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M 000	Initial Comments The State Agency (SA) conducted six (6) Complaint Investigations (CI MS #24008, CI MS #24884, CI MS#25027, CI MS #25192, CI MS#25296, and CI MS# 25297), from 5/28/24 through 5/31/24. During the investigation, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. The SA identified deficient practice related to CI MS # 25192, related to allegations of abuse and neglect and cited M500 and M640. The facility submitted CI MS #25296 and CI MS #25297 on 5/31/24 as part of the Removal Plan with no action necessary. The SA did not identify deficient practice for CI MS # #24008, CI MS #24884, and #25027 related to Quality of Care and Physical Environment. The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 5/30/24, which began on 11/17/23, when the facility neglected to identify and ensure appropriate services and interventions for residents with behavioral needs. The facility's failure to provide appropriate person-centered behavioral interventions resulted in the physical assault and death of a resident on 5/22/24. This placed all residing residents at risk, and in a situation which was likely to cause serious injury, harm, impairment, or death. On 5/30/24 at 10:30 AM, the SA informed the Nursing Home Administrator of the Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC). IJ and SQC existed at: Rule 45.17.2 Resident Rights M500 Level IV	M 000		

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M 000	Continued From page 1 Rule 45.21.8 Accidents M640 Level IV The facility submitted an acceptable Removal Plan on 5/30/24 at 5:30 PM, in which the facility alleged all corrective actions to remove the IJ and SQC were completed on 5/30/24 and the IJ was removed as of 5/31/24. The SA validated the Removal Plan on 5/31/24 and determined the IJ was removed prior to exit. Therefore, the scope and severity for Rule 45.17.2 Resident Rights M500 and Rule 45.21.8 Accidents M640 were lowered to a Level II, while the facility develops and implements a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. The facility had a census of 108 at the time of the survey and held a license for 111 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for	M 500		6/30/24

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M 500	Continued From page 2 services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule,	M 500		

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M 500	Continued From page 3 regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;	M 500		

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M 500	Continued From page 4 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available	M 500		

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M 500	Continued From page 5 choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level IV Based on staff interviews, record review, and facility policy review the facility failed to protect one (1) of 108 residents right to be free from neglect as evidenced by 11/17/23 Resident #3 being unwilling to sleep in his room with his roommate due to Resident #1 getting in the bed with Resident #3. This resulted in the death of another resident (Resident #2) when Resident #1 laid on top of Resident #2 who was placed in the room with Resident #1. The facility's neglect to identify roommate incompatibility and provide appropriate person-centered behavioral interventions from 11/17/23-5/22/24 placed Resident #2 at risk, caused his death and placed other residents in a situation which was likely to cause serious injury, harm, impairment, or death. The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 5/30/24, which began on 11/17/23, when the facility neglected to ensure appropriate services for residents with behavioral needs. The facility's failure to provide appropriate person-centered behavioral interventions resulted in Resident #1 lying on Resident #2 until death on 5/22/24. On 5/30/24 at 10:30 AM, the SA informed the Nursing Home Administrator of the Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) and provided the IJ Templates. The facility submitted a credible Removal Plan on	M 500	Resident #3 was provided a room change on 12/15/23. Resident #3 had no ill effects from this deficient practice. Resident #1 laid on top of Resident #2 on 05/22/24 and resulted in death of Resident #2. 1 on 1 supervision was provided for Resident #1 immediately on 05/22/24 until he was discharged on 05/23/24 to the custody of the local police department. All residents in the facility have the potential to be affected by this deficient practice. An in-service was initiated by the Vice President of Operations on 5/30/24 on all staff regarding Prevention and Supervision of Accidents, Abuse and Neglect, Abuse Reporting, Residents Rights, Implementing Interventions to prevent Reoccurrence and Updating Care Plans to Reflect Interventions and Monitoring of Behaviors. In-service details: When residents are observed in another resident□s bed to immediately intervene and separate. Staff instructed to notify the nurse immediately and protect the alleged victim by remaining 1 on 1 supervision with the alleged aggressor. No staff will be allowed to work until in-serviced. All new hire staff will be in-serviced upon hire. On 05/30/24 100% audit was completed by Social Services to determine if there were issues with Residents lying in other	

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M 500	Continued From page 6 5/30/24, in which the facility alleged all corrective actions to remove the IJ were completed on 5/30/24 and the IJ removed as 5/31/24. The SA validated the Removal Plan on 5/31/24 and determined the IJ was removed before exit. Therefore, the scope and severity for Rule 45.17.2 Resident Rights was lowered from a Level IV to a Level II while the facility develops and implements a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Review of the facility policy titled, "Abuse Prevention," dated 10/22 revealed: " Policy: The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to facility staff, other residents...." ...Definitions: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish .... Abuse may be resident -to -resident...Neglect: A failure of the facility, its employees, or service providers to provide goods and services necessary to avoid physical harm, mental anguish, emotional distress, or pain...Identification: Identify events, such as occurrences, pattens and trends that may constitute abuse; and determine the direction of the investigation..." Review of the facility policy titled, "Resident Bill of Rights" revealed a facility resident shall have the right to a safe environment and the right to be free of abuse and neglect. Record review of the facility reported incident	M 500	Residents' bed. No further concerns were identified. Starting on 06/03/24 the Administrator initiated making rounds five (5) times a week times 12 weeks to interview staff and residents to determine if there are any issues with Residents attempting to lie in other Residents' bed. Starting 06/03/24 the Director of Nurses initiated audits by reviewing nurses notes, twenty-four hour reports and incident reports 5 times a week times 12 weeks to determine if there are any issues with residents attempting to lie in other residents' bed. Any concerns will be immediately addressed. The results of the audits will be forwarded to the monthly Quality Assurance Committee times three (3) months beginning June 20, 2024. The Quality Assurance Committee will recommend the frequency of audits based upon the results achieved.	

