| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255111 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 08/07/2025 |
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| **WEST POINT COMMUNITY LIVING CENTER** | **2056 N ESHMAN AVENUE , WEST POINT, Mississippi, 39773** |

| (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) COMPLETION DATE |
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| F0000 | INITIAL COMMENTS<br><br>On 08/04/25 through 08/07/25 the State Agency (SA) conducted an annual recertification and complaint investigations (CI) MS 480632 for Quality of Care (QOC), CI MS# 480653 for a facility reported incident (FRI) of abuse of a resident (Resident #20), and CI MS# 2578818 for environmental concerns. During the survey, the facility was determined to not be in compliance with the requirements of participation in Medicare and Medicaid. An extended survey was completed, and deficiencies were cited at F600, F610, F645, F656, F699, F759, F808 and F880.<br><br>The SA identified Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 06/30/25, when Resident #65 choked a resident and the facility failed to protect the right of residents to be free from abuse. On 06/30/25, Resident #65, a resident with a history of behaviors and aggression towards others, stood up from his chair while sitting in the dining room, and had gotten behind Resident #20 while he sat in his wheelchair and choked him. Staff heard other residents yelling for help and the staff separated Resident #65 from choking Resident #20. Resident #20 immediately began to have seizures that lasted for three or more minutes and continued to have multiple seizures a day until he was sent out to the hospital on 07/02/25.<br><br>The SA determined that Resident #45, Resident #46 and Resident #65 had aggressive behaviors towards other residents in the facility and were not monitored, nor were protective measures taken to prevent the abuse of Resident #5, Resident #20, Resident #21, Resident #34, Resident #41 and Resident #50. These residents sustained verbal, physical and mental abuse.<br><br>The SA notified the facility's Administrator of the IJ and SQC on 08/06/25 at 12:20 PM and provided the Administrator with the IJ Template.<br><br>The IJ and SQC existed at:<br><br>CFR 483.12(a)(1) Freedom from Abuse and Neglect (F600)<br>Scope/Severity (S/S) =K | F0000 | | |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F0000 | Continued from page 1<br>The facility's failure to ensure the right to be free from abuse and neglect placed Resident #5, Resident #20, Resident #21, Resident #34, Resident #41 and Resident #50 and other residents at risk in a situation that has caused and is likely to cause serious injury, serious harm, serious impairment, or death.<br><br>The facility provided an acceptable Removal Plan on 08/06/25, in which the facility alleged all corrective actions were completed to remove the IJ on 08/06/25 and the IJ removed on 08/07/25.<br><br>The SA validated the Removal Plan on 8/7/25 and determined the IJ was removed on 8/7/25, prior to exit. Therefore, the scope and severity for CFR 483.12(a)(1) Freedom from abuse and neglect F600 was lowered to a "E", while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.<br><br>At the time of the survey the facility was licensed for 100 beds and had a census of 55. | F0000 | | |
| F0600<br>SS = SQC-K | Free from Abuse and Neglect<br><br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br><br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, staff and resident interview, record review and facility policy review, the facility failed to ensure residents right to be free from abuse for six (6) of 6 residents reviewed for abuse and neglect. Resident #20, #21, #5, #41, #34 and #50. | F0600 | | |

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| F0600 SS = SQC-K | Continued from page 2<br>On 06/30/25 the facility reported that a resident with a history of behaviors and aggression towards others, (Resident #65) stood up from his chair while sitting in the dining room, and had gotten behind Resident #20 while he sat in his wheelchair and choked him. Staff heard other residents yelling for help and the staff separated Resident #65 from choking Resident #20. Resident #20 immediately began to have seizures that lasted for three or more minutes and continued to have multiple seizures a day until he was sent out to the hospital on 07/02/25.<br><br>Additionally, the SA determined that Resident #45, Resident #46 and Resident #65 had aggressive behaviors towards other residents in the facility and were not monitored, nor were protective measures taken to prevent the abuse of Resident #5, Resident #20, Resident #21, Resident #34, Resident #41 and Resident #50. These residents sustained verbal, physical and mental abuse.<br><br>During the annual survey of the investigations of the complaints and the FRI, the SA identified Immediate Jeopardy (IJ) and SQC which began on 06/30/25, when Resident #65 choked Resident #20 who began to have seizures.<br><br>The IJ and SQC existed at:<br><br>CFR 483.12(a)(1) Freedom from Abuse and Neglect (F600) Scope/Severity (S/S) =K<br><br>The facility's failure to ensure the right to be free from abuse and neglect placed Resident #5, Resident #20, Resident #21, Resident #34, Resident #41 and Resident #50 and other residents at risk and placed them in a situation that has caused and is likely to cause serious injury, serious harm, serious impairment, or death.<br><br>The SA notified the facility's Administrator of the IJ and SQC on 08/06/25 at 12:20 PM and provided the Administrator with the IJ Template.<br><br>The facility provided an acceptable Removal Plan on 08/06/25, in which the facility alleged all corrective actions were completed to remove the IJ on 08/06/25 and the IJ removed on 08/07/25.<br><br>The SA validated the Removal Plan on 8/7/25 and determined the IJ was removed on 8/7/25, prior to exit. Therefore, the scope and severity for CFR 483.12(a)(1) Freedom from abuse and neglect F600 was lowered to a "E", while the facility develops and implements a plan | F0600 | | |

