STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106017	A. Building B. Wing	03/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Palma Sola Bay	6305 Cortez Rd W Bradenton, FL 34210

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42798 Based on observation, interview, and record review, the facility failed to ensure one (Resident #250) of four resident's advanced directives were verified and accurate within a timely manner. Findings included: Resident #250's admission record revealed an admitted [DATE] with medical diagnoses of major depressive disorder and heart disease. Resident #250's medical certification for Medicaid long-term care services and patient transfer form (3008), dated 3/17/2022, revealed the resident required a healthcare surrogate for decision making and had an advanced care planning selection of DO NOT Resuscitate (DNR). An interview on 03/21/22 at 11:56 a.m., with Resident #250's Healthcare Representative/Friend, revealed the representative had documentation within her bag that indicated she was the resident's healthcare surrogate. The Representative stated that should Resident #250 be found non-responsive and without breathing, they had made the code status selection of DNR. A record review of Resident #250's order summary report revealed an active physician order for a code status of full code, which indicated that should the resident be found non-responsive and without breathing, live saving measures would be provided. A record review of Resident #250's progress notes, from 03/18/22 (date of admission) to 3/20/22, revealed no notations related to advanced directives discussions with either the resident or the resident's representative. Interviews on 03/21/22 with Staff A, Licensed Practical Nurse (LPN) at 12:00 p.m and Staff B, LPN at 12:15 p. m., revealed the procedure was for the admitting nurse to confirm the resident's advanced directives for code status selection. Also, the online medical physician orders should match the hard medical chart related to advanced directive selection. An interview with Staff C, LPN/Unit Manager on 03/21/22 at 1:14 p.m., revealed the admitting nurse should review a resident's admission paperwork to determine the advanced directives. This was done in-conjunction with speaking with both the resident and/or resident's representative. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 03/21/22 at 1:18 p.m., with the Director of Nursing (DON), Regional Director of Clinical Services, and Interim-DON, revealed the admitting nurse should ask the resident what their code status selection was, and if they were not their own person, the resident's representative. The code status verification process should be done as quickly as possible. If there was conflicting information with the resident's medical record, staff would be expected to contact their higher ups to determine the next steps. This process could be done by the weekend nurses as well. A policy review of Advanced Directives, revised on 11/14/2018, revealed the policy is The center will abide by state and federal laws regarding advanced directives. The center will honor all properly executed advanced directives that have been provided by the resident and/or resident representative . Upon admission, Social Services Director or Business Development Coordinator/designee will: a) Communicate to resident and/or resident representative his or her right to make choices concerning health care and treatments, including life sustaining treatments. B) Determine Whether the resident has an advance directive and, if not, determined whether the resident wishes to establish an advance directive. C) document in the resident's record via the Advance Discussion Form that the resident and/or resident representative has been apprised of his or her right to formulate an advance directive . Advanced Directives will be reviewed . Identify and clarify the content and intent of the existing care instructions, and whether the resident wishes to change or continue these instructions.

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40521 Based on observation, record review, interview, and policy review, the facility failed obtain physician's admission orders related to 1. continuous oxygen for two (Residents #198 and #76) of ten residents who wear oxygen, 2. failed to input physician orders related to wound care for one (Resident #346) of two residents, and 3. catheter care for two (Resident, #52, #197) of six residents with indwelling catheters. Findings included: 1. On 03/21/2022 at 10:14 a.m., an observation was conducted of Resident #198 sleeping and receiving four liters of oxygen via nasal cannula (NC) from an oxygen concentrator next to her bed. On 03/22/2022 at 10:52 a.m., Resident # 198 was observed speaking to a facility staff member and receiving four liters of oxygen via nasal cannula from an oxygen concentrator next to her bed. On 3/23/2022 at 2:30 p.m. Resident #198 was observed lying in bed sleeping and receiving four liters of oxygen via nasal cannula from an oxygen concentrator next to her bed. Record review of the facility profile sheet for Resident #198 indicated she was initially admitted on [DATE] and readmitted on [DATE], She was admitted with multiple diagnoses that included Chronic Obstructive Pulmonary Disease, (COPD). A review of the physician orders revealed no active order for Resident #198 to receive continuous oxygen at four liters per nasal cannula. Record review of Resident #198's Treatment Administration Record (TAR) indicated on 3/3/2020, the resident had oxygen saturations taken each shift, and the four liters of continuous oxygen was to be discontinued on 3/7/2022. Record review of the facility re-admission assessment dated [DATE] under respiratory revealed the following information. 