident #1] in the face multiple times. CNA separated and notified the nurse. [Resident #1] had a 1.8 cm x 2.8 cm discolored raised area under his left eye and a superficial abrasion 0.8 cm x 2.8 cm to neck under left ear. [Resident #10] was placed on 15-minute checks. During a telephone interview on [DATE] at 12:15 PM, TNA N stated she no longer worked for the facility. She stated she voiced her concerns about working alone on the hall's multiple times to the Administrator and the DON. She stated she received no CNA training and no training regarding behaviors or abuse and neglect. She stated she worked alone most of her shifts, but she could not state the exact dates. She stated she was alone on Hall 200/Unit 2 (male secured locked unit) when Resident #1 and Resident #3 got into resident-to-resident altercation on [DATE]. She stated she had to scream for help and a LVN P at the nurse's station behind the locked doors heard her and came to help her. She stated after the altercation, Resident #3 was placed on every 15-minute checks. She stated the facility did not provide another staff member to help. She stated she was required to perform 15-minute checks on Resident #9 and care for the other residents alone for the rest of her shift. Record review of 15-minute check documentation revealed no signatures of who performed the checks. The document just provided the location of Resident #9 every 15-minutes. Record review of the facility employee timecards for [DATE] at 3:55 PM revealed Station 2 had 2 LVNs, 1 CNAs, and 1 TNAs working with a census of 108. Record review of the facility staff schedule, dated [DATE], revealed 7 nursing aides. Record review of the facility staff schedule, dated [DATE], revealed there was 1 TNA working Hall 200/Unit 2 (male secured locked unit), without the supervision of a CNA, with a census of 18 residents with known aggressive behaviors. Record review of the Provider Investigation Report, dated [DATE], revealed on [DATE] at 4:29 PM, [Resident #10] pushed [Resident #1] against the wall and [Resident #1] slid down the wall. [Resident #1] complained of lower back pain. X-ray results showed acute L1 compression fracture. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on [DATE] at 5:00 PM, TNA O stated she was working Hall 200/Unit 2 (male secured locked unit) alone on [DATE] when Resident #9 and Resident #1 got into a resident-to-resident altercation. She stated the nurse was not on the unit. She stated a CNA had come to the unit to relieve her for a lunch break. She stated if the CNA had not come, she would have had to leave the unit unsupervised to go get help. She stated the nurses were only on the unit while passing medications. She stated she always worked the halls alone, but she could not state the exact dates. She stated she received no training and was thrown into working the halls alone. She stated she voiced her concerns about working alone, especially because she was pregnant, with the Administrator and the DON. She stated she was aware of the resident behaviors but only because she had worked on Hall 200/Unit 2 (male secured locked unit) since she was hired. She stated she left the facility because she felt unsafe and uncomfortable. She stated she was not trained on abuse and neglect. Record review of the facility employee timecards for [DATE] at 4:29 PM revealed Station 2 had 2 LVNs, 2 CNAs, and 5 TNAs working with a census of 108. Record review of the facility staff schedule, dated [DATE], revealed there was 1 TNA working Hall 200/Unit 2 (male secured locked unit), without the supervision of a CNA, with a census of 18 residents with known aggressive behaviors. Record review of 15-minute check documentation revealed no signatures of who performed the checks. The document just provided the location of Resident #10 every 15-minutes. During an interview on [DATE] at 1:30 PM, Resident #8 stated the facility never had enough staff. He stated all the residents were always arguing and fighting and no one did anything about it. Resident #8 stated he did not feel free from abuse and neglect. He stated he hated living in the facility. The resident stated that he had spoken to the Administrator and the DON multiple times. During an interview on [DATE] at 1:45 PM, Resident #7 stated he was blind and never got the help he needed. He stated he was left alone all day and became agitated because no one helped him. He stated he could never find anyone and there were many tasks he was not capable of doing on his own. He stated there was no need to report it because no one cared. Resident #7 stated he did not feel free from abuse and neglect. During an interview on [DATE] at 2:40 PM, the DON stated TNAs completed an 8-hour online course, they received in house training with a CNA, and skills check offs were completed by the DON, ADON or CNAs. She stated TNAs could do all resident care tasks alone without CNA supervision. She stated she never staffed just 1 TNA alone on a unit. She stated that she did staff 2 TNAs on units without CNA supervision. She stated TNAs were not CPR or Heimlich maneuver certified. She stated if an emergency did happen there was always a nurse on the unit. The DON stated the facility was always adequality staffed but did not provide evidence to prove adequate staffing. During an interview on [DATE] at 3:00 PM, with agency CNA D she stated she had worked on a unit alone during multiple shifts, but she could not state the exact dates. CNA D stated that she was an agency CNA and was not oriented to the facility or the residents. She stated she did not receive any facility or specialized training

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45732 Based on interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan based on assessed needs with measurable objectives that can be evaluated or quantified to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 4 (Resident #1, Resident #2, Resident #4, and Resident #5) of 16 residents reviewed for generic comprehensive person-centered care plans. 1. The facility failed to develop care plans based on assessed needs with measurable objectives in areas such as mood state, behavioral symptoms, and wandering for Resident #1. 2. The facility failed to develop care plans based on assessed needs with measurable objectives in areas such as psychotropic drug use, psychosocial well-being, and mood state for Resident #2. 3. The facility failed to develop care plans based on assessed needs with measurable objectives in areas such as Psychosocial Well-Being, Mood State, and dementia for Resident #4. 4. The facility failed to develop care plans based on assessed needs with measurable objectives in areas such as Mood State, Behavioral Symptoms, and Psychotropic Drug Use for Resident #5. These failures could affect the residents by placing them at risk for not receiving care and services to meet their individual needs. Findings included: Resident #1 Record review of Resident #1's electronic face sheet accessed on 07/14/2022 revealed a [AGE] year-old male admitted on [DATE] with diagnosis to include: seizures, dementia, fractured lumbar, and depression. Record review of Resident #1's Discharge MDS dated [DATE] revealed a BIMS score of 03 indicating severe cognitive impairment. Further review of Discharge MDS dated [DATE] revealed: Section E: Behavior: E0200. Behavioral Symptoms: A. Physical behavioral symptoms directed towards others occurred 1 to 3 days. B. Verbal behavioral symptoms directed towards others occurred 1 to 3 days. E0900 Wandering: occurred 1 to 3 days. Section N: Medications: Number of days received in the last 7 days. C. Antidepressant 7. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident's #1's Care Plan dated 05/25/2022 revealed the objectives lacked the ability to be evaluated or quantified were: Problem: Mood State Goal: Resident will express/exhibit satisfaction. Approach: Assess, monitor, and document mood, Be reassuring and listen to concerns, Meds as ordered. Problem: Category: Behavioral Symptoms. I have aggressive behaviors at times. Goals: I will have fewer aggressive behaviors. Approach: Staff will redirect as needed. Staff will notify physician with any increase in behaviors. Problem: Resident exhibits wandering (moves with no rational purpose, seemingly oblivious to needs or safety). Goal: Resident will wander safely within specified boundaries. Approach: Avoid over-stimulation, Convey an attitude of acceptance toward the resident, Place resident in a secure environment. During an interview on 07/14/2022 at 4:30 PM, Resident #1's family member stated she had never been involved in a Care Plan meeting and had never discussed any alternatives for Resident #1's behaviors. Resident #2 Record review of Resident #2's electronic face sheet accessed on 07/14/2022 revealed an [AGE] year-old male admitted on [DATE] with diagnosis to include: Schizoaffective disorder, Bipolar, dementia, and depression. Record review of Resident #2's Discharge MDS dated [DATE] revealed a BIMS interview was not performed. Further review of MDS dated [DATE] revealed: Section E: Behavior: E0200. Behavioral Symptoms: A. Physical behavioral symptoms directed towards others occurred 1 to 3 days. B. Verbal behavioral symptoms directed towards others occurred 1 to 3 days. Section N: Medications: Number of days received in the last 7 days. C. Antidepressant 7. Record review of Resident's #2's Care Plan dated 05/25/2022 revealed the objectives lacked the ability to be evaluated or quantified were: Problem: Psychotropic Drug Use. Goal: Benefit without side effects. Approach: Refer to Social Services if needed, Gradual dose reduction, Monitor for side effects, Monitor target behaviors. Problem: Psychosocial Well-Being Goal: Resident will express/exhibit satisfaction Approach: Allow to express feelings, Listen carefully and be non-judgmental, Keep topics of conversation light and cheerful, Customary routines adhered to: (specify). Problem: Mood State Goal: Resident will express/exhibit satisfaction. Approach: Assess, monitor, and document mood, Be reassuring and listen to concerns, Meds as ordered. Resident #4 Record review of Resident #4's electronic face sheet accessed on 07/14/2022 revealed a [AGE] year-old male admitted on [DATE] with diagnosis to include: Dementia, Bipolar disorder, major depression, and anxiety. Record review of Resident #4's Discharge MDS dated [DATE] for Resident #4 revealed a BIMS score of 08 indicating moderate cognition impairment. Further review of MDS revealed: Section E: Behavior: E0200. Behavioral Symptoms: A. Physical behavioral symptoms directed towards others occurred 1 to 3 days. B. Verbal behavioral symptoms directed towards others occurred 1 to 3 days. E0900 Wandering: occurred 1 to 3 days. Section N: Medications: Number of days received in the last 7 days. A. Antipsychotic 7 C. Antidepressant 7. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident's #4's Care Plan dated 06/29/2022 revealed the objectives lacked the ability to be evaluated or quantified were: Problem: Psychosocial Well-Being Goal: Resident will express/exhibit satisfaction Approach: Allow to express feelings, Listen carefully and be non-judgmental, Keep topics of conversation light and cheerful. Problem: Mood State Goal: Resident will express/exhibit satisfaction. Approach: Assess, monitor, and document mood, Be reassuring and listen to concerns, Meds as ordered. Problem: Cognitive Loss related to dementia Goal: Resident will be as alert and oriented as possible Approach: Anticipate needs and observe for non-verbal cues, Approach in calm manner, Introduce self. Resident #5 Record review of Resident #5's electronic face sheet accessed on 07/14/2022 revealed an [AGE] year-old male admitted on [DATE] with diagnoses to include: Schizophrenia, Bipolar disorder, and dementia. Record review of Resident #5's Discharge MDS dated [DATE] revealed a BIMS score of 07 indicating severe cognitive impairment. Further review of MDS revealed: Section E: Behavior: E0200. Behavioral Symptoms: A. Physical behavioral symptoms directed towards others occurred 1 to 3 days. B. Verbal behavioral symptoms directed towards others occurred 1 to 3 days. C. Other behavioral symptoms not directed towards others occurred 4 to 6 days. E0800. Rejection of Care: Occurred 1 to 3 days. E0900 Wandering: occurred 1 to 3 days. Section N: Medications: Number of days received in the last 7 days. A. Antipsychotic 7. Record review of Resident's #5's Care Plan dated 06/29/2022 revealed the objectives that lacked the ability to be evaluated or quantified were: Problem: Mood State Goal: Resident will express/exhibit satisfaction. Approach: Assess, monitor, and document mood, Be reassuring and listen to concerns, Meds as ordered. Problem: Behavioral Symptoms. Goals: I will have fewer episode of physical aggression. Approach: Staff will redirect as needed. Staff will notify physician with any increase in behaviors. Problem: Psychotropic Drug Use. Goal: Benefit without side effects. Approach: Refer to Social Services if needed, Gradual dose reduction, Monitor for side effects, Monitor target behaviors. During interview on 07/15/2022 at 4:00 PM, the DON stated she had been working on care plans with the entire interdisciplinary team. She stated they had made care plans the facilities focus daily. She stated she understands that the objectives are not measurable. The Don stated not having measurable goals could cause residents not to get their needs met. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility's policy Care Plans, Comprehensive Person-Centered revised December 2020 revealed: The comprehensive, person-centered care plan will: A. include measurable objectives and time frames; B. describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; C. Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; . E. Include the resident's stated goals upon admission and desired outcomes G. Incorporate identified problem areas; H. Incorporate risk factors associated with identified problems . Reflect treatment goals, timetables and objective in measurable outcomes; L. Identify the professional services that are responsible for each element of care; M. Aid in preventing or reducing decline in the residents functional status and or functional ; N. Enhance the optimal functioning of the resident by focusing on a rehabilitative program, and O. Reflect current recognized standards of practice for problem areas and conditions . Care plan interventions are chosen only after careful data gathering, proper sequence of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45732 Based on observations, interview, and record review, the facility failed to ensure residents received adequate supervision to prevent accidents for 1 of 1 residents (Resident #6) reviewed for accidents and supervision. The facility failed to ensure there was sufficient staffing on Hall 100/Unit 1 (male secured locked unit) to meet the needs of Resident #6 to ensure he was supervised and did not have access to food that was the wrong texture, which resulted in a choking episode requiring emergency services and hospitalization . An Immediate Jeopardy (IJ) situation was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated with actual harm that is not immediate, due to the facility's need to evaluate the effectiveness of their corrective systems. These failures could place residents at risk for choking resident-to-resident altercations, serious harm in the event of an emergency, hospitalization s, and death. Findings include: Record review of facility assessment dated [DATE] Part 3 titled Facility Resourced Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies revealed: Staff: Licensed nurses: Station 2: LVN/RN Days: 2 and Nights: 2 Direct Care Staff/CNAs: Station 2: Days 8, Evenings 8, Nights 5. Resident #6 Record review of Resident #6's electronic face sheet accessed on [DATE] revealed an [AGE] year-old male admitted on [DATE] to Hall 100/Unit 1 (male secured locked unit) with diagnosis to include: bipolar disorder, dementia, difficulty swallowing, and depression. Record review of Resident #6's Quarterly MDS, dated [DATE], revealed a BIMS score interview was not performed. Further review of MDS, revealed: Section E: Behavior: E0100. Potential Indicators of Psychosis: B. Delusions. E0200. Behavioral Symptoms: A. Physical behavioral symptoms directed towards others occurred 1 to 3 days. B. Verbal behavioral symptoms directed towards others occurred 1 to 3 days. Section G: Functional Status: G0110. Activities of Daily Living Assistance: H. Eating:1. Self-Performance Supervision. 2. Support: One-person physical assist. Section K: Swallowing/Nutrition Status: K0100. Swallowing Disorder: A. Loss of liquids/solids from mouth when eating or drinking. K0510: Nutritional Approaches: C. Mechanically altered diet. D. Therapeutic Diet. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident's #6's Care Plan dated [DATE] revealed: Problem: Nutritional Status Diet. Goal: Maintain Stable Weight. Approach: Diet as ordered: Dysphagia advanced pureed, carbohydrate consistent, and Report problems to charge nurse. Further review of Care Plan revealed no evidence of interventions to prevent resident choking or stealing food. The Care Plan showed no evidence of supervision needs for Resident #6. During an interview attempt on [DATE] at 12:45 PM Resident #6 was unable to answer any questions due to his level of cognitive impairment. Record review of Provider Investigation Report dated [DATE] revealed on [DATE] at approximately 07:30 pm, [Resident #6] was found unresponsive with no pulse and no reparations. Staff immediately started CPR. [Resident #6] responsive at time of transport. [Resident #6] expelled a portion of food. [Resident #6] is on a pureed diet. [Resident #6] was sent to the emergency room after staff performed CPR. [Resident #6] did respond to paramedics that arrived shortly after the 911 call was placed. During an observation on [DATE] at 12:40 PM on Hall 100/Unit 1 (male secured locked unit) revealed 9 residents sitting in the dining room. TNA M assisted one unsampled resident with eating lunch. CNA G assisted one unsampled resident with eating lunch. No nurse was observed in the dining room. Resident #6 sat next to CNA G and was redirected continuously not to grab food from other residents' plates. During an Observation on [DATE] 04:45 PM Hall 100/Unit 1 (male secured locked unit) had 1 Business Office Manager and 1 Assistant Business Office Manager staffed. No nurse was observed on Hall 100/Unit 1 (male secured locked unit). During an interview on [DATE] at 11:00 AM, DON stated Station 2 had 6 wings: Hall 100/Unit 1 (male secured locked unit), Hall 200/Unit 2 (male secured locked unit), Hall 300, Hall 400, Hall 500, and Hall 600/Unit 3 (female secured locked unit). The DON stated that Station 2 always had 2 CNAs on each of the 3 secured locked units. She stated the facility tried to keep the same staff on the same units for continuity of care. DON stated station 2 was to be staffed with 2 nurses at night and day, 8 CNAs for days and evenings, and 5 CNAs at night. She stated licensed nurses' shifts were: Day shift 6:00 AM to 6:00 PM and night shift 6:00 PM to 6:00 AM. She stated CNA shifts were: Day shift 6:00 AM to 2:00 PM, Evening shift 2:00 PM to 10:00 PM, and Night shift 10:00 PM to 06:00 AM. During an interview on [DATE] at 2:40 PM, DON stated TNAs completed an 8-hour online course, they received in house training with a CNA, and skills check offs were completed by the DON, ADON, or CNAs. She stated TNAs can do all resident care task alone without CNA supervision. She stated that she never staffed just 1 TNA alone on a unit. She stated that she did staff 2 TNAs on units without CNA supervision. She stated TNAs are not CPR and Heimlich maneuver certified. She stated if an emergency did happen there is always a nurse on the unit. DON stated the facility is always adequality staffed but did not provide evidence to prove adequate staffing. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3:00 PM, with CNA D she stated she had worked on a unit alone during multiple shifts, but she could not state the exact dates. CNA D stated that she was an agency CNA and was not oriented to the facility or the residents. She stated she did not receive any facility or specialized training for residents with behavioral or psychological issues. CNA D stated it was impossible to take care of the residents appropriately with only on CNA. She stated she was concerned about the residents in the facility's safety. She did not state if she reported this to DON or Administrator. During an interview on [DATE] at 4:00 PM, the administrator stated the facility was short staffed. During an interview on [DATE] at 5:00 PM, TNA J stated she was CPR and Heimlich maneuver certified but most of the other TNAs were not. She stated she was working Hall 100/unit 1 (male secured locked unit) on [DATE] when Resident #6 choked. TNA J stated LVN-B was on the unit at the time of the incident. She stated generally the nurse was at the nurse's station and not easily accessible. She stated LVN B was working Hall 100/Unit1 (male secured locked unit) was available and started CPR. TNA J stated there had been times when she was the only staff on Hall 100/Unit1 (male secured locked unit) but she could not state the exact dates and if an emergency occurred, she would not be able to get help. She stated she would have to scream until someone heard her. She stated the nurse would be at the nurses' station located off Hall 100/Unit1 (male secured locked unit) passed the locked doors and she would not be able to get help. She stated if a TNA that was not certified was alone on Hall 100/Unit1 (male secured locked unit) it would be a very unsafe environment. She stated Hall 100/Unit1 (male secured locked unit) was often staffed with only 1 TNA. TNA J stated she believed failure occurred because the facility did not have enough staff to prevent Resident #6 to get the food from the other resident's room. TNA J stated she was not aware that Resident #6 had a history of stealing food and required enhanced supervision around food. TNA J stated she had not done or received any training at all. During a confidential interview on [DATE] at 11:30 AM, an anonymous staff member stated they were uncomfortable with things happening at the facility. The anonymous staff member stated the facility was always short staffed and did not have the staff to appropriately care for the residents with the behavior issues that were being admitted . The anonymous staff member stated they felt that the facility did not having adequate staff to care for the residents. The anonymous staff member did not state if she reported this to DON or Administrator. During an interview on [DATE] at 5:25 PM, TNA K stated she was not CPR and Heimlich maneuver certified. She stated there had been several times she worked the units alone, but she could not state the exact dates She stated the nurses were rarely on the unit and the nurses were at the nurse's station passed the locked doors. She stated in an emergent situation she would stay with resident and scream for help. TNA K stated if no one came for help she would have to leave the resident unattended, punch in the key code, and push the door open to call for help. TNA K stated she had felt she had been put in an unsafe situation many times. She stated she took an 8-hour course online and CNAs showed her what to do but felt like she was thrown in without adequate training. She stated she did not remember doing any specialized training on caring for residents with behavioral issues. She did not state if she reported this to DON or Administrator. During an interview on [DATE] at 11:50 AM, the DON stated agency CNAs did not receive any specialized training from the facility. She stated CNAs were given a verbal change of shift report regarding the resident's care needs by the CNAs from the previous shift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 12:15 PM, CNA F stated she had worked in the facility for 2 years. She stated she worked the units alone most of her shifts. She stated it was unsafe and 1 staff was not enough to properly handle the resident behaviors. She stated the facility placed too many untrained staff on the units which leaded to resident altercations. She stated the nurses were only available during medication pass. She did not state if she reported this to DON or Administrator. During an interview on [DATE] at 12:30 PM, TNA L stated she had been a TNA for 7 weeks. She stated she was never trained or checked off on her skills. She stated she followed a CNA for one shift then was placed alone to work on a unit. She stated she worked the units alone most of her shifts, but she could not state the exact dates. She stated she used her personal cell phone to call for help when she needed it. She stated the facility did not staff the units with consistent staff which she believed contributed to the resident behaviors. She stated the facility did not do any activities with the residents. TNA C stated she felt the residents were very unsafe and the facility needed to get some help. She stated she had addressed her concerns with the administrator and the DON. During an interview on [DATE] at 12:45 PM, CNA G stated the facility was never staffed with 2 CNAs per unit/hall. She stated she worked units alone multiple shifts, but she could not state the exact dates. She stated Resident #6 had always tried to steal food and he had to be constantly monitored during mealtimes. She did not state if she reported this to DON or Administrator. During an interview on [DATE] at 12:55 PM, TNA M stated she had been a TNA since [DATE]. She stated she was not CPR and Heimlich maneuver certified and had not received any training regarding resident's behaviors. She stated she worked alone on units almost every shift but could not state the exact dates. She stated Hall 100/Unit 1 (male secured lock unit) had 2 (unsampled) residents that required feeding assistance and Resident #6 who stole food. She stated she would assist one resident eating and the other resident waited until she was done before she could assist him with eating. She stated she also had to redirect Resident #6 continuously while assisting residents with eating. She stated nurses were never on the units during mealtimes. She stated multiple residents had voiced concerns about their care and safety but could not state exactly which resident voiced or when. She did not state if she reported this to DON or Administrator. During a telephone interview on [DATE] at 5:00 PM, TNA O stated the nurses are only on the unit while passing medications. She stated she always worked the halls alone, but she could not state the exact dates. She stated she received no training and was thrown into working the halls alone. She stated she voiced her concerns about working alone, especially because she was pregnant with the Administrator and the DON. She stated she left the facility because she felt unsafe and uncomfortable. During an interview on [DATE] at 5:30 PM, CNA C stated she was an agency CNA and she had not received any special training to work with residents with behaviors. She stated she had no orientation to the facility, and she did not sign any training or orientation paperwork. She stated she had worked halls alone with no other aides many times, but she could not state the exact dates. She stated it was rare that she worked with another CNA. She did not state if she reported this to DON or Administrator. (continued on next page)

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	675746	A. Building B. Wing	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 05:55 PM, LVN A stated she was covering as a nurse aide for hall 300 as well as being the nurse on duty for Hall 100/Unit 1 (male secured locked unit), Hall 200/Unit 2 (male secured locked unit), and half of Hall 300. She stated the other nurse was covering as a nurse aide for hall 400 as well as being the nurse on duty for Hall 600/Unit 3 (male secured locked unit) and hall 300. She stated that on occasion she had to work as nurse and aide, but she could not state the exact dates. She stated that it was crazy because she had 37 residents and 8 blood sugars to be completed on her shift. She stated that she came in early and left late for many shifts. She stated that the regular staff knew the resident's triggers, but the agency staff did not know the resident's triggers. She stated that she had told management that she would not be able to train a new nurse properly. During a telephone interview on [DATE] at 12:15 PM, TNA N stated she no longer worked for the facility. She stated she voiced her concerns about working alone on the hall's multiple times to the Administrator and the DON. She stated she left the facility because she felt the staff and the residents were in danger. She stated she received no CNA training and no training regarding behaviors. She stated she worked alone most of her shifts, but she could not state the exact dates. During an interview on [DATE] at 5:30 PM, CNA E stated she was an agency CNA and she had not received any specialized training to work with residents with behaviors. She stated she did not work specific halls in the facility, so she had worked every hall in the facility. She stated the nurses were very hard to locate and are only on the hall to pass medications. She stated sometimes she received report from the CNA leaving from the previous shift, but not often. She stated when she worked alone, she had to take residents out for their smoke break and leave the rest of the residents on the hall unattended, but she could not state the exact dates. She did not state if she reported this to DON or Administrator. During an interview on [DATE] at 10:00 AM, CNA H stated that she had worked the units/halls alone multiple times but could not state the exact dates. She stated the facility kept putting staff on Hall 100/Unit 1 (male secured locked unit) that did not know the residents. She stated that Hall 100/Unit 1 (male secured locked unit) had 2 (unsampled) residents that required assistance with meals. She stated Resident #6 had always tried to steal food and it was worse after he started a pureed diet. She did not state if she reported this to DON or Administrator. During an interview on [DATE] at 10:10 AM, agency CNA I stated she was an agency aide and had worked every hall in the facility. She stated she never received any training regarding behaviors. She stated she did not know that Resident #6 needed to be monitored for stealing food and was to be monitored at mealtimes. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3:00 PM, the DON stated that she was responsible for making the licensed nurses and nurse aides schedules. She stated the facility was using agency aides to help cover. She stated she believed the facility had enough staff. She stated the TNAs had worked at the facility for a long time, they have had online course for CNA and were placed with a CNA for on-the-job training. She stated the staff used personal phones because it was quicker since the staff already had cell phones in their pockets. She stated the facility was in process of getting all TNAs and CNAs certified for CPR. She stated the facility should always schedule a CNA with TNA, but there was not an abundance of CNAs available. DON stated when new residents were admitted the facility tried to see who the resident would interact with best. She stated the IDT team visited with the residents and find out what the residents enjoy. She stated with the residents that had been in the facility a while would be reevaluated to see what kind of activities should be incorporated. Record review of the facility employee timecards for [DATE] at 7:30 pm revealed that Station 2 had 2 LVNs, 2 CNAs (1 of the 2 was Agency), and 5 TNAs working with a census of 111. Record review of the facility daily staff schedule dated [DATE] revealed there were 2 TNAs assigned Hall 100/Unit 1 (male secured locked unit) without the supervision of a CNA and census of 12 residents with known behaviors. Record review of grievance log revealed no evidence of residents complaining about their concerns for their care and safety. Record review of agency CNA D's employee file revealed no evidence of facility or specialized training for residents with behavioral or psychological issues Record review of TNA J's employee file revealed no evidence of training related to resident behaviors or competency skills checkoffs or CPR and Heimlich maneuver certification. Record review of TNA K's employee file revealed no evidence of training related to resident behaviors or competency skills checkoffs or CPR and Heimlich maneuver certification. Record review of TNA L's employee file revealed no evidence of competency skills checkoffs or CPR and Heimlich maneuver certification. Record review of TNA M's employee file revealed no evidence of training related to resident behaviors or competency skills checkoffs or CPR and Heimlich maneuver certification. Record review of TNA O's employee file revealed no evidence of training related to resident behaviors or competency skills checkoffs or CPR and Heimlich maneuver certification. Record review of agency CNA C's employee file revealed no evidence of training related to resident behaviors. Record review of TNA N's employee file revealed no evidence of training related to resident behaviors or competency skills checkoffs or CPR and Heimlich maneuver certification. Record review of agency CNA E's employee file revealed no evidence of training related to resident behaviors. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of agency CNA I's employee file revealed no evidence of training related to resident behaviors. Record review of TNA F's employee file revealed no evidence of competency skills checkoffs. Record review of the facility's policy Staffing revised [DATE] revealed: Policy Statement: Our center provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the center assessment. Policy Interpretation and Implementation: 1. Licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services. 2. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care. Record review of facilities policy Behavior Assessment, Intervention, and Monitoring revised [DATE] revealed: Policy Statement: 1. Behavioral symptoms will be identified using facility-approved screening tools and the comprehensive assessment Assessment: 1. As part of the initial assessment, the nursing staff and attending physician will identify individuals with a history of impaired cognition, altered behavior, or mental illness. 2. As part of the comprehensive assessment, staff will evaluate, based on input from the resident, family, and caregivers, review of medical record and general observation: a. The residents' usual patterns of cognition, mood, and behavior; B. the resident's usual method of communication things like pain, hunger, thirst, and other physical discomforts; and c. The residents typical or past responses to stress, fatigue, fear, anxiety, frustration, and other triggers .Management: 1. The IDT team will evaluate behavioral symptoms in residents to determine the degree of severity, distress, and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies will be implemented if necessary to protect the resident and others from harm .11. The Director of Nursing will evaluated whether the staffing needs have changed based on acuity of the residents and their plans of care. Additional staff and/or staff training will be provided if it determined that the needs of resident cannot be met with the current of staff or staff training. The [NAME] President of Operations, Administrator, and Director of Nurses were notified on [DATE] at 12:00 PM that an Immediate Jeopardy was identified, and a Plan of Removal was requested at that time. This was determined to be an Immediate Jeopardy (IJ) on [DATE]. The [NAME] President of Operations, Administrator, and Director of Nurses were notified. The Administrator as provided with the IJ template on [DATE] at 12:00 PM. The following Plan of Removal was accepted on [DATE] at 11:00 AM and included: Actions: A. The facility failed to provide supervision to prevent choking episodes: Action 1: Assigned unit staff will ensure snacks are out of reach of residents in the secured unit who lack the capacity to know their appropriate diet texture. Snacks will be handed out upon receipt and residents will be monitored and/or snacks will be behind a locked door and/or cabinet. Staff education and testing to verify understanding. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Agency and new staff will be educated and tested prior to working their next/first shift. Test results will be reviewed, and any missed questions will be reviewed with staff members, and they will be re-educated. Date Initiated: [DATE], revisiting/completing [DATE] Action 2: Residents' diet orders will be available and accessible at each nurses' station and each secured unit on Matrix Care (Electronic Charting System). Staff will be able to validate diets and ensure residents are receiving the appropriate diet texture. All direct care staff has access to the resident's diet orders through Matrix Care. The Resident's diet orders are updated by charge nurses and communicated with dietary through a communication form. Director of Nursing will review any diet order changes during the clinical meeting. Staff is aware of any changes by the shift-to-shift report, education, care plan updating, and documentation. Date Initiated: [DATE], revisiting/completing [DATE] Action 3: Staff assigned to the specified unit/areas will redirect and monitor residents' consumption of meals/snacks to ensure residents are consuming their appropriate diet texture. The staff has been educated through formal in-servicing and employee-to-employee reports regarding resident #6's tendencies to grab food that is inappropriate for his diet texture. A monitoring form will be located on each unit that includes the date, time, staff name, and whether monitoring occurred or not. Director of Nursing, Administrator, and designee will ensure Agency and new staff will be educated and tested before working their next/first shift. Test results will be reviewed, and any missed questions will be reviewed with staff members and re-educated. Date Initiated: [DATE], revisiting/completing [DATE] Action 4: The Director of Nursing, Administrator, and/or designee will ensure employees are in-serviced and educated regarding residents' diet orders, snack accessibility, passing of snacks, and monitoring residents' consumption of snacks, and mealtime monitoring. In-service records will be checked against the employee roster to ensure 100% completion. Date Initiated: [DATE], revisiting/completing [DATE] Action 5: Testing will be completed regarding residents' diet orders, snack accessibility, passing of snacks, and monitoring residents' consumption of snacks. Testing will be