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report that occurred on May 22, 2024, at approximately 3:30 AM, the following information was found: the staff responded to the call light in Resident #1's room, and he was observed unclothed and lying on top of Resident #2. Licensed nurses and Certified Nursing Assistants (CNA) intervened. Resident #2's body fell to the floor and cardiopulmonary resuscitation (CPR) measures were initiated. The emergency management services (EMS), and police department were notified. EMS arrived at the facility at approximately 3:50 AM. The EMS continued CPR measures until 4:12 AM when they discontinued life resuscitating measures. The local police arrived at the facility at approximately 3:50 AM and interviewed Resident #1, licensed nurses and CNAs. The local police took statements and confirmed Resident #2 was deceased. The local coroner arrived to examine Resident #2's body and then removed the body from the facility.

A phone interview with CNA #1 on 5/28/24 at 3:30 PM, revealed on the early morning of 5/22/24 at approximately 3:30 AM she responded to the call light going off and went into the room and observed Resident #1 naked and lying on top of Resident #2 in Resident #2's bed. She stated she instructed Resident #1 to get off of Resident #2 several times, but he would not get up, so she immediately went out into the hall and yelled for the nurse to come now, and Registered Nurse (RN) #1 came in and took over. CNA #1 revealed she had not heard any noises coming from the room that night.

A phone interview with CNA #2 on 5/28/24 at 5:36 PM revealed she was assigned to Resident #1 and Resident #2 on the early morning of 5/22/24. She stated at approximately 1:30 AM

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she was making rounds and observed Resident #1 was lying in bed listening to music and talking to himself which was normal behavior for both residents to have conversations with themselves, and Resident #2 was asleep in his bed. CNA #2 revealed around 3:00 AM she was making rounds and walked by the room and saw Resident #1 standing naked in front of his window but did not find that uncommon because Resident #1 often slept naked, and Resident #2 was in his bed on his side and appeared asleep. She stated that around 3:30 AM she was in an adjacent room and could hear one of the staff calling for the nurse to come help because Resident #1 was on top of Resident #2.

A phone interview with RN #1 on 5/29/24 at 7:30 AM, revealed on the morning of 5/22/24 at approximately 3:30 AM he was called to the room of Resident #1 and Resident #2. As he entered the room he observed Resident #1 lying naked on top of Resident #2 with only the hands of Resident #2 could be seen. Resident #1 was severely obese weighing 489 pounds and was covering his entire torso and head area. He stated he instructed Resident #1 to get up several times and when he did Resident #2 fell off the bed, on to the floor on his back and was not breathing. Resident #2 was a full code and CPR was immediately started, EMS was called and CPR was continued but was unable to revive Resident #2. RN #1 stated he asked Resident #1 what his date of birth and social security number were and Resident #1 answered correctly. When asked what he was doing, Resident #1 said, we were arguing and fighting I went to the nurses station and asked to call the police but we would not let him, he went back to his room and continued to argue and said Resident #2 said "I am going to kill you," I took offense to that so I hit

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him and got on top of him. RN #1 confirmed at no time during the shift did he see Resident #1 come to the nurse's station asking to call police but stated at some point Resident #1 stated he put the call light on when Resident #2 stopped fighting him. RN #1 then stated he interviewed Resident #1 after the incident and he was alert and oriented, and answered questions appropriately. He followed RN #1's command when he asked Resident #1 to go in the bathroom and he stayed when the CPR was started. RN #1 stated Resident #1 is alert and oriented most of the time, with frequent episodes of delusional episodes. He also revealed Resident #2 had frequent episodes of delusions and talking to himself. He stated he was not made aware of concerns that night, related to the residents. RN #1 then stated he has observed Resident #1 in bed with his roommates on two other occasions in the past but was not sure of the dates and confirmed it was reported to Administration by the nurses assigned to Resident #1 immediately. RN #1 revealed that the female nursing staff call him to help when some of the male residents will not respond to them. RN #1 confirmed Resident #1 was placed on one-on-one supervision after the incident but was not on any special monitoring before the incident.

Review of the facility investigation interview summary with Resident #1 under facility events for the incident that occurred on 5/22/24 revealed, Resident #1 was interviewed but his statement was disorganized speech, delusional, and at times nonsensical. Resident #1 told the nurse that he tried to use the phone at the nurses' station to call police before the incident but, the staff denied that he was at the nurse's station or requested to use the phone. During an interview with the Executive Director/Administrator, Director

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of Nursing (DON), and Regional Nurse Consultant they revealed that Resident #1 did not verbalize that he had called or tried to call the police before the incident. The information gathered from Resident #1 was that Resident #2 was "tormenting" him. Resident #1 said he got scared and went into the bathroom where he waited. After some time waiting in the bathroom, he said he wasn't going to wait for Resident #2 to "Choke my neck". According to Resident #1 he came out of the bathroom, then he said he hit Resident #2 multiple times on the head area. Initially, Resident #1 stated he hit Resident #2 once in the back of the head when he came out of bathroom before grabbing him. Resident #1 stated they tussled and wrestled for a while on the bed where Resident #2 was bear hugging him and scratching and biting him. Resident #1 said as he was holding Resident #2 on the bed, and then Resident #2 "gave up" after he got on "top of him". Resident #1 stated that he pressed the intercom for (staff) help. He stated that he held him down until staff could come to the room. Resident #1 also stated that he had called his dad who was working and that the police came and got his body. The resident at times rambled with disorganized speech and delusions. Resident #1 had increased delusions every time he was asked to recall the event even though there were times when his statements were consistent.