8 A. Oxygen lists 4 L/NC, 8 B. Oxygen Saturation 93%, and 8 C. Continuous Cannula. The transfer form 5000-30008 dated 3/18/2022 from the local hospital listed under Treatment Devices -Oxygen 4 L continuous. On 3/23/2022 at 2:00 p.m., an interview was conducted with Staff D, Registered Nurse (RN). Staff D revealed the process for admission orders was to have two nurses check the physician's orders when a new admission came into the facility. An interview was conducted with the Regional Director of Clinical Services and the Director of Nursing (DON) on 3/23/2022 at 3:00 p.m., related to Resident #198 wearing continuous oxygen without an active physician order. The Regional Director of Clinical Services indicated the DON was brand new to the facility, and to the process of the facility to verify all orders for newly admitted residents, and stated, if it is prescribed ., it should be in the orders. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #76's Admission Record revealed that he was admitted to the facility on [DATE] with diagnoses to include but not limited to, acute respiratory failure with hypoxia, emphysema, and chronic obstructive pulmonary disease. A review of the Minimum Data Set (MDS) assessment dated [DATE], Section C: Cognitive Patterns revealed a Brief Interview for Mental Status (BIMS) score of 09, which indicated Resident #76 had moderately impaired cognition. Section O: Special Treatments, Procedures, and Programs revealed Resident #76 used oxygen therapy. A review of the Care Plan dated 03/04/22, revealed Resident #76 had a focus area for altered respiratory status, difficulty breathing related to a history of COVID-19 and respiratory failure. Goals included: the resident will have minimal risk of complications related to shortness of breath. Interventions included administer medications and puffers as ordered. A review of Resident #76's most recent physician orders revealed no orders for the use of oxygen therapy. A review of the nursing progress notes revealed that Resident #76 received oxygen via the nasal cannula on 03/22/22, 03/16/22, 03/15/22, 03/12/22, 03/11/22, 03/09/22, 02/26/22 and 02/22/22. On 03/21/21 at 10:59 a.m., Resident #76 was observed in bed, wearing a nasal cannula connected to an oxygen concentrator set at two liters per minute. Additionally, an oxygen tank was observed on the back of the resident's wheelchair. On 03/22/22 at 12:08 p.m., Resident #76 was observed in bed wearing a nasal cannula connected to an oxygen concentrator set at two liters per minute. Resident #76 stated that he was not sure if his oxygen was supposed to be set at two or three liters. Additionally, an oxygen tank was observed on the back of the resident's wheelchair (photographic evidence obtained). On 03/23/22 at 12:39 p.m., Resident #76 was observed in bed. The resident was not observed wearing the nasal cannula. The oxygen concentrator was observed in the room but was not turned on. The oxygen tank remained on the back of the wheelchair. The resident stated that the nurse told him he no longer needed to use the oxygen concentrator. He stated that his breathing was ok for now and he was able to breathe fine without the oxygen concentrator. On 03/24/22 at 10:18 p.m., an interview was conducted with Staff I, Certified Nursing Assistant, CNA and Staff J, CNA. She stated Resident #76 used his nasal cannula and oxygen concentrator most of the time. On 03/24/22 at 1:27 p.m. an interview was conducted with Staff C, Licensed Practical Nurse (LPN), Unit Manager. She confirmed Resident #76 used oxygen therapy via nasal cannula. She confirmed that she could input orders into the electronic health record (EHR), but it depended on what information was provided from the Admissions Department. Staff C stated if she received a new admission packet that contained only a hospital transfer form (3008) and a medication list, she could only input those along with the general orders into the EHR. If she had not received all the information, the nurse would have been responsible to input the information that remained. She did not confirm who was responsible for inputting the admission orders for Resident #76's usage of oxygen therapy. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #346's Admission Record revealed she was admitted to the facility on [DATE] with a primary diagnosis of cellulitis of the lower limb. A review of the admission notification form revealed a section titled Special needs that indicated a wound vacuum was needed upon admission. A review of the hospital transfer form (3008) revealed a section titled Skin care- Stage and assessment that indicated a right leg wound vacuum. A review of Physician orders dated 11/24/21 revealed wound vacuum suction and change dressing biweekly. Xeroform petrolat patch 2 (Bismuth Tribromoph-Petrolatum), apply to right lower leg topically every day shift, every three days for wound. Cleanse right lower limb with normal saline and pat dry. Apply Xeroform to wound site and cover with a clean dry dressing every other day and as needed. A review of the treatment administration record (TAR) revealed wound care was performed on 11/19/21, 11/24/21 and 11/30/21. A review of the initial consult with the facility wound care physician on 11/18/22 revealed Resident #346 had a surgical wound located on the right lower leg. Following the consultation, wound care orders to cleanse/irrigate the wound with normal saline/water, apply Xeroform petroleum dressing, cover with dry dressing, and change dressing every other day for three days were provided to the nursing staff. A review of the Admission/Readmission Data Collection Assessment Section M: Skin dated 11/15/21 revealed Resident #346 had a right lower leg wound with scant serous drainage, wound bed was red and wound edges were well approximated. A review of the local hospital Diagnosis, Assessment and Plan dated 11/15/21 revealed, Resident #346 had wound vacuum placement to the right leg. An additional Diagnosis, Assessment and Plan dated 11/12/21 revealed the resident was to discharge to a nursing facility with a wound vacuum. On 03/24/22 at 1:15 p.m., an interview was conducted with Staff C, LPN, Unit Manager. She confirmed Resident #346 was admitted to the facility with orders for a wound vacuum but did not have one when she arrived to the facility. She stated the information was documented on the hospital transfer form (3008). She stated after admission, the resident was assessed by Staff C and the previous Director of Nursing (DON). She stated together they agreed the wound did not require a wound vacuum. The DON called the physician for an order for wound care. Staff C confirmed the resident was assessed by the facility Wound Care Physician the following day but did not provide the exact date. Staff C stated during the assessment she was notified that the wound was a surgical wound. Staff C stated the resident's family member notified her that Resident #346 was previously going to the local wound care center for treatment. Staff C called the local wound care center to schedule an appointment. The appointment was scheduled for 11/24/21 and the resident received a wound vacuum the same day. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/24/22 at 6:14 p.m. an interview was conducted with the Nursing Home Administrator (NHA). He confirmed Resident #346 was admitted to the facility on [DATE] and he was aware she needed a wound vacuum upon admission. He stated the facility always had at least three wound vacuums on hand and Resident #346 was discussed in the morning meeting after admission on 11/16/21. He stated on 11/17/21 Staff C and the previous DON confirmed the resident no longer had a wound vacuum because she did not need it. He confirmed he should not have trusted the clinical team. He stated a grievance was filed later that week or the following week by a family member related to the wound vacuum. The NHA stated the family member told him Resident #346 was supposed to receive a wound vacuum upon admission to the facility. The NHA stated he informed the family member according to his clinical team, she no longer needed the wound vacuum. The NHA stated after Resident #346 was assessed by the facility wound care physician the NHA filed a grievance related to the incident. He confirmed they had the wound vacuum on hand at the facility however, the resident did not receive it. The resident did not receive a wound vacuum until after her appointment at the local wound care center on 11/18/21. He stated that the facility dropped the ball. 3. An observation on 03/21/22 at 10:21 a.m. of Resident #52 revealed the resident lying in bed with an indwelling urinary catheter bag and tubing in place. Resident #52's admission record revealed an admitted [DATE] with a medical diagnosis of neuromuscular dysfunction of the bladder. Resident #52's medical certification for Medicaid long-term care services and patient transfer form (3008), dated 1/31/22, revealed the resident had an indwelling catheter inserted on 1/20/22. The hospital attempted to remove the catheter on 1/18/22 but was not successful. A record review of Resident #52's order summary report revealed the resident did not have physician orders put into place upon admission for the care and treatment of the urinary indwelling catheter. An observation on 03/23/22 at 12:37 