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| F0600 SS = SQC-K | Continued from page 3<br>of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.<br><br>Findings Include:<br><br>Record review of facility policy titled, "Abuse, Neglect, Exploitation, and Misappropriation Prevention Program" dated 10/22, revealed, "Residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The resident abuse, neglect, and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation, or misappropriation of property by anyone including but not necessarily limited to: a. facility staff; b. other residents".<br><br>Resident #65 and Resident #20<br><br>Record review of the Facility Reported Incident revealed on June 30, 2025, it was reported to Administrator that a physical altercation transpired between Residents #20 and #65. According to a resident who witnessed the incident, the residents were all hanging out in their typical hangout spot prior to dinner-the dining area. During their fellowship time, there was a verbal exchange between Residents #20 and #65. Resident stated Resident #65 first acted playfully with his hands, pretending he was going to hit Resident 20. Their verbal exchange then got serious and led to Resident #65 wrapping his arms around the other resident's neck in a choking manner. Resident #65 is ambulatory, but Resident #20 is wheelchair bound. Resident #65 let Resident #20's neck go before the staff approached them. Resident #20 has a history of having seizures. Because of that, the incident triggered Resident #20 to have a seizure. Administrator attempted to interview Resident #65 who quickly answered, "I ain't done s***!" Immediately afterwards, Resident #65 approached Social Services and admitted to her that he had choked the other resident due to him "always talking s**t." Social Services followed Resident #65 to his room to redo his BIMs (Brief Interview for Mental Status). Prior to beginning her BIMS interview, the resident asked, "Is doing this | F0600 | | |

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| F0600 SS = SQC-K | Continued from page 4<br>going to help me get the h*** out of here?" Resident #65 began answering the questions better than he ever has since being admitted to the facility. The resident had never scored a 15 on his BIMS since being admitted. Resident #65 was placed on 1 :1 per shift from 06/30/2025-07/02/2025 for safety and well-being of all residents' safety. The facility attempted to find an alternate placement for Resident #65. However, the resident was booked into the County Jail due to charges being pressed against him from Resident #20 and his resident representative. The facility does substantiate abuse.<br><br>During interviews with Resident #20 on 8/4/25 at 3:10 PM and 8/5/25 at 2:45 PM, Resident #20 revealed he was in his wheelchair in the dining room on 06/30/25 when Resident #65 approached him from behind and wrapped his arm around his neck and tightened the grip with his other arm squeezing his neck and choking him. He expressed how this frightened him and said, “He could have killed me”. He stated he had five (5) seizures after the event and was sent to the hospital for evaluation and his last seizure prior to this incident was months ago. He was glad that Resident #65 had to leave the facility but stated he did not feel as safe now as he did before the incident occurred.<br><br>An interview with the Social Worker on 8/5/25 at 1:35 PM, revealed the facility was aware of Resident #65’s aggressive behaviors towards staff and other residents and had tried several times to get him admitted into a psychiatric facility, but due to his insurance type and his diagnosis of dementia, they could not find placement. She acknowledged the staff held meetings to discuss his behaviors and monitoring needs. They monitored him one-on-one when he showed signs of aggression, they placed him in a private room, and offered tasks and activities for him to participate in. She stated, “I think we did everything possible to monitor him” but acknowledged that if Resident #65 had been on one-on-one supervision, he would have been unable to harm Resident #20. She confirmed that one-on-one monitoring would have kept Resident #65’s aggressive behavior from causing harm to others but the facility failed to consistently have him under this supervision.<br><br>An interview with the Administrator on 8/5/25 at 1:45 PM revealed Resident #65 was difficult to redirect and had aggressive behaviors with staff and other residents. There were multiple incidents documented of | F0600 | | |

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| F0600 SS = SQC-K | Continued from page 5<br>Resident #65's aggression and physical and verbal altercations. She acknowledged that Resident #65's aggressive behavior was an ongoing concern, and they had been unsuccessful in finding a behavioral health facility placement for him. She stated they implemented interventions such as one-on-one observations when he had aggressive behaviors, but once behaviors improved, the interventions were discontinued. She acknowledged that one-on-one supervision was "sporadic" during his stay depending on his behaviors and if he had remained on this constant supervision, Resident #20 and other residents would have been protected, but this did not occur. When the incident occurred, Resident 65 was not on one-on-one supervision. He was unsupervised in the dining room with other residents. Resident #65 was ambulatory, and Resident #20 was in his wheelchair and Resident #65 went behind the wheelchair and choked Resident #20. She stated Resident #20 had a history of seizures with his last documented seizure dated 4/11/25 and with the choking incident, the resident was "traumatized" and this incident "triggered" his seizures. At that time, Resident #65 was placed on one-on-one supervision, which continued until he left the facility. The Medical Director was notified of the incident, and Resident #20 was treated in-house until the third day, and he was then sent to the hospital with a physician's order for evaluation. Resident #20's family chose to press charges. Resident #65 remained in facility until he was arrested. She acknowledged that each resident had the right to be free from abuse and should feel safe in their home. She confirmed residents with known aggressive behaviors, such as Resident #65, required more supervision to ensure safety of all residents. She confirmed the facility failed to protect residents by not providing adequate supervision to ensure each resident was free from abuse from other residents.<br><br>During an interview with Registered Nurse (RN) #2 on 8/5/25 at 3:00 PM, she revealed she did not witness the incident of Resident #65 choking Resident #20, but after it occurred, Resident #20 was "upset and embarrassed" about what happened to him. She stated she asked Resident #65 why he did that, and he told her, "So I could shut him up" An interview with the Interim Director of Nursing on 8/5/25 at 3:15, revealed Resident #65 had aggressive behaviors towards staff and residents and had previously hit other residents. He could not be redirected and was not compliant with following requests by the staff. She was not in the dining room when the incident between Resident #65 and Resident #20 occurred, but she came in quickly when she heard other residents calling out for assistance. | F0600 | | |