An interview with the Attorney General officer on 5/28/24 at 1:40 PM revealed he interviewed Resident #1 on 5/23/24 while Resident #1 was sitting in his chair in his room and he pointed to Resident #2's bed and stated, "I killed him right over there on that bed I smothered his nose." The Attorney General officer also revealed he notified the facility on 5/23/24 that the sheriff's office

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would be picking Resident #1 up to meet with mental health services.

Record review of an incident report dated 5/22/24 at 3:30 AM by Licensed Practical Nurse (LPN) #1 for Resident # 1 revealed, Incident description: Resident was observed lying on top of his roommate Resident #2, Resident #1 was redirected by RN #1 to go to the restroom. Resident #1 was assessed to have a scratch to his right interior shoulder measuring five inches by 0.4 inches and an abrasion to the last digit on his left hand measuring 0.2 inches by 0.2 inches. Immediate actions: Resident placed on 1-1 supervision. Mobility: Ambulates independently.

Record review of the incident report dated 5/22/24 at 3:30 AM by LPN #1 for Resident #2 revealed Resident #1 was found on top of Resident #2. Resident #2 was not responding to name being called loudly, no movement, CPR was started until the EMT arrived and continued CPR. Unable to obtain vital signs, no pulse noted, code call stopped at 4:12 AM. Resident #2 was observed to have ½ inch circular abrasion to his lower right eye and his nose was misshapen. Coroner was on site and pronounced Resident #2 expired at 4:12 AM and the body was released to the Coroner. Family, responsible party, medical provider, DON and Executive Director were notified.

Record review of the Behavior/Intervention Monthly Flow record for May 2024 for Resident #1 revealed behaviors to be monitored were physically/fighting aggressive, verbally aggressive (cursing), delusional, easily agitated, refusing care, and socially inappropriate with females (touching and remarks) with only one day of documentation of monitoring for the month of

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 500	Continued From page 12 May which was on 5/18/24 and revealed no behavior noted. There was no behavior monitoring for the behavior of getting into other resident's beds. Record review the departmental note for Resident #1 revealed a note by LPN #3 dating back to 11/17/23 at 2:25 AM that read CNA #4 who was assigned to Resident #1 reported during her rounds Resident #1 was noted lying in bed bedside his roommate, Resident #3. Resident #1 stated he was trying to keep his roommate warm. CNA #4 reported she did not see Resident #1 do anything wrong. LPN #1 informed Resident #1 he could not get into bed with other residents. Resident #1 stated "okay I was just trying to help him." The (ED) Executive Director/ Administrator, social services, and DON were notified. A phone interview with LPN #3 on 5/29/24 at 7:00 AM revealed she was assigned to Residents #1 and #3 on the early morning of 11/17/23. She revealed CNA #4 was working the hall that night and informed her that while she was making rounds, she observed Resident #1 lying in bed with his roommate Resident # 3. Resident #3 is a deaf mute, she stated CNA #4 told her that both residents were fully clothed. LPN #3 stated that she did not think anything about it because when she asked Resident #1 why he was in the bed with Resident #3 he told her he thought that was his son and wanted to keep him warm. She stated she and CNA #4 made statements and notified the Director of Nursing and the Social Services, but she was unaware if the incident was reported and confirmed that Resident #3 was assessed and had no visible injuries. She also confirmed she did not increase monitoring of Resident #1 or notify the provider because it just did not cross her mind that Resident #1 could	M 500		

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have attempted to abuse Resident #3 and stated, "I see now why I should have recognized that."

Record review of the departmental note for Resident #1 by Social Service #1, dated 11/17/24 at 2:14 PM revealed the writer was informed by a nurse that a CNA reported to her she observed resident lying in bed with his roommate: resident stated he was trying to keep his room-mate warm. CNA reported she did not see the resident doing anything. Resident #1 was counseled by social services and Resident #1 voiced understanding and will observe for any further behaviors.

Record review of the progress notes for Resident #1 revealed a note by LPN #2 on 12/10/23 at 1:22 AM that Resident #1 was observed in Resident #3's bed unclothed, refusing to get in his bed stating, " there are rats over there," after multiple failed attempts to redirect resident, he finally put his mattress on the floor and laid down.

A phone interview with LPN #2 on 5/28/24 at 5:00 PM, revealed she was assigned to Resident #1 and Resident #3 on the early morning of 12/10/23. During rounds she found Resident #1 lying naked in the bed with his roommate, Resident #3, and confirmed Resident #1 had to be instructed several times to get up before he would, stating "there were rats on his side of the room". She stated he finally got up and put his mattress on the floor and settled down. She revealed Resident #3 was severely cognitively impaired, a deaf mute and would not be able to call for assistance. She stated Resident #3 had a shirt and brief on at the time of the incident and was assessed to have no visible injuries. LPN #2 confirmed she notified the social worker, Administrator, the DON and confirmed she did

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not increase monitoring or supervision of either Resident #1 or #3 and did not notify the provider of the behavior. LPN #2 also revealed on the early morning of 5/11/24 she observed Resident #1 in another bed with no resident in the room and stated he did not want to go to his room because there were spiders in the room.

A document provided by Social Services #1 revealed Resident #3 resided with Resident #1 from 8/31/23-12/15/23.

Record review of the departmental notes for Resident #3 revealed a note by LPN #3 dated 11/17/23 at 12:25 AM that CNA #4 had reported Resident #3's roommate was noted lying in the bed with him.

Record review of the departmental notes for Resident #3 revealed a note by Social Service #1 a follow up visit related to roommate lying in bed with him. Resident is a deaf-mute unable to interview due to cognitive impairment but has not had any changes in mood, behavior, cognition or daily routine.

Record review of the Face Sheet revealed the facility admitted Resident #3 on 7/11/07 with the diagnoses of Deaf non-speaking and Autistic disorder.