p.m., revealed Resident #197 sitting up in her wheelchair with an indwelling catheter bag in place underneath the wheelchair within a privacy bag. Resident #197's admission record revealed an admitted [DATE]. Resident #197's 3008, dated 3/11/22, revealed the resident had a urinary catheter in place due to urinary retention. A record review of Resident #197's order summary report revealed the resident did not have physician orders put into place upon admission for the care and treatment of the indwelling urinary catheter. A review of the facility policy titled Physician Orders, with revision made on 03/03/2021, Page 01 reads as follows POLICY: The center will ensure that Physician Orders are appropriately and timely documented in the medical record. Procedure: (Admission Orders) (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Information received from the referring facility or agency to be reviewed, verified with the physician, and transcribed to the electronic medical record. The attending physician will review and confirm orders. Confirmation of admission orders requires that the physician sign and date the order during, or as soon as practicable after it is provided, to maintain an accurate medical record. 45003 42798

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on observations, record reviews, and interviews, the facility failed to ensure one (Resident #7) of eighteen residents residing on the secured memory care unit received hair care as necessary to prevent matting. Findings included. Resident #7 was admitted on [DATE]. The Admission Record included diagnoses not limited to unspecified dementia without behavioral disturbance, and schizophreniform disorder. Resident #7 was observed on 3/21/22 at 11:32 a.m., with hair that extended to mid-back and combed straight down in the front, the top, and a thin layer of tendrils in the back, underneath appeared to be matted at the nape. On 3/22/22 at 10:53 a.m., the residents hair continued to be matted at the nape of the neck. Staff L, Licensed Practical Nurse (LPN), stated, at 11:11 a.m. on 3/22/22, the resident did not allow staff to brush the back of hair. On 3/22/22 at 11:30 a.m., Staff L reported the attempt to brush the resident's hair (attempted between interviews on 11:11 a.m. and 11:30 a.m. on 3/22/22) did not go well. The LPN stated Resident #7 would not allow it and then would make it worse by rubbing the back of the head. She reported staff had untangled the resident's hair on Sunday (3/20/22). On 3/23/22 at 12:16 p.m., the resident was observed sitting near the living room with her hair matted against the nape of the her neck. Staff L stated, on 3/23/22 at 1:01 p.m., another aide was going to bring in detangler for Resident #7 tomorrow (3/24/22). During an interview with the Regional Director of Clinical Services (RDCS) and Director of Nursing (DON), on 3/23/22 at 2:40 p.m., the RDCS stated Resident #7 could be difficult. If staff were unable to take care of the matting of the resident's hair, the Power of Attorney should be notified and asked for assistance and how they wanted the hair to be kept. A review of the Admission Record for Resident #7 identified that the resident had short hair when the photo was taken. An observation was made, on 3/24/22 at 11:46 a.m. of Resident #7 ambulating in the secured memory care unit. Her hair was in a ponytail and unmatted. Staff L stated staff had applied a detangler to the resident,s hair, reapplied it and left it like 2 hours, bathed the resident, and was able to comb the hair out. On 3/25/22 at 10:13 a.m., Resident #7 was observed ambulating in the hallway of the unit. The resident was wearing a ponytail that was knotted up in the back around the hair tie. The Visual/Bedside Kardex Report for Resident #7 identified the resident was to shower on Tuesday and Friday on the 3:00 p.m.-11:00 p.m. shift, required set up assistance with bathing, and staff were to provide assistance as needed. The Kardex indicated that the resident required assistance with personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Policies and Procedures - Bathing/Showering, effective 11/30/2014 and revised 9/1/2017, indicated that assistance with showering and bathing would be provided at least twice a week and as needed (prn) to cleanse and refresh the resident. The policy did not identify how staff should assist residents with personal hygiene such as the maintenance of hair. The care plan for Resident #7 identified that the resident had a behavior problem of delusional thoughts and included the refusal of personal care. A review of Resident #7's February and March 2022 Medication Administration Records(MAR) identified that staff were to monitor for behaviors every shift related to the administration of psychoactive medications. The legend included on the MAR for the behaviors exhibited indicated that staff were to document 10 - resists care, neither MAR (February or March) indicated that Resident #7 had resisted care during any shift.