checked against the employee roster to ensure 100% completion. If test results are below par, employees will be reeducated. Director of Nursing, Administrator, and/or designee will be responsible for Action 5. Date Initiated: [DATE], revisiting/completing [DATE] (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Action 6: At random, x 5 days weekly, IDT members (and/or designee) will rotate and monitor a meal and/or snack pass to ensure compliance with the above actions. Director of Nursing, Administrator and/or designee will be responsible for ensuring this action is completed. Date Initiated: [DATE], revisiting/completing [DATE] Action 7: Director of Nursing updating care plan regarding resident #6's history of stealing food and appropriate interventions to reduce the risk of future incidents. I will be monitored while I eat, staff will set up my tray for all snacks/meals, and I will consume my appropriate diet texture (puree). Interventions will be assessed for effectiveness quarterly. Date Initiated: [DATE] B. The Facility failed to provide supervision to prevent resident-to-resident altercations. Action 1: Minimum of 2 scheduled staff members for both ,d+[DATE] and ,d+[DATE] shifts on each secured unit, one scheduled staff member for ,d+[DATE] with the nurse rotating units for assistance, breaks, and coverage. If coverage is ineffective through incident and accident tracking and trending and/or staff and resident interviews, staff shall be added to the identified areas of concern. Administrator Director of Nursing, Assistant Director of Nursing, will be responsible for ensuring adequate staffing. Date: Initiated on [DATE], ensured through [DATE], and on-going Action 2: Continue to request, schedule, and utilize our staff and our contingency staff, agency, our corporate Mobile Clinical Support Nurses/Mobile Certified Aides, and continue with our internal and corporate recruiting and retention program to recruit and retain sufficient staff. Contingency Staff: Department heads, and other employees that have completed TNA education/course or can work in the role of a hospitality aide to assist with care needs. Mobile Clinical Support Nurses/Mobile Certified Aides: Nurses and CNAs employed by corporate deployed to Corporation nursing homes around Texas. Sufficient staff: Adequate in numbers and education to meet the needs/acuity of our current secured units. Date: Continual, revisited [DATE] & [DATE], and on-going until facility's staffing is sufficient Action 3: At a minimum, Administrator and Director of Nursing will be on a daily staffing call x5 days, starting [DATE], (Monday through Friday, Friday to cover Saturday and Sunday, Monday to recap the weekend), and on-going with no stop date, to ensure adequate staffing is scheduled and anticipated with a contingency plan in place, with Regional Nurse Manager, and Regional [NAME] President of Operations. Staffing is discussed during a morning-clinical meeting between IDT, as well. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Staffing calls will include: 1. Per secured unit-Census, 2. The remainder of station 2's census, 3. station 1's-Census, 4. Staffing breakdown (by discipline) for each individual unit, 5. Staffing (by discipline) for the remainder of station 2, 6. Staffing (by discipline) for sides 1, 7. (When off admission hold) pending admissions for the day, 8. Planned discharges that day. Staffing will be appropriate/adequate and identified through a review of the facility assessment, employee and resident interviews/conversations, incident and accident tracking, and the QAPI process. Date: Initiated [DATE], continuing [DATE], and ongoing until facility's staffing is sufficient Action 4: Regional [NAME] President of Operations, in-serviced Administrator, and Director of Nursing, on Adequate and sufficient supervision/staffing. Date: Initiated/Completed [DATE] Action 5: Administrator, Director of Nursing, Social Worker, or designee in-servicing all staff (including external staff such as agency or Mobile Clinical Support Nurses/Mobile Certified Aides) on Behavioral Health Services, Behavioral Assessment, Intervention, and Monitoring, and Managing Behaviors. All new staff (internal or external) will be in-serviced prior to the first shift by Administrator, Director of Nursing, Social Worker, or designee. Ensuring all staff completion prior to the next shift worked by tracking against the staff roster. Date: Initiated [DATE], continuing [DATE], and completed [DATE]. Action 6: A test to ensure competency of Behavioral Health Services, Behavioral Assessment, Intervention, and Monitoring, and Managing Behaviors. Ensuring all staff completion prior to the next shift worked by tracking against the staff roster. If staff does not meet standards on test, they will be re-in-service to ensure competency by Administrator Director of Nursing, Social Worker, or designee. Date: Initiated [DATE], continuing [DATE], and completed [DATE]. Action 7: Administrator, Director of Nursing, and/or a designee in-servicing all staff (including external staff such as agency or Mobile Clinical Support Nurses/Mobile Certified Aides) on Incidents and Accidents Policy, Resident to Resident Altercation Policy, and Abuse/Neglect Policy. Ensuring all staff completion, prior to next shift worked, by tracking against the staff roster. Date: Initiated [DATE], continuing [DATE], and completed [DATE]. Action 8: A test to ensure competency of Incidents and Accidents Policy, Resident to Resident Altercation Policy, and Abuse/Neglect Policy. Ensuring all staff completion, prior to next shift worked, by tracking against the staff roster. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	If staff does not meet standards on test they will be re-inserviced to ensure competency by Administrator, Director of Nursing, Social Worker, or designee. Date: Initiated [DATE], continuing [DATE], and completed [DATE]. Action 9: Agency LVNs and CNAs have an orientation packet and are educated before working their assigned shift by the Director of Nursing, Assistant Director of Nursing, and/or designee. Agency Orientation Packet includes: Agency orientation guidelines, center map with identified areas, electronic charting system directions, Policies: Abuse Prevention Program, Resident Rights, Behavioral Health Services, Behavioral Assessment, Intervention, and Monitoring, and Managing Behaviors. Temporary Nursing Aides and Hospitality Aides have been checked off through the Temporary Nursing Aide Check-Offs and have been in-serviced and tested in accordance with the above noted education actions. Date: Initiated [DATE], continuing [DATE], and completed [DATE]. Action 10: Tracking and trending resident-to-resident altercations by location, time of incident, residents involved, staff present at time of incident, investigation, interventions, and care plan updates, daily, x5 days (Monday through Friday, Monday to cover weekend incidents) to be completed by the IDT during morning clinical meeting to establish root causes and better understand/prevent behaviors/altercations. These results will be shared during monthly QAPI meeting. Communication with direct care s [TRUNCATED]

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45732 Based on observation, interview, and record review the facility to have enough qualified staff to provide adequate care for residents with mental and psychosocial disorders for 8 of 8 residents (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #9, and Resident #10) reviewed for staffing. 1. The facility failed to ensure there was sufficient staffing on Hall 100/Unit 1 (male secured locked unit) to meet the needs of Resident #6 to ensure he was supervised and did not have access to food that was the wrong texture, which resulted in a choking episode requiring emergency services and hospitalization . 2. The facility failed to ensure there was sufficient staffing on Hall 200/Unit 2 (male secured locked unit) to meet the needs of Resident #2 and Resident #5 to prevent a resident-to-resident altercation that led to hospitalization of Resident #2 and Resident #5. 3. The facility failed to ensure there was sufficient staffing on Hall 200/Unit 2 (male secured locked unit) to meet the needs of Resident #1 and Resident #4 to prevent a resident-to-resident altercation that led to hospitalization of Resident #4 and Resident #1. 4. The facility failed to ensure there was sufficient staffing on Hall 200/Unit2 (male secured locked unit) to meet the needs of Resident #1 and Resident #3 to prevent a resident-to-resident altercation that led to an injury of Resident #1. 5. The facility failed to ensure there was sufficient staffing on Hall 200/Unit2 (male secured locked unit) to meet the needs of Resident #1 and Resident #9 to prevent a resident-to-resident altercation. 6. The facility failed to ensure there was sufficient staffing on Hall 200/Unit2 (male secured locked unit) to meet the needs of Resident #1 and Resident #10 to prevent a resident-to-resident altercation that led to a fracture for Resident #1. An Immediate Jeopardy (IJ) situation was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of pattern with actual harm that is not immediate, due to the facility's need to evaluate the effectiveness of their corrective systems. These failures could place residents at risk for choking resident-to-resident altercations, serious harm in the event of an emergency, hospitalization s, and death. Findings include: Record review of facility assessment dated [DATE] Part 3 titled Facility Resourced Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies revealed: Staff: (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Licensed nurses: Station 2: LVN/RN Days: 2 and Nights: 2 Direct Care Staff/CNAs: Station 2: Days 8, Evenings 8, Nights 5. Resident #6 Record review of Resident #6's electronic face sheet accessed on [DATE] revealed an [AGE] year-old male admitted on [DATE] to Hall 100/Unit 1 (male secured locked unit) with diagnosis to include: bipolar disorder, dementia, difficulty swallowing, and depression. Record review of Resident #6's Quarterly MDS, dated [DATE], revealed a BIMS score interview was not performed. Further review of MDS, revealed: Section E: Behavior: E0100. Potential Indicators of Psychosis: B. Delusions. E0200. Behavioral Symptoms: A. Physical behavioral symptoms directed towards others occurred 1 to 3 days. B. Verbal behavioral symptoms directed towards others occurred 1 to 3 days. Section G: Functional Status: G0110. Activities of Daily Living Assistance: H. Eating:1. Self-Performance Supervision. 