Review of the departmental notes for Resident #3 revealed a note by Social Service #1 dated 12/15/23 at 11:09 AM that Resident #3 is being moved to another room related to roommate incompatibility.

An interview with the Social Service #1 assigned to the West wing on 5/29/24 at 1:00 PM, revealed she was informed of the incident on 11/17/23

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M 500	Continued From page 15 when Resident #1 was observed in Resident #3's bed. She stated that Resident #1 was clothed at the time of the incident, and she counseled him not to do that again. She stated she felt Resident #1 meant no harm because he said he thought Resident #2 was his son and was trying to keep him warm and was at times delusional. She stated she did not update Resident #1's plan of care or increase monitoring and confirmed she did not recognize this as a behavior. Social service #1 also confirmed that by not updating Resident #1's plan of care, the Interdisciplinary team not putting interventions in place to alert staff and potentially protect the residents in the facility. All residents were at risk. Resident #1 did not have increased monitoring, was ambulatory, very obese, and could have gotten into to any resident's bed, placing them at risk to be accidentally hurt or abused. Social Service #1 revealed she was not aware of the incident that occurred on 12/10/23, in the early morning hours, when Resident #1 was observed unclothed in Resident #3's bed. When asked if increased monitoring or treatment was put in place she stated she did not put any new interventions or monitoring in place because that was nursing's responsibility. An interview with the Vice President of Operations on 5/29/24 at 2:00 PM, revealed that the previous DON and Administrator were let go from the company on 1/22/24 and she was not able to find any investigations for the Resident #1 related incidents in November and December. She revealed she was unable to find any 1-1 supervision/ monitoring for Resident #1 for the Month of November and December 2023. She provided one document of 1-1 supervision for Resident #1 that was initiated after the death of Resident #2 on the morning of 5/22/24. She also	M 500		

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confirmed that she could not find evidence were Resident #1's behavior interventions or increased monitoring were ever updated after the incidents in November and December 2023 and confirmed that the potential was there for the other residents in the facility to be at risk for harm such as being smothered if Resident #1 got into their bed. She also confirmed after review of Resident #1's Behavior/Intervention Monthly Flow Record that staff were not completing the forms correctly and it appeared the resident was not monitored for behaviors. No increased monitoring forms were provided to the SA from the facility for Resident #2 or Resident #3.

An interview on 5/30/24 at 8:00 AM, with the previous Administrator whose last date of employment was 1/22/24 revealed she was not aware of any incidents of Resident #1 getting in the bed with another resident naked or clothed. She stated she would have reported and investigated it immediately because it could have been abuse and the residents in the facility are all vulnerable adults.

An interview on 5/30/24 at 8:30 AM, with the previous DON whose last date of employment was 1/22/24 revealed no one had ever reported Resident #1 getting into bed with his roommate. She stated if she had that information, she would have reported it immediately and measures in place to protect both residents.

An interview with the current DON on 5/30/24 at 9:30 AM, revealed she was not aware of Resident #1's behavior of getting into other residents' beds and was not employed at the facility during the time of the first two incidents. She confirmed the incident on 11/23 and 12/23 should have been thoroughly investigated, and

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interventions put in place to protect the residents. She went on to say that if after the first incident on 11/23 Resident #3, should have been moved, interventions put in place and there may not have been another incident with Resident #1 getting into resident's beds. The DON also confirmed Resident #1 should have been placed on 1-1 observation and the plan of care should have been updated for staff to be aware of the behavior to possibly intervene.

An interview with the Medical Director on 5/29/24 at 3:00 PM revealed the facility notified him of the incident on 5/22/24 related to the resident-on-resident death, but confirmed he was never notified of Resident #1 ever getting into any other residents' bed clothed or unclothed.

An interview with the psychiatric Nurse Practitioner (NP) on 5/29/24 at 3:30 PM, confirmed she was informed of the incident on 5/22/24 related to the death of Resident #2 but revealed she was not aware of Resident #1 getting into another resident's bed. She stated that she was aware of Resident #1's delusional/hallucinations.

Record review of the psychiatric encounter notes for Resident #1 dated 12/14/23, 3/5/24, and 5/22/24 revealed no mention of the behavior of getting into other resident beds.

An interview with the current Administrator/Executive Director on 5/31/24 at 8:00 AM, revealed all the incidents related to Resident #1 getting into his roommate's bed should have been thoroughly investigated.

Record review of the Face Sheet the facility admitted Resident #1 on 8/1/23 with the

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M 500	Continued From page 18 diagnoses of Unspecified Mood Affective Disorder, Unspecified Psychosis, and Anxiety disorder Record review of the quarterly Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) on 4/16/24, revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) score of 7 which indicated that he was severely cognitively impaired. Section E- Mood revealed no behaviors checked. Section GG-Functional Abilities and Goals revealed resident was independent with walking. Section K-Swallowing/Nutritional Status revealed a height of 76 inches and weight of 486 pounds. Record review of the Face Sheet revealed the facility admitted Resident #2 on 8/1/23 with the diagnoses of Unspecified mood affective disorder, Unspecified psychosis, and Generalized anxiety disorder. Record review of the quarterly MDS Section C with an ARD on 4/16/24, revealed that Resident #2 had a BIMS score of 9 which indicated that he was moderately cognitively impaired. Review of the Mortician Record/Record of Death for Resident #2 dated 5/22/24 time of death was 4:12 AM, body was released to local Coroner's office. The facility submitted an acceptable Removal Plan for the IJ. Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ: Summary of events: The facility was informed by the state agency on	M 500		