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on observations, record reviews, and interviews, the facility failed to ensure a change in condition was documented and monitored for one (Resident #97) of one resident sampled. Findings included: Resident #97 was admitted on [DATE]. The Admission Record for the resident included diagnoses not limited to subsequent encounter for fracture with routine healing fracture of other parts of pelvis, unspecified chronic obstructive pulmonary disease, and unspecified atrial fibrillation. The Admission Minimum Data Set (MDS), dated [DATE], identified a Brief Interview of Mental Status (BIMS) score of 13 out of 15, indicative of an intact cognition. The MDS indicated Resident #97 received oxygen therapy prior to admission and received two days of Occupational and Physical Therapy, which started on 1/3/22. A review of Resident #97's progress notes identified on 1/3/22 at 2:27 p.m., the nurse noticed the resident looked a lil [sic] lethargic. The note indicated the residents' vital signs were not stable and an unsuccessful attempt was made to contact the physician. The review of assessments completed for Resident #97 did not indicate any further documentation of the resident's condition until a Skilled Note dated 1/5/22, indicated the resident was oriented to person, had swallowing problems, was depressed, lung sounds were clear with no cough, and oxygen was not in use. The COVID-19 Symptom Monitor assessment, dated 1/8/22, indicated the resident had a cough, shortness of breath, and fatigue. The COVID-19 PCR test for Resident #97, reported on 1/9/22, indicated the resident had positive results. The assessments of Resident #97 did not include any COVID-19 Symptom Monitor assessments from 1/8/22 until 1/12/22. The progress notes included documentation of a skilled note on 1/8/22, eMedication Administration Record (eMAR) notes on 1/10/22 which indicated the resident's blood pressure was low, the resident refused a recheck, and a skilled note on 1/12/22. Neither of the eMAR notes indicated the physician was notified of the resident's blood pressure or the Metoprolol had been withheld. The clinical record did not indicate an assessment was completed for the resident's change in condition on 1/10/22 or that the physician and representatives were notified. The review of the progress notes for Resident #97 indicated staff had documented three daily skilled notes on 1/5/22 at 6:37 a.m., 1/8/22 at 11:36 a.m., and 1/12/22 at 8:49 p.m. during the resident's stay at the facility. The January 2022 Medication Administration Record (MAR) included an order for, Daily Skilled Note UDA (user defined assessment). Due every shift. Please complete the Daily Skilled Note UDA. The MAR indicated staff had administered a Daily Skilled Note every shift except for the day shift on 1/1/22 and the evening shift on 1/13/22. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/23/22 at 2:27 p.m., the Regional Director of Clinical Services (RDCS) stated she would expect the resident to be seen on the next visit by physician and the nurse would have followed up with the family. The RDCS reported staff should have done COVID symptom monitoring and would have expected documentation regarding the residents change in condition and to follow up with it. The policies and procedures - Notification of Change in Condition, effective 11/30/2014 and revised on 12/16/2020, indicated that The Center to promptly notify the Patient/Resident, the attending physician, and the Resident Representative when there is a change in the status or condition. The procedure identified that the nurse was to notify the attending physician and resident representative when there was Significant change in the patient/resident's physical, mental, or psychosocial status. The procedure instructed staff to complete an evaluation of the patient/resident, to document the evaluation in the medical record, notify the patient/resident and the resident representative of the change in condition and document in the medical record, and to complete a Situation, Background, Assessment, and Recommendation (SBAR) as indicated.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44329 Based on observations, interviews, and record review, the facility did not ensure one (Resident #34) of three residents sampled for nutrition was weighed at least monthly and documented in their health record. Findings included: A review of Resident #34's admission record revealed the resident was admitted to the facility on [DATE]. Resident #34 had diagnoses of dysphagia, diabetes mellitus (DM), anemia, and Alzheimer's disease upon admission. A review of Resident #34's care plan completed on 01/05/2022 showed a nutritional problem focus related to diagnoses of dysphagia, DM, anemia and Alzheimer's disease. Interventions included monitor, document, and report any signs or symptoms of malnutrition to include significant weight loss. A review of Resident #34's electronic medical record (EMR) revealed no weights documented for February or March of 2022. On 03/23/22 at 12:30 p.m., Staff F, Licensed Practical Nurse (LPN), stated Resident #34 should be weighed at least once a month and confirmed there were no weights documented in the EMR since January 2022. On 03/23/22 at 1:00 p.m., Staff G, Certified Nursing Assistant, CNA, stated they (CNAs) were responsible for all resident's weights. She confirmed Resident #34 was not weighed in February of 2022, was weighed in March, but the weight had not been entered into the EMR. A review of the facility's Weighing the Resident Policy and Procedure revealed that residents would be weighed, unless ordered otherwise by the physician, at least monthly.