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| F0600 SS = SQC-K | Continued from page 6<br>Resident #20 appeared upset and embarrassed and was crying. He complained of a sore throat and neck pain and soon had a seizure. She acknowledged that Resident #65 had been on one-on-one monitoring at times due to his aggression, but he was not on this supervision when this incident occurred and if he was under this supervision, the incident would not have occurred. She confirmed the facility failed to adequately supervise Resident #65 with known aggressive and physical behaviors, therefore allowing Resident #20 to be choked.<br><br>An interview on 8/5/25 at 3:25 PM with Certified Nursing Assistant (CNA) #4 revealed she came into the dining room when incident occurred. Resident #65 had released his hold from Resident #20's neck but was attempting to get back to him and Resident #65 told Resident #20 that he was "going to choke him again". She stated she asked Resident #65 why he did that and was told "to get him to shut up" and that "he didn't care, and he would choke him again". Resident #20 was crying after the incident. She stated Resident #65 had a history of being difficult to redirect and had behaviors which included physical and verbal aggression towards staff and other residents. He had been in one-on-one supervision at times but was not when this incident occurred.<br><br>During a phone interview on 8/6/25 at 11:40 AM, the facility's Medical Director stated he was notified of the incident when Resident #20 was choked by Resident #65 but was uncertain if it was immediately when the incident occurred or shortly after that. He stated he did not remember specifically that the resident had multiple seizures after the incident and if he had been notified that the resident was having recurrent seizures, he would have given the order to send to the emergency room for evaluation. If the seizure was a one-time event he would attempt to treat it in house, with medication, monitoring, lab work, and observation of how the resident responded. He acknowledged that stress could be a contributing factor and an altercation like what Resident #20 went through would be stressful and could stimulate a seizure. He acknowledged his expectation was if a resident had behaviors that escalated to the point that they were abusive to residents that could not protect themselves, the psychiatric Nurse Practitioner (NP) should evaluate them, and the resident should remain on one-on-one supervision until evaluated by the NP for safety. The Medical Director stated that this was not occurring in the facility. | F0600 | | |

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| F0600 SS = SQC-K | Continued from page 7<br><br>Record review of a Progress Note dated 6/30/25 for Resident #20 revealed “After residents were separated, he began sobbing and shaking. Resident went into full clonic seizure activity that lasted 3 (three) minutes. RP (responsible party) made aware, and PRN (as needed) given…”<br><br>Record review of a Progress Note dated 7/2/25 at 8:19 AM revealed Resident sitting among peers talking and began having a seizure. Seizure lasted two minutes PRN Nayzilam Nasal Solution given. Resident assisted to bed via two staff with mechanical lift. RP notified MD notified orders to send to ER for evaluation.<br><br>Record review of Resident #20’s "Order Summary Report" revealed an order dated 3/20/25 for Nayzilam Nasal Solution 5 (five) milligrams (mg)/0.1 milliliter (ml) 5 gram in both nostrils every six (6) hours as needed for seizures related to conversion disorder with seizures or convulsions. Record review revealed an order dated 2/24/24 for Acetaminophen 650 mg by mouth every 4 (four) hours as needed for general discomfort.<br><br>Record review of Resident #20’s electronic “Medication Administration Record” revealed the resident received Acetaminophen 650 mg for neck pain on 7/1/25 at 3:25 AM. Resident received no Acetaminophen during the month of June 2025. Record review revealed the resident received Nayzilam Nasal Solution as needed for seizures on 6/30/25 at 5:10 PM and on 7/2/25 at 8:05 AM. He did not receive this any other time during the months of June or July 2025.<br><br>Record review of Resident #20’s “Admission Record” revealed the facility admitted the resident on 11/09/24, with diagnoses that included conversion disorder with seizures or convulsions.<br><br>Record review of Resident #20’s Minimum Data Set (MDS) Section C dated 6/2/25 revealed a Brief Interview for Mental Status (BIMS) score of 9 which indicated a moderate cognitive impairment.<br><br>Record review of Resident #65’s “Admission Record” revealed resident was admitted to the facility on 9/14/23, with diagnoses that included dementia and | F0600 | | |

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| F0600 SS = SQC-K | Continued from page 8<br>psychosis.<br><br>Record review of Resident #65's Minimum Data Set (MDS) Section C dated 6/11/25 revealed a Brief Interview for Mental Status (BIMS) score of 9 which indicated a moderate cognitive impairment. The latest MDS dated 07/02/25 indicated a BIMS score of 15.<br><br>Resident #65 and Resident #21<br><br>Record review of Facility Investigation revealed that around lunch time on 05/24/25, a physical altercation occurred between Resident #21 and Resident #65. According to CNA #3 (Proper Name) Resident #65 slapped Resident #21 on the side of the head. CNA #3 heard (Proper Name) Resident #65 say to (Proper Name) Resident 21, "Stop stealing my stuff! Do not come in my room anymore." CNA #2 (Proper Name) helped CNA #3 (Proper Name) separate the two residents to de-escalate the situation. Resident (Proper Name) #65 was immediately moved to another room on a different hall. Residents were assessed with no injury to either resident. Upon notification of the incident, Administrator questioned Resident (Proper Name) #65 and he stated, "I did not slap him. I pushed him against the side of his head for taking my snacks…." Resident (Proper Name) #65 received counsel and education that physical contact was not allowed and to report further issues to personnel.<br><br>Record review of "Witness Statement" completed by CNA #3 (Proper Name), revealed that "On Saturday, May 24, 2025, during lunch. (Proper Name) Resident #65 turned and slapped (Proper Name) Resident #21 on the side of his head. Then yelled at him 'stop stealing my stuff, don't come in my room anymore.' I told (Proper Name) CNA #2 what happened, and she stood between the two men to deescalate the situation. Then nurse, (Proper Name), was notified of the incident.<br><br>An interview with Certified Nursing Assistant (CNA) #2 on 08/05/2025 at 11:05 AM, revealed that there was an altercation between Resident #21 and Resident #65 back in May. She revealed that she did not witness the incident, but she was called by CNA #3, and she assisted with the two residents. CNA #2 revealed that the incident occurred in the hallway near the opening of the small dining area at the end of the 400 hall. She revealed that CNA #3 witnessed Resident #65 slap | F0600 | | |