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M 500	Continued From page 19 5/30/24 at 10:30 AM of five immediate jeopardies. The state agency provided the facility with IJ template for F600, F609, F657, F689 and F742. On November 17, 2023, Resident #1 was clothed and observed in bed with Resident #3. Resident #3 was a vulnerable, deaf, mute male Resident. The facility failed to investigate, implement interventions, and revise Resident #1's care plan for this behavior. December 10, 2023, Resident #1 was observed in Resident #3 bed unclothed. Resident #3 was a vulnerable deaf, mute male Resident. The facility failed to investigate, implement interventions, and revise Resident #1's care plan for the behavior. On May 22, 2024, at approximately 3:30 AM, the staff responded to the call light in Resident #1's room, and he was observed unclothed and lying on top of Resident #2. licensed nurses and certified nursing assistants intervened. Resident #2's body fell to the floor and cardiopulmonary resuscitation measures (CPR) were initiated. The emergency management services (EMS), and police department were notified. EMS arrived at the facility at approximately 3:50 AM. The emergency management services continued cardiopulmonary resuscitation measures until 4:12 AM and discontinued life resuscitating measures. The local police arrived at the facility at approximately 3:50 AM and interviewed Resident # 1, licensed nurses and certified nursing assistants (CNA). The local police took statements and confirmed Resident # 2 was deceased. The local coroner arrived to examine Resident # 2's body and removed the body from the facility with the understanding that an autopsy would be completed to determine the final cause of death.	M 500		

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M 500	Continued From page 20 Corrective Actions: 1. On 05/22/2024 Resident #1 was placed on one-on- one (1-1) supervision immediately. Psychiatric placement was initiated on 05/22/24 at approximately 8:00 am but was unsuccessful. A telehealth visit was conducted with the psychiatric nurse practitioner on 05/22/24 at approximately 12:00 PM. Resident #1 remained on 1-1 supervision until he was discharged to the custody of the local police department on 05/23/24 at 3:45 PM. 2. The Administrator presented to the facility on 05/22/2024 at approximately 4:40 AM and initiated an investigation with assigned licensed nurses and certified nursing assistants. 3. On 05/22/24 The Administrator notified the MS State Department of Health at 5:50 AM, Attorney General Office at 9:00 PM and Ombudsman on 05/22/24 at 11:08 AM. 4. An in-service was initiated for all staff on 05/22/24 at approximately 5:30 AM regarding supervision of accidents and incidents, abuse/neglect, how to handle resident to resident altercations, reporting of any resident with delusional behaviors or verbalizing harmful behaviors to others, how to deal with aggressive behaviors. 5. A special resident council meeting was conducted on 05/22/24 11:30 AM by the Administrator and Director of Nurses to ensure that the facility's residents felt safe. 21 out of 21 Residents verbalized feeling safe in the facility. 6. On 05/22/24 at approximately 3:30 PM, the social service department completed a 100%	M 500		

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M 500	Continued From page 21 audit on roommate compatibility. 100% of the roommates were compatible or chose to be roommates. 7. On 5/30/24 an in-service was initiated at approximately 10:00 am by the Vice President of Operations for all staff on prevention/supervision of accidents, abuse/neglect, abuse reporting, resident rights, implementing interventions to prevent reoccurrence and updating care plans to reflect interventions and monitoring of behaviors. In-service details: When residents are observed in another resident's bed to immediately intervene and separate. The staff was instructed to notify the nurse immediately and protect the alleged victim by remaining 1-on-1 supervision with the alleged aggressor. The nurses were instructed to immediately perform head to toe skin assessments for both Residents while ensuring and notifying the Executive Director and Director of Nurses. The Administrator and Director of Nurses were instructed to ensure that a thorough investigation is completed and reported to the state agencies. The Administrator and Director of Nurses was instructed to ensure that interventions are put in place to protect other Residents and the alleged aggressor's care plan is updated and behavior is monitoring is in place. In-service also included notifying the nurse, Administrator, and Director of nurses immediately if any Resident verbalize or exhibits delusional behaviors that are harmful towards others. No staff will be allowed to work until the in-service is received. 8. On 05/30/24 at 9:00 AM, the Vice President of Operations in serviced the Administrator and Director of Nurses on abuse/neglect and ensuring to investigate and report all instances of abuse/neglect to regulatory agencies.	M 500		

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M 500	Continued From page 22 9. On 05/30/24 at 10:15 AM, the Vice President of Operations in serviced the social service department on ensuring that care plans are revised to reflect interventions and behaviors are monitored. 10. On 05/30/24 at approximately 11:30 AM, an interview was initiated for 28 cognitive residents to determine if they have incurred any issues with other residents lying in their beds. 28 of 28 Residents denied any concerns. 11. A 100% audit was initiated on 05/30/24 at 1:30 PM by the social services department to ensure that all Residents had compatible roommates. No issues identified. 12. A 100% audit was conducted on 05/30/24 at 2:00 PM by the social services department to ensure that Residents' behaviors are care planned and monitoring is in place. 13. The Administrator reported the 12/10/23 incident involving Resident #1 and Resident #3 to the Mississippi State Department of Health at 2:13 PM on 05/30/24. 14. An emergency quality assurance committee met on 05/30/24 at 2:50 PM. The attendees of the meeting were the Administrator, Director of Nurses, Assistant Director of Nurses, Social Services Assistant, Staff Development Coordinator, Nurse Practitioner, Regional Clinical Operations Nurse, and Regional Vice President. The facility discussed the current survey IJ outcomes. 5 IJ were cited for abuse/neglect, abuse reporting, revision of care plans, behavioral monitoring, and accidents/incidents. Upon investigation, Resident #1 had previous	M 500		