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 42798 Based on interview, resident record, and policy review, the facility failed to provide the least restrictive behavioral health services to one (Resident #251) of two residents to aid in behavioral de-escalation. Findings included: Resident #251's progress notes, dated 12/31/2021 at 9:25 p.m., revealed patient was very upset and agitated over her cigarettes so she refused to take all her medications and refused for her vitals to be taken. Further review of the resident's progress notes, dated 12/31/21 at 10:05 p.m. and written by Staff ZZ, Licensed Practical Nurse (LPN) revealed, This resident was transferred out of facility after screaming, yelling . People are stealing, I'm out of here! . This occurring at the nursing desk on [NAME] [west unit], during a code. When this writer attempted to explain that she would need to wait as we had an emergency, she began shouting . She responded . I'm gonna go sit somewhere, I know [City Name] . She continued to be disruptive and exit seeking. [Nursing Home Administrator (NHA)] had her moved to the Memory Unit for her own safety. While a memory unit she was yelling and refusing to move so as not to disturb others. Call place to [Physician] and administrator. this behavior was reported to be a change in resident's baseline . N.O. [new order] to send to [Hospital Name] ED [emergency department] for evaluation with Sheriff Dept [department] escort. Once resident knew she had a ride she calmed right down . Resident #251's admission record revealed the resident's medical diagnoses included cerebral infraction, alcohol abuse, dementia, anxiety disorder, major depressive disorder, and tobacco use. A psychiatric evaluation, dated 12/6/21, revealed Resident #251 . will be a long term resident of this SNF [skilled nursing facility], and [Resident #251] past medical history includes dementia, anxiety, depression, and tobacco abuse . Staff reports patient is cooperative with care, is complaint with medications . Per Staff, {Resident #251] has been increasingly tearful and depressed. On page 2 of this document, a goal for the resident stated Patient will not experience any adverse effects throughout the review period. Resident #251's Care Plan revealed a focus area, with a cancellation date of 01/31/2022, . is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t [related to] Cognitive deficits, Disease Process . [Resident #251] also likes the outdoors. Interventions for this focus area included providing the resident with individualized activities as desired. A smoking evaluation was completed for Resident #251 on 10/25/2021 which revealed the resident was a safe smoker and did not require supervision while smoking. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Resident #251's Family Member on 03/24/22 at 10:41 a.m. revealed the resident had a long history of abusiveness and schizophrenia. The resident was currently homeless with a history of signing herself out of medical facilities against medical advice. The facility notified her after the event in December 2021 that Resident #251 was lashing out at staff. The resident liked being outside and moving around and could be redirected, however, . is a difficult person. Interviews on 03/24/22 at both 11:27 a.m. with Staff P, Registered Nurse (RN) and 11:30 a.m. with Staff O, LPN confirmed if a resident requested to go outside and smoke an aide would go with them. There was usually a CNA assigned to smoking duties. If a resident was exhibiting aggressive behaviors or having an outburst, they would be redirected and reapproached. An interview with Staff N, Certified Nursing Assistance (CNA) on 03/24/22 at 1:07 p.m., revealed all smoking materials were located and provided to the residents outside where a CNA stayed with them until they were finished. This was the same procedure during the evening and night shift. The memory unit had an outside patio that could be used for residents that wanted to go outside and smoke. An interview on 03/24/22 at 4:26 p.m. with Staff ZZ, LPN revealed, on the night of 12/31/22, there was an emergency with another resident that required immediate attention by staff. Upon Staff ZZ's arrival to the west unit, Resident #251 was standing by the nursing station screaming, saying she wanted to leave the facility against medical advice because someone stole her cigarettes. Resident #251 kept repeating the desire to walk around