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| F0600 SS = SQC-K | Continued from page 9<br>Resident #21 in the head with an open hand. She revealed that Resident #21 went into Resident #65's room and took some snacks, Resident #65 followed Resident #21 down the hall and slapped him. CNA #2 revealed that they separated the residents to de-escalate the situation and Resident #65 was moved to another room on a different hall. CNA #2 revealed that Resident #21 and Resident #65 had adjoining rooms and shared a bathroom. She revealed that Resident #21 often wandered and took snacks from wherever he could find them. She revealed that he had taken Resident #65's snacks more than once and on that particular day, it made Resident #65 mad. CNA #2 revealed that Resident #65 was a "handful" and always kept other residents "worked up." She revealed that it was the best thing to get him out of there. She revealed that Resident #65 was always grabbing at the staff and residents, cursing loudly, and it was chaos while he was there. CNA #2 revealed that they had to redirect Resident #65 frequently, he knew he was messing up, but he wouldn't listen to them. CNA #2 stated, "I hope he's at a place to get some help; we never knew what he would do or say here."<br><br>An interview with Administrator on 08/05/25 at 3:10 PM revealed that on 05/24/25 Resident #21 went into Resident #65's room and took his snacks. She revealed that this made Resident #65 mad and he (Resident #65) hit him (Resident #21). She revealed that she investigated the incident, they moved Resident #65 to another room and educated him that he could not hit other people and told him to report further issues to staff.<br><br>An interview with Interim Director of Nursing (DON) on 08/06/25 at 8:50 AM, revealed that Resident #21 and Resident #65 stayed in adjoining rooms and shared a bathroom at the time of the incident. She revealed that Resident #21 often went into Resident #65 and other residents' rooms and took their snacks. DON revealed that on 05/24/25, staff reported to her that Resident #21 went into Resident #65's room and took some of his snacks. Interim DON revealed that Resident #65 got mad, came up the hall behind Resident #21, he yelled at and slapped him on the head. Interim DON revealed that CNA #3 witnessed the incident, separated the two residents and the nurse checked them out and there were no injuries identified. Interim DON revealed that they should have monitored Resident #65 more closely and that he should have had 1:1 supervision from the day he slapped the other three residents. Interim DON revealed that had the staff been closely monitoring Resident | F0600 | | |

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| F0600 SS = SQC-K | Continued from page 10<br>#65, they could have redirected him and prevented the incident. She revealed that they implemented 1:1 monitoring after this altercation, but it did not continue when his behavior improved. She stated, “The close monitoring should have continued.”<br><br>Record review of Resident #21's Progress Note dated 05/24/25 revealed: "Nurse was notified by CNA (Certified Nursing Assistant) that resident was hit in head by another resident with open hand. Nurse immediately assessed resident, neuros complete…., no c/o pain or discomfort, no bruises or wounds noted. Nurse separated from peer. Nurse noted that resident took resident snacks from room…”<br><br>Record review of Resident #65’s “Progress Note” dated 05/24/25 revealed: “Nurse was notified by CNA that resident hit peer in head with open hand. Nurse immediately separated resident from peer and completed an assessment, neuros completed……..no c/o (complain of) pain or discomfort, no bruises or wounds noted. Resident (#65) stated, ‘that mother f****r (explicit language) stealing my stuff out my room.’...”<br><br>Record review of Resident #21 "Admission Record" revealed an admission date of 02/20/25 and that he had diagnoses that included Cerebral Infarction due to Unspecified Occlusion or Stenosis of Basilar Artery Aphasia, Schizoaffective Disorder and Aphasia.<br><br>Record review of Resident #21’s Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 07/10/25 under Section C revealed that Brief Interview for Mental Status (BIMS) should not be completed due to resident is rarely/never understood.<br><br>Resident #65 and Resident #5<br><br>Record review of the facility “Resident-to-Resident Abuse Investigation” revealed, “On August 14, 2024, Unsampled Resident #1, Unsampled Resident #2, and Resident #5 all came to Nursing Home Administrator (NHA) between 4:30 and 5:00 PM to report that they were all hit by Resident #65. Unsampled Resident #2 stated she was sitting in her chair earlier that day in her bedroom when Resident #65 entered her room and hit her on the top of the head. Unsampled Resident #1 stated Resident #65 forcefully slapped her on the right cheek | F0600 | | |

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| F0600 SS = SQC-K | Continued from page 11<br>in the dining area. Resident #5 stated Resident #65 also slapped him on the right cheek in the dining area. Resident #15 and Resident #1 said they both witnessed Resident #5 and Unsampled Resident #1 being slapped by Resident #65 in the dining room. Resident #65 was immediately separated from the other residents."<br>Further review revealed, "Due to Resident #65 being Medicaid only and having a primary diagnosis of dementia, psych facilities have denied him entry. The facility will continue one-on-one supervision and proper monitoring until alternate placement is found."<br>According to the facility investigation, Resident #65 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment and had a diagnosis of Dementia with Behavior Disturbance. Resident #65 received counsel and was instructed not to hit others, although he denied hitting either of the residents.<br><br>An interview with Resident #5 on 8/04/2025 at 10:52 AM revealed he had an altercation with another male resident a while back ago (unsure of the exact date). He explained that he was in the dining room, and he saw Resident #65 cursing and hit a female resident in the face. He stated he went over to Resident #65 and told him, "You don't hit on women" and stated the resident slapped him in the face. The resident stated the facility took no effective action and allowed Resident #65's violent behavior toward others to continue in the facility. He revealed Resident #65 was frequently touching the nurses, physically assaulting residents, verbally abusing staff and residents before the incident, and it continued afterward. He stated Resident #65 was arrested recently and in jail due to an altercation with another resident in the facility. When asked how the incident made him feel and if he felt safe now since the resident was arrested, he replied, "No, I don't feel safe. That's why I don't go out of my room." The resident explained that Resident #65 was his roommate at the time of their altercation. He revealed the staff did move Resident #65 out of the room that day and stated, "They moved him because I told them if they left him in the room, he was going to have a pillow over his face in the morning."<br><br>Record review of Resident #5's "Progress Note" dated 8/14/25 revealed, "Resident stated that he was slapped by Resident #65 on his right cheek. Resident does appear to have some swelling under his right eye."<br><br>Record review of the "Proper name of police department | F0600 | | |