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M 500	Continued From page 23 behavioral issues on 12/10/23 with Resident #3. Resident # 1 was unclothed. The facility failed to report, investigate and implement interventions based on the behaviors. In-services modified as of 05/30/24 to include protecting residents from others who get into their beds by intervening and providing 1-on-1 supervision. In addition, reporting and investigating alleged events. All policies were reviewed for accidents/incidents, abuse prevention, revision of care plans, behavioral monitoring. No changes required. 14. The Ombudsman was notified of the 12/102/23 on 05/30/24 at 3:27 PM by the Administrator. 15. The Administrator reported the 12/10/23 incident involving Resident #1 and Resident # 3 to the Attorney General Office online system on 05/30/24 at 3:40 PM. Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of 5/30/2024 and the Immediate Jeopardy was removed 5/31/2024. Validation: The SA Validations were made onsite during the complaint investigation (CI) MS #25192. On 5/31/24, the SA validated through interviews and record reviews that all corrective actions had been taken by the facility to remove the IJ and the IJ was removed on 5/31/24.	M 500		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate	M 640		6/30/24

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M 640	Continued From page 24 supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level IV Based on record review, staff interviews, and facility policy review, the facility failed to provide adequate supervision to reduce the risk of an accident/hazards when a resident with behaviors got into other resident's beds and did not have any increased supervision/monitoring put in place resulting, in the physical assault and death of a resident for (1) one of (4) four residents reviewed for accidents. (Resident #2) The facility's failure to provide adequate supervision and monitoring, placed Resident #2 and other residents residing in the facility at risk, and in a situation which caused Resident #2's death and was likely to cause serious injury, serious harm, serious impairment, or death for others. The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 5/30/24, which began on 11/17/23, when the facility failed to provide increased supervision/monitoring and ensure appropriate services for residents with behavioral needs. The facility's failure to provide supervision/monitoring, resulted in the physical assault and death of a resident on 5/22/24. On 5/30/24 at 10:30 AM, the SA informed the Nursing Home Administrator of the Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) and provided the IJ Templates.	M 640	Resident #2 was pronounced deceased on 05/22/24 as a result of Resident #1 lying on top of him. Resident #1 was placed 1 on 1 supervision immediately on 05/22/24 until he was discharged on 05/23/24 to the custody of the local police department. All residents have the potential to be affected by this deficient practice. An in-service was initiated by the Vice President of Operations on 5/30/24 on all staff regarding Prevention and Supervision of Accidents, Abuse and Neglect, Abuse Reporting, Residents Rights, Implementing Interventions to prevent Reoccurrence and Updating Care Plans to Reflect Interventions and Monitoring of Behaviors. In-service details: When residents are observed in another resident's bed to immediately intervene and separate. Staff instructed to notify the nurse immediately and protect the alleged victim by remaining 1 on 1 supervision with the alleged aggressor. No staff will be allowed to work until in-serviced. All new hire staff will be in-serviced upon hire. Starting on 06/03/24 the Administrator initiated making rounds five (5) times week times 12 weeks to interview staff and residents to determine if there are any	

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M 640	Continued From page 25 The facility submitted a credible Removal Plan on 5/30/24, in which the facility alleged all corrective actions to remove the IJ were completed on 5/30/24 and the IJ removed as of 5/31/24. The SA validated the Removal Plan on 5/31/24 and determined the IJ was removed before exit. Therefore, the scope and severity for Rule 45.21.8 Accidents M640 was lowered from a Level IV to a Level II while the facility develops and implements a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Record review of the facility policy "Accident & Incident Documentation & Investigation Resident Incident" reviewed 7/18 revealed "POLICY: Accidents and/or incidents involving resident care will ...be analyzed for trends or patterns to enable the facility to enhance preventative measures to reduce the occurrence of incidents ..." Record review of an incident report dated May 22, 2024, at approximately 3:30 AM, the staff responded to the call light in Resident # 1's room, and he was observed unclothed and lying on top of Resident #2. Licensed nurses and Certified Nursing Assistants (CNAs) intervened. Resident #2's body fell to the floor and cardiopulmonary resuscitation measures (CPR) was initiated. The emergency management services (EMS) and the police department were notified. EMS arrived at the facility at approximately 3:50 AM. EMS continued CPR until 4:12 AM and then discontinued life resuscitating measures. The local police arrived at the facility at approximately	M 640	issues with Residents attempting to lie in other Residents' beds and all other behaviors. Starting 06/02/24 the Director of Nurses initiated audits by reviewing nurses notes, twenty-four hour reports, and incident report 5 times a week times 12 weeks to determine if there are any issues with Residents attempting to lie in other Residents' bed. Any concerns will be immediately addressed. The results of the audits will be forwarded to the monthly Quality Assurance Committee times three (3) months beginning June 20, 2024. The Quality Assurance Committee will recommend the frequency of audits based upon the results achieved.	

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3:50 AM and interviewed Resident #1, licensed nurses and CNAs. The local police took statements and confirmed Resident #2 was deceased. The local coroner arrived to examine Resident # 2's body and then removed the body.

Record review of the Face Sheet revealed the facility admitted Resident #1 on 8/1/23 with the diagnoses that included Unspecified mood affective disorder, Unspecified psychosis, and Anxiety Disorder.

Record review of the quarterly Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 4/16/24, revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) score of 7 which indicated that he was severely cognitively impaired. Section E- Mood revealed no behaviors checked. Section GG-Functional Abilities and Goals revealed the resident was independent with walking. Section: K-Swallowing/Nutritional Status revealed a height of 76 inches and weight of 486 pounds.

Record review of the Face Sheet revealed the facility admitted Resident #2 on 8/1/23 with the diagnoses of Unspecified Mood Affective disorder, Unspecified Psychosis, and Generalized Anxiety disorder.

Record review of the quarterly MDS Section C with an ARD on 4/16/24, revealed that Resident #2 had a BIMS score of 9 which indicated that he was moderately cognitively impaired.