the city. Staff ZZ, LPN stated she was not sure what specifically caused the resident to escalate in behaviors. Staff ZZ stated the resident's behaviors of screaming and yelling continued to escalate even after being moved onto the memory unit which resulted in the police needing to be called along with emergency medical services. Staff ZZ confirmed the memory care unit also had an outside patio area for residents to sit and also smoke cigarettes if needed. An interview on 03/24/22 at 1:45 p.m. with Staff XX, Advanced Registered Nurse Practitioner (ARNP) revealed Resident #251 was a patient that was not able to express themselves well due to having confusion and forgetfulness. The ARNP stated it could take time for a resident to adjust to their new environment, and that new places could take a toll on a resident. Residents might have behavioral changes and if they had an outburst or change in behavior, it might just be the approach to the situation as to why they were not calming down. An interview on 03/24/22 at 2:43 p.m. with the Executive Director (ED), also known as the Nursing Home Administrator, revealed on 12/31/21 Resident #251 started displaying a change in demeanor with escalating behaviors of screaming, yelling, and wanting to leave the facility. The resident was moved onto the secured memory care unit. However, this did not help the resident and the behaviors only worsened. At this point outside services were called and the resident was sent to the hospital. The resident was baker acted at the hospital. During this interview, the ED said usually during morning meetings, these types of situations would be reviewed, however, the facility was waiting on information from the hospital which did not come. The ED stated he was not aware of any reasons or factors as to why the resident was having the escalating behaviors. The ED confirmed the expectation during these situations was for the staff to attempt to deescalate the resident's behaviors. If the resident requested to smoke and was having a change in behavior, one intervention to deescalate the situation would be to go outside and smoke with the resident. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #251's medical record was reviewed during this interview. The ED confirmed he was not aware of the notations that the resident had requested to go outside and smoke, was denied, and therefore this could have been the root-cause as to why the resident had a change in behavior. A policy review of Behavior Management, revised on 3/21/2019, revealed the policy is to Resident with dementia or related disorders are not responsible for their reactions due to the irreversible changes in the brain. Reactionary conduct can only be prevented and controlled by well-trained therapeutic caregivers. The purpose is to improve the quality of life by proving therapeutic interventions to address behavioral concerns which occur as a result of changes in the brain from dementia and related disorders. Primary interventions for this policy include All staff must act in the best interests of the residents at all times. The actions of the staff shall be based on relevant knowledge of dementia and related disorders, specific knowledge of the residents, empathy and knowledge of interventions as listed below to maintain dignity and prevent injury . Hold out your hand and ask the resident to come with you. Take the resident for a short walk, offer a snack or involve in an activity.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on observations, record reviews, and interviews, the facility failed to ensure one (Resident #7) of five residents sampled for the administration of unnecessary medications received adequate monitoring for abnormal movements related to the use of antipsychotic medications. Findings included: Resident #7 was admitted on [DATE]. The Admission Record included diagnoses not limited to schizophreniform disorder, unspecified anxiety disorder, unspecified single episode major depressive disorder, and unspecified dementia without behavioral disturbance. Resident #7 was observed ambulating on 3/21/22 at 10:28 a.m. in the secure memory care unit. The resident ambulated to the doors leading to main unit of facility, was brought back to unit's living room by Staff M, Certified Nursing Assistant (CNA). The resident continued to wander throughout the unit. Resident #7 was observed on 3/22/22 at 10:47 a.m. wandering in the hallway of the secure unit. On 3/23/22 at 12:16 p.m., the resident was observed sitting near the unit's living room where other residents had gathered. Resident #7 was observed on 3/24/22 at 11:46 a.m. self-ambulating in the hallway of the secure unit. A review of the March 2022 Medication Administration Record (MAR) identified physician orders: - Risperdal 0.5 milligram (mg) - Give one tablet by mouth two times a day related to Schizophreniform Disorder. The order was started on 2/8/22 and discontinued on 3/9/22. - Risperdal 1 mg - Give one tablet by mouth two times a day related to Schizophreniform Disorder. The active order was started on 3/9/22. A review of the February 2022 MAR identified a physician order: - Risperdal 0.5 mg - Give one tablet by mouth two times a day related to Schizophreniform Disorder. This order was started on 2/8/22. According to MedlinePlus, located at https://medlineplus.gov/druginfo/meds/a694015.html, Risperdone (Risperdal) is in a class of medications called atypical antipsychotics that is used to treat symptoms of schizophrenia, amongst other conditions and works by changing the activity of certain natural substances in the brain. The website information identified that some serious side effects that may occur while users are administered Risperdal included unusual movements of your face or body that you cannot control. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #7's clinical record identified that the previous Abnormal Involuntary Movement Scale (AIMS) assessment was completed on 11/4/21. Photographic evidence was obtained. According to Medscape.com the AIMS assessment is recommended for patients receiving treatment with substances that may cause tardive dyskinesia (TD) and the assessment should be administered at baseline to document if any movements are present prior to medication usage and then at least every 3 months thereafter during the course of treatment. (Medscape.com indicated the role of the assessment (https://www.medscape.com/answers/1151826-4275/what-is-the-role-of-the-abnormal-involuntary-movement-scale-aims-in-the-evaluation-of-tardive-dyskinesia-td, updated October 17, 2018) During an interview, on 3/23/22 at 2:32 p.m., the Regional Director of Clinical Services (RDCS) stated if a resident was receiving a psychotropic medication the expectation was that an AIMS assessment would be done on admission, quarterly and annually. The policy and procedure: Medication Management - Psychotropic Medications, effective 11/30/2014 and revised 3/23/2018, identified that Resident(s) receiving anti-psychotic medications to have an AIMS completed quarterly, with initiation of new antipsychotic medication or increase in dosage.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 42798 Based on observation, interviews, and record review, the facility failed to ensure up to date resident assessments were completed related to 1) quarterly elopement assessments for three (Resident #58, #7, and #24) of three residents sampled. Findings included: Resident #58's admission record revealed medical diagnoses of muscle weakness, and dementia. The resident's care plan revealed a focus area of . is at risk for elopement, with a Last Care Plan Review Completed: 03/23/2022. A medical record review for Resident #58, under completed assessments, revealed the last completed Elopement Risk Assessment was done on 09/24/2021. Resident #7's admission record revealed medical diagnoses of cognitive communication deficit, muscle weakness, and schizophreniform disorder. The resident's care plan revealed a focus area of . is at risk for elopement, with a Last Care Plan Review Completed: 12/20/2021. A medical record review for Resident #7, under completed assessments, revealed the last completed Elopement Risk Assessment was done on 09/24/2021. Resident #24's admission record revealed medical diagnoses of Alzheimer's disease, dementia, and major depressive disorder. The resident's care plan revealed a focus area of . is an elopement risk/wanderer . with a Last Care Plan Review Completed: 12/17/2021. A medical record review for Resident #24, under completed assessments, revealed the last completed Elopement Risk Assessment was done on 09/24/2021. Interviews conducted on 03/23/22 at 11:40 a.m. with Staff D, Licensed Practical Nurse (LPN), 11:41 a.m. with Staff O, LPN, and at 11:45 a.m. with Staff E, Registered Nurse (RN) revealed an elopement risk assessment should be completed upon a resident's admission to the facility, and if any exit seeking behaviors were observed. During these interviews, it was revealed none of the staff members were sure how often after a resident's admission an elopement risk assessment should be updated and completed. During an interview on 03/23/22 at 1:56 p.m. with the Director of Nursing and Regional Director of Clinical Services, it was revealed an elopement risk assessment should be completed quarterly. The elopement risk assessments were normally completed when the quarterly minimum data set assessments were done. An interview with the Director of Nursing and Regional Director of Clinical services on 03/23/22 at 2:20 p.m., revealed quarterly means the assessment should be completed every 90 days. The nursing staff were normally involved in completing these assessments and ensuring they were up to date. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A procedure review for Elopement Assessment Procedure, not dated, revealed Initial elopement assessment done in admission assessment. Assessment triggered again on day 7 of stay. Assessment completed quarterly, significant change, annual, or any behaviors/wandering/exit seeking behavior. 37999