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| F0600 SS = SQC-K | Continued from page 12<br>Incident Report" dated 8/15/25 revealed an officer responded to the facility in reference to the altercation that occurred on 8/14/24 with no indication charges were filed.<br><br>An interview with the Administrator on 8/4/25 at 3:10 PM revealed Resident #65 was admitted to the facility with a diagnosis of dementia on 9/14/23. She explained that he had a lot of behaviors on admit such as inappropriately touching the nurses, cursing, hitting other residents and was aggressive toward the staff and residents. She stated he was unable to be redirected by staff, and they had tried to get him into psych facilities, but no one would accept him because he had Medicaid and a primary diagnosis of dementia. She revealed at the time of the altercation on 8/14/24, the staff separated the residents involved and they did one-on-one monitoring for Resident #65. However, she could not account for any one-on-one monitoring and could not verify how long the facility did these actions to keep the other residents safe since Resident #65 remained in the facility. She revealed they did move Resident #65 from the room with Resident #5 and acknowledged Resident #65 continued to pose a threat to the safety of all residents residing in the facility.<br><br>An interview on 8/4/25 at 3:30 PM with Resident #15, who witnessed the event on 8/14/24 confirmed he did see Resident #65 slap Resident #5 across the face in the dining room. He stated, "It was a while ago, but I remember it was in the dining room while the residents were just sitting around."<br><br>Record review of the "Admission Record" revealed the facility admitted Resident #5 on 9/6/19 with medical diagnosis of Sarcoidosis.<br><br>Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/24/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #5 was cognitively intact.<br><br>Resident #46 and Resident #41<br><br>Record review of the "Facility Investigation" of the altercation between Resident #41 and Resident #46 on 07/21/25, revealed that CNA #1 witnessed the aftermath | F0600 | | |

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| F0600 SS = SQC-K | Continued from page 13<br>of a physical altercation between the residents. They were tussling over Resident #41's walker. CNA #1 called CNA #2 for assistance to help separate the two residents. Both CNAs saw bleeding on Resident #46's hand and bleeding and swelling on Resident #41's eye. Administrator interviewed both residents. Resident #46 stated Resident #41 kicked his foot out to trip him up, which led to the physical altercation. Resident #41 stated he was sitting on the side of the room watching television and was suddenly hit in the eye with a closed fist by Resident #46. Resident #41 stated that he was not in any pain but was confused as to why he was hit by his roommate. Assessments were completed by the Interim DON and injury was noted to both residents. Resident #41 had a cut above the left eyebrow open 2 inches by 1 inch. Resident #46 had a skin tear to the knuckle on the right hand. They both received counsel that physical contact was not allowed and to report any issues to staff for proper handling. First aid was provided to both residents. On 07/21/25, Resident #46 was transported to (Proper Name) behavioral health facility for psych treatment and behavior management. Resident #41 was transported to hospital on 07/23/25 due to his swollen eye worsening with no orbital fracture or major concerns noted. Behavioral Health facility called and notified the facility staff that Resident #46's right hand began to swell which led to x-ray conducted on 07/23/25. The x-ray findings revealed that Resident #46 had a right-hand fracture because of the recent physical altercation. There were no signs of pain and showed good hand mobility prior to leaving the facility following the physical altercation.<br><br>Record review of "Statement" written by CNA #1 revealed, "I had got up to go get more linen before the next shift started. Passing by resident room I noticed (Proper Name) Resident #46 and Resident #41 both tussling over the walker. I called for my partner we immediately separated them. (Proper Name) Resident #46 hand was bleeding. (Proper Name) Resident #41 had a gash on left eye, bleeding." This written statement was dated 07/21/25 and signed by CNA #1.<br><br>Record review of "Statement" written by CNA #2 revealed, "The other CNA was down the hall. She yelled up the hall for me. I came running got to the room (Proper Names) Resident #46 and Resident #41 was tussling over the walker and we took it from them. Both of them was bleeding. (Proper Name) Resident #46 was bleeding on the hand, and (Proper Name) Resident #41 was bleeding on the head and his eye was swollen." This | F0600 | | |