On 5/29/24 at 7:30 AM, during a phone interview with Registered Nurse (RN) #1 revealed on the morning of 5/22/24 at approximately 3:30 AM he was called to the room of Resident #1 and Resident #2 and observed Resident #1 lying

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naked on top of Resident #2 with only the hands of Resident #2 could be seen. RN #1 revealed Resident #1 was severely obese, weighing 489 pounds, covering Resident #2's entire torso and head. RN #1 confirmed Resident #1 was placed on one-on-one monitoring after the incident, but was not on any special monitoring before the incident.

Record review of the coroner report, revealed Resident #2 was pronounced deceased on 5/22/24 at 4:12 AM and then released to the coroner's office.

Review of the Departmental Notes for Resident #1 revealed a note by Licensed Practical Nurse (LPN) #3 on 11/17/23 at 2:25 AM, CNA #4 reported while she was making rounds Resident #1 was noted lying in bed bedside roommate, Resident #3. Resident #1 stated he was trying to keep his roommate warm. LPN #2 informed Resident #1 he could not get into bed with other residents. Resident #1 stated, "okay, I was just trying to help him."

On 5/29/24 at 7:00 AM, in a phone interview LPN #3 revealed on the early morning of 11/17/23 CNA #4 that was working the hall that night informed her that while she was making rounds, she observed Resident #1 lying in bed with his roommate Resident # 3, who is a deaf mute. She also confirmed she did not increase monitoring of Resident #1 because it just did not cross her mind that Resident #1 could have attempted to abuse Resident #3 stating "I see now why I should have recognized that."

Record review of the Departmental Note for Resident #1 revealed a note by Social Service #1 dated 11/17/23 at 2:14 PM revealed the writer

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was informed by a nurse that a CNA reported to her, she observed Resident #1 lying in bed with his roommate: Resident #1 stated he was trying to keep his roommate warm. The CNA reported she did not see the resident doing anything. The resident was counseled by social services and the resident voiced understanding and will observe for any further behaviors.

Record review of the Departmental Note for Resident #1 revealed a note by LPN #2 on 12/10/23 at 1:22 AM Resident #1 was observed in roommate's bed unclothed, refusing to get in his bed stating, "there are rats over there," after multiple failed attempts to redirect he finally put his mattress on the floor and laid down.

On 5/28/24 at 5:00 PM, a phone interview with LPN #2 revealed on the early morning of 12/10/23 she found Resident #1 lying naked in the bed with Resident #3. She confirmed she did not increase monitoring of either Resident #1 or Resident #3.

On 5/29/24 at 1:00 PM, in an interview with the Social Service staff #1 assigned to the West wing on 11/17/23 revealed she was informed of the incident on 11/17/23 early in the morning hours when Resident #1 was observed in Resident #3's bed. Social Service #1 stated she did not update Resident #1's increase monitoring and confirmed she did not recognize this as a behavior. Social Service #1 also confirmed that by not putting interventions/increased monitoring in place to alert staff and potentially protect the residents in the facility, all residents were at risk. Due to Resident #1 was ambulatory, very obese, and could have gotten into to any resident's bed placing them at risk to be accidentally hurt. When asked if increased monitoring or treatment was

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put in place after the incident on 12/10/23, she stated she did not put any new interventions or monitoring in place because that was nursing's responsibility.

Record review of the Departmental Notes for Resident #3 revealed a note by Social Service #1 dated 12/15/23 at 11:09 AM, that resident is being moved related to roommate incompatibility.

Record review of the Face Sheet revealed the facility admitted Resident #3 on 7/11/07 with the diagnoses of Deaf non-speaking and Autistic disorder.

On 5/29/24 at 2:00 PM, an interview with the Vice President of Operations, revealed she was unable to find any 1-1 supervision/monitoring for Resident #1 related to the incidents in November and December 2023. She provided a document of 1-1 supervision for Resident #1 that was initiated after the death of Resident #2 on the morning of 5/22/24. She also confirmed that she could not find evidence where Resident #1's behavior interventions/ monitoring were updated after the incidents in November and December 2023. She also confirmed that the potential was there for the other residents in the facility to be at risk of harm, such as being smothered if Resident #1 got into their bed. No increased monitoring forms were provided to the SA from the facility for Resident #2 or Resident #3.

Record review of the Resident Location Monitoring form for Resident #1 provided by the facility, revealed resident to only be on increased monitoring 1-on 1 supervision starting at 3:45 AM on 5/22/24 -3:45 PM on 5/23/24 when Resident #1 was released to the Sheriff's department.

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M 640	Continued From page 30 The facility submitted an acceptable Removal Plan for the IJ. Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ: Summary of events: The facility was informed by the state agency on 5/30/24 at 10:30 AM of five immediate jeopardies. The state agency provided the facility with IJ template for F600, F609, F657, F689 and F742. On November 17, 2023, Resident #1 was clothed and observed in bed with Resident # 3. Resident # 3 was a vulnerable, deaf, mute male Resident. The facility failed to investigate, implement interventions, and revise Resident #1's care plan for this behavior. December 10, 2023, Resident # 1 was observed in Resident #3 bed unclothed. Resident # 3 was a vulnerable deaf, mute male Resident. The facility failed to investigate, implement interventions, and revise Resident #1's care plan for the behavior. On May 22, 2024, at approximately 3:30 AM, the staff responded to the call light in Resident # 1's room, and he was observed unclothed and lying on top of Resident # 2. Licensed nurses and certified nursing assistants intervened. Resident # 2's body fell to the floor and cardiopulmonary resuscitation measures (CPR) were initiated. The emergency management services (EMS), and police department were notified. EMS arrived at the facility at approximately 3:50 AM. The emergency management services continued cardiopulmonary resuscitation measures until 4:12 AM and discontinued life resuscitating measures. The local police arrived at the facility at approximately 3:50 AM and interviewed	M 640		