2. Support: One-person physical assist. Section K: Swallowing/Nutrition Status: K0100. Swallowing Disorder: A. Loss of liquids/solids from mouth when eating or drinking. K0510: Nutritional Approaches: C. Mechanically altered diet. D. Therapeutic Diet. Record review of Resident's #6's Care Plan dated [DATE] revealed: Problem: Nutritional Status Diet. Goal: Maintain Stable Weight. Approach: Diet as ordered: Dysphagia advanced pureed, carbohydrate consistent, and Report problems to charge nurse. Further review of Care Plan revealed no evidence of interventions to prevent resident choking or stealing food. The Care Plan showed no evidence of supervision needs for Resident #6. Record review of Provider Investigation Report dated [DATE] revealed on [DATE] at approximately 07:30 pm, [Resident #6] was found unresponsive with no pulse and no reparations. Staff immediately started CPR. [Resident #6] responsive at time of transport. [Resident #6] expelled a portion of food. [Resident #6] is on a pureed diet. [Resident #6] was sent to the emergency room after staff performed CPR. [Resident #6] did respond to paramedics that arrived shortly after the 911 call was placed. During a random observation on [DATE] at 12:40 PM on Hall 100/Unit 1 (male secured locked unit) revealed 9 residents sitting in the dining room. TNA M assisted unsampled resident with eating lunch. CNA G assisted unsampled resident with eating lunch. No nurse was observed in the dining room. Resident #6 sat next to CNA G and was redirected continuously not to grab food from other residents' plates. During an interview attempt on [DATE] at 12:45 PM Resident #6 was unable to answer any questions due to his level of cognitive impairment. During an interview on [DATE] at 11:00 AM, DON stated Station 2 had 6 wings: Hall 100/Unit 1 (male secured locked unit), Hall 200/Unit 2 (male secured locked unit), Hall 300, Hall 400, Hall 500, and Hall 600/Unit 3 (female secured locked unit). The DON stated that Station 2 always had 2 CNAs on each of the 3 secured locked units. She stated the facility tried to keep the same staff on the same units for continuity of care. DON stated station 2 was to be staffed with 2 nurses at night and day, 8 CNAs for days and evenings, and 5 CNAs at night. She stated licensed nurses' shifts were: Day shift 6:00 AM to 6:00 PM and night shift 6:00 PM to 6:00 AM. She stated CNA shifts were: Day shift 6:00 AM to 2:00 PM, Evening shift 2:00 PM to 10:00 PM, and Night shift 10:00 PM to 06:00 AM. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 5:00 PM, TNA J stated she was CPR certified and Heimlich maneuver certified but most of the other TNAs were not. She stated she was working Hall 100/unit 1 (male secured locked unit) on [DATE] when Resident #6 choked. TNA J stated LVNB was on the unit at the time of the incident. She stated generally the nurse was at the nurse's station and not easily accessible. She stated LVN B was working Hall 100/Unit1 (male secured locked unit) was available and started CPR. TNA J stated there had been times when she was the only staff on Hall 100/Unit1 (male secured locked unit) but she could not state the exact dates and if an emergency occurred, she would not be able to get help. She stated she would have to scream until someone heard her. She stated the nurse would be at the nurses' station located off Hall 100/Unit1 (male secured locked unit) passed the locked doors and she would not be able to get help. She stated if a TNA that was not certified was alone on Hall 100/Unit1 (male secured locked unit) it would be a very unsafe environment. She stated Hall 100/Unit1 (male secured locked unit) was often staffed with only 1 TNA. TNA J stated she believed failure occurred because the facility did not have enough staff to prevent Resident #6 to get the food from the other resident's room. TNA J stated she was not aware that Resident #6 had a history of stealing food and required enhanced supervision around food. TNA J stated she had not done or received any training at all. During an interview on [DATE] at 12:45 PM, CNA G stated the facility was never staffed with 2 CNAs per unit. She stated she worked units' alone multiple shifts, but she could not state the exact dates. She stated Resident #6 had always tried to steal food and he had to be constantly monitored during mealtimes. She did not state if she reported this to DON or Administrator. During an interview on [DATE] at 12:55 PM, TNA M stated she had been a TNA since [DATE]. She stated she was not CPR certified and had not received any training regarding resident's behaviors. She stated she worked alone on units almost every shift but could not state the exact dates. She stated Hall 100/Unit 1 (male secured lock unit) had 2 (unsampled) residents that required feeding assistance and Resident #6 who stole food. She stated she would assist one resident eating and the other resident waited until she was done before she could assist him with eating. She stated she also had to redirect Resident #6 continuously while assisting residents with eating. She stated nurses were never on the units during mealtimes. She stated multiple residents had voiced concerns about their care and safety but could not state exactly which resident voiced or when. She did not state if she reported this to DON or Administrator. Record review of grievance log revealed no evidence of residents complaining about their concerns for their care and safety. During an interview on [DATE] at 10:00 AM, CNA H stated that she had worked the units/halls alone multiple times but could not state the exact dates. She stated the facility kept putting staff on Hall 100/Unit 1 (male secured locked unit) that did not know the residents. She stated that Hall 100/Unit 1 (male secured locked unit) had 2 (unsampled) residents that required assistance with meals. She stated Resident #6 had always tried to steal food and it was worse after he started a pureed diet. She did not state if she reported this to DON or Administrator. During an interview on [DATE] at 10:10 AM, CNA I stated she was an agency aide and had worked every hall in the facility. She stated she never received any training regarding behaviors. She stated she did not know that Resident #6 needed to be monitored for stealing food and was to be monitored at mealtimes. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility employee timecards for [DATE] at 7:30 pm revealed that Station 2 had 2 LVNs, 2 CNAs (1 of the 2 was Agency), and 5 TNAs working with a census of 111. Record review of the facility daily staff schedule dated [DATE] revealed there were 2 TNAs assigned Hall 100/Unit 1 (male secured locked unit) without the supervision of a CNA and census of 12 residents with known behaviors. Resident #2 Record review of Resident #2's electronic face sheet accessed on [DATE] for Resident #2 revealed an [AGE] year-old male admitted on [DATE] to Hall 200/Unit2 (male secured locked unit) with diagnosis to include Schizoaffective disorder, Bipolar, dementia, and depression. Record review of Resident #2's Discharge MDS dated [DATE] for Resident # 2 revealed a BIMS interview was not performed. Further review of MDS dated [DATE] revealed: Section E: Behavior: E0200. Behavioral Symptoms: A. Physical behavioral symptoms directed towards others occurred 1 to 3 days. B. Verbal behavioral symptoms directed towards others occurred 1 to 3 days. Section N: Medications: Number of days received in the last 7 days. C. Antidepressant 7. Record review of Resident's #2's Care Plan dated [DATE] revealed the objectives lacked the ability to be evaluated or quantified were: Problem: Psychotropic Drug Use. Goal: Benefit without side effects. Approach: Refer to Social Services if needed, Gradual dose reduction, Monitor for side effects, Monitor target behaviors. Problem: Psychosocial Well-Being Goal: Resident will express/exhibit satisfaction Approach: Allow to express feelings, Listen carefully and be non-judgmental, Keep topics of conversation light and cheerful, Customary routines adhered to: (specify). Problem: Mood State Goal: Resident will express/exhibit satisfaction. Approach: Assess, monitor, and document mood, Be reassuring and listen to concerns, Meds as ordered. Resident #5 Record review of Resident #5's electronic face sheet accessed on [DATE] for Resident #5 revealed an [AGE] year-old male admitted on [DATE] to Hall 200/Unit2 (male secured locked unit) with diagnosis to include Schizophrenia, Bipolar disorder, and dementia. Record review of Resident #5's Discharge MDS dated [DATE] revealed a BIMS score of 07 indicating severe cognitive impairment. Further review of MDS revealed: Section E: Behavior: E0200. Behavioral Symptoms: A. Physical behavioral symptoms directed towards others occurred 1 to 3 days. B. Verbal behavioral symptoms directed towards others occurred 1 to 3 days. C. Other behavioral symptoms not directed towards others occurred 4 to 6 days. E0800. Rejection of Care: Occurred 1 to 3 days. E0900 Wandering: occurred 1 to 3 days. Section N: Medications: Number of days received in the last 7 days. A. Antipsychotic 7. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident's #5's Care Plan dated [DATE] revealed the objectives that lacked the ability to be evaluated or quantified were: Problem: Mood State Goal: Resident will express/exhibit satisfaction. Approach: Assess, monitor, and document mood, Be reassuring and listen to concerns, Meds as ordered. Problem: Behavioral Symptoms. Goals: I will have fewer episode of physical aggression. Approach: Staff will redirect as needed. Staff will notify physician with any increase in behaviors. Problem: Psychotropic Drug Use. Goal: Benefit without side effects. Approach: Refer to Social Services if needed, Gradual dose reduction, Monitor for side effects, Monitor target behaviors. Resident #4 Record review of Resident #4's electronic face sheet accessed on [DATE] revealed a [AGE] year-old male admitted on [DATE] to Hall 200/Unit2 (male secured locked unit) with diagnosis to include: Dementia, Bipolar disorder, major depression, and anxiety. Record review of Resident #4's Discharge MDS dated [DATE] for Resident #4 revealed a BIMS score of 08 indicating moderate cognition impairment. Further review of MDS revealed: Section E: Behavior: E0200. Behavioral Symptoms: A. Physical behavioral symptoms directed towards others occurred 1 to 3 days. B. Verbal behavioral symptoms directed towards others occurred 1 to 3 days. E0900 Wandering: occurred 1 to 3 days. Section N: Medications: Number of days received in the last 7 days. A. Antipsychotic 7 C. Antidepressant 7. Record review of Resident's #4's Care Plan dated [DATE] revealed: Problem: Resident exhibits wandering. Goal: Resident will wander safely within specified boundaries over the next 90 days. Approach: Remove resident from other resident's rooms and unsafe situations, Assess resident for placement in a specially designed therapeutic unit, and Avoid over-stimulation. Problem: Behavioral Symptoms [DATE] aggression towards others and impulsiveness Goal: Resident will have less than 3 episodes of Verbal and/or physical aggression towards others over the next 90 days. Approach: Remove from public area when behavior is unacceptable, Keep environment calm and relaxed, Encourage diversional activities, Redirect me when I am in the day room around others if they get to close to me, and staff will assist me to a quiet area if I become inappropriate with others. Resident #3 Record review of Resident #3's electronic face sheet accessed on [DATE] for Resident #3 revealed a [AGE] year-old male admitted [DATE] to Hall 200/Unit 2 (male secured locked unit) with diagnosis to include diabetes, dementia, depression, and stroke. Record review of Resident #3's Quarterly MDS dated [DATE] for Resident #3 revealed a BIMS interview was not performed. Further review of MDS revealed: Section E: Behavior: E0200. Behavioral Symptoms: A. Physical behavioral symptoms directed towards others occurred 1 to 3 days. Section N: Medications: Number of days received in the last 7 days. A. Antipsychotic 7 B. Antianxiety 7 C. Antidepressant. Record review of Resident #3's Care Plan dated [DATE] for Resident #3 revealed: Problem: I was exhibiting physically aggressive behavior towards others. Goal: I will have less than 2 physical altercations over the next 90 days. Approach: Assist me to a quiet area when I become agitated to reduce stimuli and Monitor for pain, injuries. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #9 Record review of Resident #9's electronic face sheet accessed on [DATE] revealed a [AGE] year-old male admitted on [DATE] to Hall 200/Unit 2 (male secured locked unit) with diagnosis to include anxiety, Alzheimer's, dementia, and depression. Record review of Resident #9's Discharge MDS dated [DATE] revealed a BIMS interview was not performed. Further review of MDS revealed: Section N: Medications: Number of days received in the last 7 days. A. Antipsychotic 7 C. Antidepressant 7. Record review of Resident #9's Care Plan dated [DATE] revealed: Problem: Mood remains agitated and anxious. Goal: Resident will express/exhibit less anxiousness and agitation. Approach: Assess, monitor, and document mood, Be reassuring and listen to concerns, Encourage group activities, and Meds as ordered. Resident #10 Record review of Resident #10's electronic face sheet accessed on [DATE] revealed a [AGE] year-old male admitted on [DATE] to Hall 200/Unit 2 (male secured locked unit) with diagnosis to include heart failure, dementia, stroke, and high blood pressure. Record review of Resident #10's Quarterly MDS dated [DATE] revealed a BIMS score of 07 indicating moderate cognitive impairment. Further review of MDS revealed: Section E: Behavior: E0200 Behavior Symptoms: B. Verbal behavior symptoms directed towards others occurred 1 to 3 days. Section N: Medications: Number of days received in the last 7 days. C. Antidepressant 7. Record review of Resident #10's Care Plan dated [DATE] revealed: Problem: Behavioral Symptoms Goal: Resident will have fewer episodes of wandering. Approach: Always ask for help if resident becomes abusive/resistive, Encourage diversional activities, and Remove from public area when behavior is unacceptable. Resident #1 Record review of Resident #1's electronic face sheet accessed on [DATE] revealed a [AGE] year-old male admitted on [DATE] on Hall 200/Unit2 (male secured locked unit) with diagnosis to include: seizures, dementia, fractured lumbar, and depression. Record review of Resident #1's Discharge MDS dated [DATE] for Resident #1 revealed a BIMS score of 03 indicating severe cognitive impairment. Further review of MDS revealed: Section E: Behavior: E0200. Behavioral Symptoms: A. Physical behavioral symptoms directed towards others occurred 1 to 3 days. B. Verbal behavioral symptoms directed towards others occurred 1 to 3 days. E0900 Wandering: occurred 1 to 3 days. Section N: Medications: Number of days received in the last 7 days. C. Antidepressant 7. Record review of Resident's #1's Care Plan dated [DATE] revealed: Problem: Resident exhibits wandering as evidence by resident went out the side gate to the front door Goal: Resident will wander safely within specified boundaries. Approach: Place resident in a secure environment, Remove resident from other resident's rooms and unsafe situations, and Avoid over-stimulation. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the Provider Investigation Report dated [DATE], revealed on [DATE] at 2:00 pm, [Resident #5] was leaning against the door frame with arms crossed and an agitated expression on his face arguing with a nurse stating. Get him out of my room. [ADON] got closer and was able to see why they were unable to move [Resident #2]. [Resident #2] was sent to the emergency room for a suspected fracture of the hip. [Resident #5] stated, He was eating my snacks, so he told him to get out. When [Resident #2] did not leave, I pushed him room. [Resident #2] was assessed and 911 called. [Resident #2] went to the hospital and was later admitted for delirium with no fracture noted. Record review of Resident #5's electronic progress note dated [DATE] at 4:54 PM by the ADON revealed Resident #5 was placed on one-on-one monitoring to which Administrator did while removing Resident to his office to deescalate the situation. Record review of the facility employee timecards for [DATE] at 2:35 PM revealed Station 2 had 2 LVNs, 6 CNAs (5 agency and 1 TNA) working with a census of 110. Record review of the facility staff schedule dated [DATE] revealed there was 1 agency CNA working Hall 200/Unit 2 (male secured locked unit), which had a census of 18 residents including Resident #2 and Resident #5. Record review of Provider Investigation Report dated [DATE], revealed on [DATE] at 7:00pm agency [CNA C] reported she was sitting at the desk in the day room (CNA E was helping the residents come in from smoking) when she heard [Resident #4] yelling get the hell out of my room. [CNA C] entered room [ROOM NUMBER]. [Resident #1] was lying on the floor in the room. [Resident #4] was pulling [Resident #1] by his legs. [CNA C] separated the residents. [Resident #1] started kicking at CNA A so that he could proceed to have further contact with Resident #4. Resident #4 pushed [CNA C] out of the way to get back to physical contact with [Resident #1] again. [Resident #4] made second contact with [Resident #1]. Per [CNA C's] statement [Resident #4] pulled at [Resident #1's] arm and face. [CNA C] stepped in between residents to separate the residents again. Nurse was called and assessment begun. 911 was called for [Resident #1]. All appropriate notifications made. Resident was sent out with EMS to the hospital. [Resident #4] received increase in supervision until he was sent to a behavior health hospital on [DATE] early morning. During an interview on [DATE] at 4:00 PM, the Administrator stated Resident #4 was placed on every 15-minute checks immediately following the resident-to-resident altercation and continued until he was discharged to a local behavior health hospital on [DATE]. Administrator stated the only interventions the facility had implemented to protect Resident #1 from further altercations was consultation with psychiatric services and playing the radio because Resident #1 liked to dance. He stated Resident #4 had been aggressive on [DATE] and his Seroquel and Zoloft was increase, then he was aggressive again on [DATE] and his Depakote was increased. He stated he felt the facility had provided proper interventions. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 5:30 PM, CNA C stated she was on Hall 200/Unit 2 (male secured locked unit) alone when on [DATE] when Resident #1 and Resident #4 got into resident-to-resident altercation. She stated the charge nurse was not on the unit and rarely was on the unit. She stated she was at the desk and heard Resident #4 yelling from room [ROOM NUMBER]. She stated when she entered, she saw Resident #1 was lying in the floor and Resident #4 was dragging him across the room. She stated she attempted to separate the residents but Resident #1 was still lying on the floor kicking and Resident #4 pushed her out of the way and grabbed Resident #1 by the arms and face. CNA C stated she separated them again and CNA E came in from being outside with the residents who were smoking. She stated CNA E then ran to get help from a nurse. She stated CNA E had to go through 2 locked doors to get help and then return through 2 locked doors with the nurse. CNA C stated she was an agency CNA and she had not received any special training to work with residents with behaviors. She stated she had no orientation to the facility, and she did not sign any training or orientation paperwork. She stated she had worked halls alone with no other aides many times, but she could not state the exact dates. She stated it was rare that she worked with another CNA. She did not state if she reported this to DON or Administrator. CNA A stated she was not aware that Resident #4 or Resident #1 had any history of behaviors. During an interview on [DATE] at 5:30 PM, CNA E stated she was an agency CNA and she had not received any specialized training to work with residents with behaviors. She stated she did not work specific halls in the facility, so she had worked every hall in the facility. She stated the nurses were very hard to locate and are only on the hall to pass medications. She stated sometimes she received report from the CNA leaving from the previous shift, but not often. She stated when she worked alone, she had to take residents out for their smoke break and leave the rest of the residents on the hall unattended, but she could not state the exact dates. She did not state if she reported this to DON or Administrator. CNA E stated she was not aware that Resident #4 or Resident #1 had any history of behaviors. CNA E stated on [DATE] she had been outside with the residents on their smoke break when she re-entered the building and heard CNA C screaming for help. She stated she ran to get help from a nurse through 2 locked doors then go back through 2 locked doors with the nurse to return to the residents. CNA E stated she was not aware that Resident #4 or Resident #1 had any history of behaviors. Record review of the facility employee timecards for [DATE] at 6:58 PM revealed Station 2 had 2 LVNs, 5 CNAs (4 of the 5 were agency, and 1 TNA) working with a census of 108. Record review of the facility staff schedule dated [DATE] revealed there were 2 agency CNAs working Hall 200/Unit 2 (male secured locked unit), which had a census of 18 residents with known aggressive behaviors. Record review of the Provider Investigation Report dated [DATE], revealed on [DATE] at 5:45 PM, CNA reported she heard a commotion and saw [Resident #3] sitting in a dining room chair with [Resident #1] standing over him. Bothe residents were immediately separated. [Resident #1] sustained red marks to the nose and left cheek and a nosebleed. [Resident #3] assessment showed 1.5 x 1.5 bump/bruise to left eye, 2. 5 cm x 2 cm bruise/redness to right side of neck, and no other injuries. [Resident #1] upper lip appeared slightly swollen. an abrasion to the right side of the neck. [Resident #1] was placed on 15-minute checks with increased supervision while out in the common area. Record review of the facility employee timecards for [DATE] at 5:45 PM revealed Station 2 had 2 LVNs, 4 CNAs (1 agency and 4 TNAs) working with a census of 108. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility staff schedule dated [DATE] revealed there was 1 agency CNA working Hall 200/Unit 2 (male secured locked unit), which had a census of 18 residents with known aggressive behaviors. Record review of the Provider Investigation Report dated [DATE], revealed on [DATE] t 3:15 PM, CNA reported [Resident #9] hit [Resident #1] in the face multiple times. CNA separated and notified the nurse. [Resident #1] had a 1.8 cm x 2.8 cm discolored raised area under his left eye and a superficial abrasion 0.8 cm x 2.8 cm to neck under left ear. [Resident #10] was placed on 15-minute checks. During a telephone interview on [DATE] at 12:15 PM, TNA N stated she no longer worked for the facility. She stated she voiced her concerns about working alone on the hall's multiple times to the Administrator and the DON. She stated she left the facility because she felt the staff and the residents were in danger. She stated she received no CNA training and no training regarding behaviors. She stated she worked alone most of her shifts, but she could not state the exact dates. She stated she was alone on Hall 200/Unit 2 (male secured locked unit) when Resident#1 and Resident #3 got into resident-to-resident altercation on [DATE]. She stated she had to scream for help and LVN P at the nurse's station behind the locked doors heard her and came to help her. She stated after the altercation, Resident #3 was placed on every 15-minute checks. She stated the facility did not provide another staff member to help. She stated she was required to perform 15-minute checks on Resident #3 and care for the other residents alone for the rest of her shift. Record review of 15-minute check documentation revealed no signatures of who performed the checks. The document just provided the location of Resident #9 every 15-minutes. Record review of the facility employee timecards for [DATE] at 3:55 PM revealed Station 2 had 2 LVNs, 1 CNAs, and 1 TNAs working with a census of 108. Record review of the facility staff schedule dated [DATE] revealed 7 nursing aides, Record review of the facility staff schedule dated [DATE] revealed there was 1 TNAs working Hall 200/Unit 2 (male secured locked unit), without the supervision of a CNA, with a census of 18 residents with known aggressive behaviors. Record review of the Provider Investigation Report dated [DATE] revealed on [DATE] at 4:29 PM, [Resident #10] pushed [Resident #1] against the wall and [Resident #1] slid down the wall. [Resident #1] complained of lower back pain. X-ray results showed acute L1 compression fracture. During a telephone interview on [DATE] at 5:00 PM, TNA O stated she was working Hall 200/Unit 2 (male secured locked unit) alone on [DATE] when Resident #9 and Resident #1 got into a resident-to-resident altercation. She stated the nurse was not on the unit. She stated a CNA had come to the unit to relieve her for a lunch break. She stated if the CNA had not come, she would have had to leave the unit unsupervised to go get help. She stated the nurses are only on the unit while passing medications. She stated she always worked the halls alone, but she could not state the exact dates. She stated she received no training and was thrown into working the halls alone. She stated she voiced her concerns about working alone, especially because she was pregnant with the Administrator and the DON. She stated she was aware of the resident behaviors but only because she had worked on Hall 200/Unit 2 (male secured locked unit) since she was hired. She stated she left the facility because she felt unsafe and uncomfortable, and she felt the residents were not safe. (continued on next page)

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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 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility employee timecards for [DATE] at 4:29 PM revealed Station 2 had 2 LVNs, 2 CNAs, and 5 TNAs working with a census of 108. Record review of the facility staff schedule dated [DATE] revealed there was 1 TNAs working Hall 200/Unit 2 (male secured locked unit), without the supervision of a CNA, with a census of 18 residents with known aggressive behaviors. Record review of 15-minute check documentation revealed no signatures of who performed the checks. The document just provided the location of Resident #10 every 15-minutes. During an interview on [DATE] at 1:30 PM, Resident #8 who resided on Hall 100/Unit 1 (male secured locked unit) stated the facility never had enough staff. He stated all the residents were always arguing and fighting and no one did anything about it. He stated he hated living in the facility. Resident stated that he had spoken to the Administrator and the DON multiple times. During an interview on [DATE] at 1:45 PM, Resident #7 who resided on hall 400 stated he was blind and never got the help he needed. He stated he was left alone all day and became agitated because no one helps him. He stated he could never find anyone and many tasks he was not capable of doing on his own. He stated there was no need to report it because no one cared. During an interview on [DATE] at 2:40 PM, DON stated TNAs completed an 8-hour online course, they received in house training with a CNA, and skills check offs were completed by the DON, ADON, or CNAs. She stated TNAs can do all resident care task alone without CNA supervision. She stated that she never staffed just 1 TNA alone on a unit. She stated that she did staff 2 TNAs on units without CNA supervision. She stated TNAs are not first aide or CPR certified. She stated if an emergency did happen there is always a nurse on the unit. DON stated the facility is always adequality staffed but did not provide evidence to prove adequate staffing. During an interview on [DATE] at 3:00 PM, with agency CNA D she stated she had worked on a unit alone during multiple shifts, but she could not state the exact dates. CNA D stated that she was an agency CNA and was not oriented to the [TRUNCATED]