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| F0600 SS = SQC-K | Continued from page 14<br>statement was signed by CNA #2 and dated 07/21/25.<br><br>An observation and interview on 08/04/25 at 11:40 AM with Resident #46, revealed him sitting up on the side of bed eating lunch with his two sisters present at his side. He had a brace intact on his right arm and had bruising to the top of his right hand down to his knuckles of his thumb, index, middle, and fourth fingers. Resident #46 revealed that he had been out of the facility and had just returned today.<br><br>An observation and interview on 08/06/25 at 8:05 AM with Resident #46 revealed him in his bed in his room and a brace was intact to his right arm. Resident #46 revealed that while he was out, his hand started hurting, they x-rayed it and found that his hand was broken. He revealed that another resident smarted off to him and he popped him in the eye. Resident #46 stated, “He (Resident #41) sure backed up when he found out I was the boss."<br><br>An interview with Certified Nursing Assistant #1 on 08/06/25 at 8:20 AM, revealed that she worked on the day that Resident #46 hit Resident #41. She revealed that these two residents were roommates at the time, and they had not had any prior issues. CNA #1 described Resident #41 as a quiet resident who kept to himself and enjoyed watching westerns on television. CNA #1 revealed that on 07/21/25, she walked down the hall and saw that Residents #41 and #46 were in their room and were "tussling" with a walker. She revealed that she called another staff member to help, and they separated the two residents. CNA #1 revealed that she observed that Resident #41’s eye was bloody and that there was blood on Resident #46’s knuckles. CNA #1 revealed that she removed Resident #46 from the room, and they watched him until he went out to behavioral health. CNA #1 revealed that there was no yelling going on, they were just fighting over a walker. She revealed that she reported the incident to the nurse, they assessed both residents and found no major injuries. CNA #1 revealed that Resident #46 returned from behavioral health on Monday, 08/04/25, with a brace on his right arm, and they moved him into another room down the hall on the opposite side. CNA #1 revealed that while Resident #46 was out of the facility, he complained of pain to his right hand, they had it x-rayed and found out his hand was broken. CNA #1 revealed that they monitored Resident #46 more closely, when they see him walking in the halls, they redirect him and try to keep him busy. | F0600 | | |

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| F0600 SS = SQC-K | Continued from page 15<br><br>An interview with Resident #41 on 08/06/25 at 8:28 AM revealed that not long ago, another resident got crazy with him and hit him in the eye for no reason. He stated, "I don't know what was wrong with him, I hadn't done nothing to him." Resident #41 revealed that it was his roommate, Resident #46, who hit him (Resident #41) with his fist in his left eye. Resident #41 revealed that his left eye bled some and swelled up but didn't hurt bad. He revealed that he went to the doctor later to have his eye looked at and stated, “it didn’t hurt anything.” Resident #41 revealed that there was a lady who came in right after it happened, saw what was going on and moved him (Resident #46) out of there. Resident #41 stated, "He's (Resident #46) back here now." Resident #41 revealed that he felt safe in the facility, he wasn't scared at all and stated, "If he hits me again, I'm hitting him back."<br><br>An interview with Interim Director of Nursing (DON) on 08/06/25 at 8:45 AM, revealed that Resident #46 walked back and forth in the halls with exit seeking behaviors. She revealed that he would often ask for his sisters, ask about going home and would get verbally aggressive frequently and need redirection. She revealed that Resident #46 and Resident #41 were roommates and had not had any previous altercations. Interim DON revealed that the staff reported to her that the two residents were fussing over a walker in their room and were tussling with it back and forth when Resident #46 got mad and hit Resident #41 in his eye. Interim DON revealed that she was called to the room and found that Licensed Practical Nurse (LPN) #1 was cleaning and dressing the laceration over Resident #41’s left eye. She revealed that his eye swelled up a few days later and they had it checked out. Interim DON revealed that Resident #46 thought it was funny and bragged that he “hit him good, as hard as I could.” She revealed that they immediately separated the two residents and within 2-3 hours, he (Resident #46) was picked up to be evaluated by behavioral health. She also revealed that Resident #46 had 1:1 supervision until he left the building. She revealed that he returned from behavioral health two days ago, 08/04/25, and was placed in a different room away from Resident #41. Interim DON revealed that Resident #46 often packed his bags, wandered up and down the halls asking to go home, and the staff all knew to watch him closely. Interim DON revealed that Resident #41 and his resident representative did not want him to go out to the Emergency Room but a few days later, when his eye began to swell, they had him checked out. She also revealed that they received a phone call from the | F0600 | | |

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| F0600 SS = SQC-K | Continued from page 16<br>behavioral health facility two days after the incident reporting that Resident #46 had complained of pain to his hand, they x-rayed it and found that he had fractured it.<br><br>An interview on 08/06/25 at 9:00 AM with Certified Nursing Assistant (CNA)#2, revealed that she worked the day of the altercation between Residents #41 and #46. She revealed that CNA #1 walked down the hall and saw that the two residents were fighting over a walker in their room. She revealed that Resident #46 had been more agitated that morning, asking for his sisters, asking repeatedly about how to get out the doors, and cursing. She revealed that he packed his bags often and walked the halls trying to get out. CNA #2 revealed that Resident #46 walked into his room with Resident #41 and started fighting over the walker. CNA #2 revealed that CNA #1 called her to the room, and they separated the two residents and reported to the nurse.<br><br>An interview on 08/06/25 at 9:10 AM with Licensed Practical Nurse (LPN) #2, revealed that Resident #46 had been more agitated all day, the day of the altercation on 07/21/25. She revealed that staff had redirected him multiple times, but he kept wanting his sisters and wanting to go home. She revealed on that same day, he walked up to the nursing station several times asking her to let him out. LPN #2 revealed that some days were worse than others with him (Resident #46) and he required a lot of redirection.<br><br>An interview on 08/06/25 at 10:39 AM with LPN #1, revealed that on 07/21/25, Resident #46 hit Resident #41 in the eye with his fist. She revealed that she assessed both residents and dressed Resident #41's eye. She revealed that Resident #41's eye swelled up two days later and they sent him out and had him checked out. LPN #1 revealed that his eye checked out fine and he came back to the facility with an order to apply eye drops for seven days. She also revealed that Resident #46 went out to behavioral health for his behavior.<br><br>An interview on 08/07/25 at 9:55 AM with Interim DON revealed that on the morning of 07/21/25, Resident #46 was more verbally aggressive and agitated with staff and residents and she confirmed that the staff should have recognized that and took care of the situation before it escalated. She also confirmed the facility failed to adequately supervise Resident #46 with known behaviors, therefore allowing Resident #41 to be hit in | F0600 | | |