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M 640	Continued From page 31 Resident # 1, licensed nurses and certified nursing assistants (CNA). The local police took statements and confirmed Resident # 2 was deceased. The local coroner arrived to examine Resident # 2's body and removed the body from the facility with the understanding that an autopsy would be completed to determine the final cause of death. Corrective Actions: 1. On 05/22/2024 Resident # 1 was placed on one-on- one (1-1) supervision immediately. Psychiatric placement was initiated on 05/22/24 at approximately 8:00 am but was unsuccessful. A telehealth visit was conducted with the psychiatric nurse practitioner on 05/22/24 at approximately 12:00 PM. Resident #1 remained on 1-1 supervision until he was discharged to the custody of the local police department on 05/23/24 at 3:45 PM. 2. The Administrator presented to the facility on 05/22/2024 at approximately 4:40 AM and initiated an investigation with assigned licensed nurses and certified nursing assistants. 3. On 05/22/24 The Administrator notified the MS State Department of Health at 5:50 AM, Attorney General Office at 9:00 PM and Ombudsman on 05/22/24 at 11:08 AM. 4. An in-service was initiated for all staff on 05/22/24 at approximately 5:30 AM regarding supervision of accidents and incidents, abuse/neglect, how to handle resident to resident altercations, reporting of any resident with delusional behaviors or verbalizing harmful behaviors to others, how to deal with aggressive behaviors.	M 640		

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M 640	Continued From page 32 5. A special resident council meeting was conducted on 05/22/24 11:30 AM by the Administrator and Director of Nurses to ensure that the facility's residents felt safe. 21 out of 21 Residents verbalized feeling safe in the facility. 6. On 05/22/24 at approximately 3:30 PM, the social service department completed a 100% audit on roommate compatibility. 100% of the roommates were compatible or chose to be roommates. 7. On 5/30/24 an in-service was initiated at approximately 10:00 am by the Vice President of Operations for all staff on prevention/supervision of accidents, abuse/neglect, abuse reporting, resident rights, implementing interventions to prevent reoccurrence and updating care plans to reflect interventions and monitoring of behaviors. In-service details: When residents are observed in another resident's bed to immediately intervene and separate. The staff was instructed to notify the nurse immediately and protect the alleged victim by remaining 1-on-1 supervision with the alleged aggressor. The nurses were instructed to immediately perform head to toe skin assessments for both Residents while ensuring and notifying the Executive Director and Director of Nurses. The Administrator and Director of Nurses were instructed to ensure that a thorough investigation is completed and reported to the state agencies. The Administrator and Director of Nurses was instructed to ensure that interventions are put in place to protect other Residents and the alleged aggressor's care plan is updated and behavior is monitoring is in place. In-service also included notifying the nurse, Administrator, and Director of nurses immediately if any Resident verbalize or exhibits delusional behaviors that are harmful towards others. No	M 640		

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staff will be allowed to work until the in-service is received.

8. On 05/30/24 at 9:00 AM, the Vice President of Operations in serviced the Administrator and Director of Nurses at 9:00 AM on abuse/neglect and ensuring to investigate and report all instances of abuse/neglect to regulatory agencies.

9. On 05/30/24 at 10:15 AM, the Vice President of Operations in serviced the social service department on ensuring that care plans are revised to reflect interventions and behaviors are monitored.
10. On 05/30/24 at approximately 11:30 AM, an interview was initiated for 28 cognitive residents to determine if they have incurred any issues with other residents lying in their beds. 28 of 28 Residents denied any concerns.
11. A 100% audit was initiated on 05/30/24 at 1:30 PM by the social services department to ensure that all Residents had compatible roommates. No issues identified.

12. A 100% audit was conducted on 05/30/24 at 2:00 PM by the social services department to ensure that Residents' behaviors are care planned and monitoring is in place.

13. The Administrator reported the 12/10/23 incident involving Resident # 1 and Resident # 3 to the MS State Department of Health at 2:13 PM on 05/30/24.

14. An emergency quality assurance committee met on 05/30/24 at 2:50 PM. The attendees of the meeting were the Administrator, Director of Nurses, Assistant Director of Nurses, Social Services Assistant, Staff Development

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M 640	Continued From page 34 Coordinator, Nurse Practitioner, Regional Clinical Operations Nurse, and Regional Vice President. The facility discussed the current survey IJ outcomes. 5 IJ cites for abuse/neglect, abuse reporting, revision of care plans, behavioral monitoring, and accidents/incidents. Upon investigation, Resident # 1 had previous behavioral issues on 12/10/23 with Resident # 3. Resident # 1 was unclothed. The facility failed to report, investigate and implement interventions based on the behaviors. In-services modified as of 05/30/24 to include protecting residents from others who get into their beds by intervening and providing 1-on-1 supervision. In addition, reporting and investigating alleged events. All policies were reviewed for accidents/incidents, abuse prevention, revision of care plans, behavioral monitoring. No changes required. 14. The Ombudsman was notified of the 12/102/23 on 05/30/24 at 3:27 PM by the Administrator. 15. The Administrator reported the 12/10/23 incident involving Resident # 1 and Resident # 3 to the Attorney General Office online system on 05/30/24 at 3:40 PM. Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of 5/30/2024 and the Immediate Jeopardy was removed 5/31/2024. Validation: SA Validations were made onsite during the complaint investigation (CI) MS #25192. On 5/31/24, the SA surveyor verified through staff and resident interview, record review, sign-in sheets, and in-service reviews that all corrective actions had been taken by the facility to remove	M 640		

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M 640	Continued From page 35 the IJ during the survey on 5/30/24 and the IJ was removed on 5/31/24.	M 640		