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| F0600 SS = SQC-K | Continued from page 17<br>the eye with such force that it fractured Resident #46's hand. Interim DON revealed that had the staff been monitoring Resident #46 more closely, it could have prevented the altercation between Resident #41 and Resident #46 and prevented the injuries. She stated, "It just slipped through."<br><br>Record review of Resident #46's "Radiology Interpretation" dated 07/23/25 revealed significant findings following his right-hand x-ray. "Impression: Acute fracture in the head of the fourth metacarpal…"<br><br>Record review of Resident #41's "Body Audit" dated 07/21/25 revealed that he had a new skin condition noted to his face above left eyebrow open.<br><br>Record review of Resident #46's "Body Audit" dated 07/21/25 revealed that he had a new skin condition on his right hand, a skin tear to knuckles.<br><br>Record review of Resident #41's "Incident Note" completed by LPN #1 dated 07/21/25 revealed "During shift change notified by staff that resident's face was bleeding from being hit by another resident. Upon observation resident has a small cut to left eye. The area was cleaned with normal saline and covered with dry dressing. Resident stated: "roommate hit me". CNA stated Resident roommate and him began arguing over a walker when we went towards room other resident began hitting resident with a closed fist and blood shot out……"<br><br>Record review of Resident #41's "Progress Notes" dated 07/23/25 revealed that his left eye was swelling after being hit in the eye with a closed fist by other resident. Orders to be sent to Emergency Room for evaluation. Resident returned with order for eye drops.<br><br>Record review of Resident #41's "After Visit Summary" dated 07/23/25 revealed that he had a CT (Computed Tomography) of Facial Bones without contrast with no acute findings.<br><br>Record review of Resident #41's "Admission Record" revealed an admission date of 10/13/23 and that he had diagnoses that included Unspecified Dementia. | F0600 | | |

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| F0600 SS = SQC-K | Continued from page 18<br><br>Record review of Resident #41's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 06/25/25 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 08 which indicated that he had moderate cognitive deficits.<br><br>Record review of Resident #46's "Admission Record" revealed an admission date of 09/12/23 and that he had diagnoses that included Unspecified Dementia.<br><br>Record review of Resident #46's MDS with ARD of 05/2/25 under Section C revealed a BIMS Score of 07 which indicated that he had moderate cognitive deficits.<br><br>Record review of Resident #46's "Progress Notes" dated 07/21/25 at 11:09 AM revealed "Resident continues to ambulate through facility wanting to leave. He needs redirection daily. Staff is aware that he is a wander risk…….He has had increased agitation toward staff today by demanding to leave. Redirection works at times." Signed by Social Services.<br><br>Record review of Resident #46's "Progress Note" dated 07/21/24 at 12:01 PM revealed, "Resident has been displaying aggression towards staff and other residents. Resident needs to be constantly redirected back to his room and away from the front door. Resident keeps stated that he wants to go home." Signed by LPN #1.<br><br>Record review of Resident #46's "Incident Note" completed by LPN #1 dated 07/21/25 at 15:56 (3:56 PM) revealed, "During shift change notified by staff that resident hit other resident. Upon observation resident has a small amount of blood on knuckles to right hand. The area was cleaned with normal saline. Resident stated: 'Yea I hit him hard as I could too.' knuckles covered in blood small skin tear cleaned with ns (normal saline) no open areas noted…." Signed by LPN #1.<br><br>Record review of Resident #46's Progress Note dated 08/04/25 at 10:35 AM revealed, "Resident returned to facility from (Proper Name) behavioral center via private vehicle. Resident returned alert and oriented to person. Resident has been moved to room and has been adjusting well back to facility." | F0600 | | |

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| F0600 SS = SQC-K | Continued from page 19<br><br>Record review of Resident #46's Medication Administration Record (MAR) for July 2025, revealed that he received Haloperidol Tablet 0.5milligrams (mg) one tablet by mouth one time a day related to Unspecified Dementia with Other Behavioral Disturbance; Unspecified Mood (Affective) Disorder with start date of 04/26/25. Resident #46 also received Remeron 30mg tablets one time a day at bedtime with effective date of 01/30/25. Record review of MAR also revealed that Resident #46 received Antipsychotic Behavior Monitoring every shift for behaviors that included physically combativeness.<br><br>Resident #45 and Resident #34<br><br>On 8/04/2025 at 10:30 AM, an observation and interview with Resident #34 revealed he was sitting in his wheelchair in his room. He explained that he was admitted to the facility in February 2025 and his only concern was another male resident residing in the facility had been making sexually inappropriate statements to him asking him to "Suck his d***" and telling him he wanted to have sex with him. He stated the encounter happened in July near 100 hall but he could not remember the exact date. He explained that he told the Administrator (ADM) and Registered Nurse (RN) # 1 after the incident. The resident stated, "I'm not gay and I'm not down for that s***." The resident explained that after the incident he came back to his room and could not get it off his mind. He stated it made him angry, and he felt violated. The resident explained that the incident occurred with other residents and staff around. He stated he wanted to handle things by "stabbing him" because if he did not do anything to the perpetrator, he felt as though it made him "look like a punk "(in the eyes of people who may have witnessed the event). He stated after he reported the incident to the ADM, he came away with the feeling nothing would be done. He revealed he called the Long-Term Care Ombudsman, and she came out to talk to him on July 29th. He stated, "I still don't know what was done about it." He revealed the perpetrator's name was (Resident #45). He revealed Resident #45 had not said anything else to him since the incident, but stated," He always watches me, and I don't like that s***." The resident stated, "I went up to him and stuck my finger in his eye and told him, I am not like that and to stop staring at me." The resident explained that he did not want to be the one that might return to jail because he retaliated against another resident. He | F0600 | | |

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| F0600 SS = SQC-K | Continued from page 20<br>stated Resident #45 made him uncomfortable and he did not want to come out of his room. He stated they have a lot of resident-to-resident interactions in the facility and stated that administration did not do anything about the resident's behaviors of cursing, threats, and aggression when they first start and wait until things are out of control before they react. When asked whether he felt safe in the facility and felt as though the staff would protect him, he stated, "I will protect myself."<br><br>On 8/4/25 at 1:36 PM, a telephone interview with the Long-Term Care Ombudsman revealed Resident #34 called her to come out and speak with him and she did so on 7/29/25. She explained it was regarding another male resident that was making obscene sexual comments to him. She stated the resident reported he had notified the Administrator (ADM) previously about the incident, but he felt that nothing was going to be done, so he called me. She revealed she spoke with the ADM on 7/29/25 and was told they had other complaints about the perpetrator, and she would be sending the resident out to Geri psych. She revealed Resident #34 never told her the name of the alleged perpetrator.<br><br>On 8/05/25 at 1:42 PM, an interview with the Administrator (ADM) confirmed Resident #34 came and reported an incident to her regarding Resident #45. She explained that Resident #34 stated that Resident #45 “threatened to interact with him sexually” and Resident #34 had inquired whether Resident #45 was gay. She confirmed the Ombudsman did come by and speak with her, but she thought it was just a misunderstanding. She explained that she did not investigate or do anything about Resident #34's concerns and stated, "He keeps changing his story." She revealed they tried to send Resident #45 out to Geri psych, but they could not find anyone to accept him.<br><br>On 8/06/25 at 8:15 AM, an interview with Registered Nurse (RN) #1 revealed Resident #34 did report to her the incident with Resident #45. She explained that she did not overhear anything, but Resident #34 had told her that Resident #45 made sexually inappropriate statements to him. She also stated that she saw Resident #34 telling a housekeeper about it, but she could not recall who the housekeeper was or the details of the incident and stated, "I have a lot to do." RN #1 confirmed she did not document or report it to anybody and acknowledged what Resident #34 reported was resident to resident abuse. | F0600 | | |

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| F0600 SS = SQC-K | Continued from page 21<br><br>Record review of the “Abuse and Neglect” sign in sheet dated 6/30/25 revealed Registered Nurse #1 was in attendance for the in-service.<br><br>Record review of the “Admission Record” revealed the facility admitted Resident #34 on 2/26/25 with a medical diagnosis of Multiple Sclerosis.<br><br>Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/26/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #34 was cognitively intact.<br><br>During interviews on 8/5/25 at 3:15 PM and 8/7/25 at 9:20 AM, the Interim Director of Nursing stated that Resident #45 was aggressive but could be redirected. She stated he incites and instigates confrontations with other residents. She stated the resident’s aggression was mostly verbal which led to other residents’ aggression since they were irritated with his talking and cussing. She stated he was a “verbal responder and stirs up others and they react to him”. She acknowledged that Resident #45 needed supervision and redirection when he was aggressive. She confirmed that this facility had multiple residents with behaviors and aggression and the facility failed to adequately supervise these residents to ensure all residents were free from abuse.<br><br>Record review of Resident #45's "Admission Record" revealed he was admitted to the facility on 7/7/21. His diagnoses included diffuse traumatic brain injury, persistent mood disorder and dementia.<br><br>Record review of Resident #45’s Minimum Data Set (MDS) Section C dated 6/30/25 revealed a Brief Interview for Mental Status (BIMS) score of 9 which indicated a moderate cognitive impairment.<br><br>Resident #45 and Resident #50<br><br>Record review of the facility “Resident to Resident Investigation” revealed, “On 6/21/25, a physical altercation transpired between Resident #50 and | F0600 | | |

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| F0600 SS = SQC-K | Continued from page 22<br>Resident #45 after smoke break due to Resident #45 making inappropriate remarks to Resident #50 and kicking her. Resident #50 then hit Resident #45 back in retaliation." The residents were separated by staff. The incident was witnessed by the Activity Director. According to the investigation, both Residents were generally pleasant and got along with each other. Resident #50 had a Brief Interview for Mental Status (BIMS) score of 11 and Resident #45 had a BIMS score of 8, both which indicated moderate cognitive impairment. Both residents were counselled and educated that physical contact was not allowed. Resident #45 had diagnoses of Dementia and Traumatic Brain Injury and stated he did not recall the incident.<br><br>Review of the facility "Resident to Resident Investigation" revealed on 7/5/25, staff witnessed a physical altercation transpire between Resident #50 and Resident #45 after smoke break. Resident #45 hit Resident #50's arm with an open hand due to Resident #50 walking toward him even after staff attempted to separate them. Resident #50 was admitted to Geri psych effective 7/10/25. Due to Resident #45's diagnosis of Dementia and Traumatic Brain Injury, he does not recall the incident."<br><br>During an interview with Resident #50 on 8/4/25 at 2:45 PM she stated, "Some guy here is bothering me; They sent me away, but it's not me, it's him." She explained the facility had taken no action against him. The resident pointed to Resident #45 who was in a wheelchair rolling in the hallway. She stated he struck her in the stomach, and she stated she retaliated by hitting him back.<br><br>An interview with the Activity Director (AD) on 8/5/25 at 8:15 AM revealed Resident #50 had to smoke separately from Resident #45 because of a couple altercations between the residents. She revealed Resident #45 picked on Resident #50 and instigated things. The AD explained that on the day of the incident, the residents were coming back inside from smoke break and Resident #45 hit Resident #50 and then she hit him back. She revealed it took several staff to separate them because they were fighting.<br><br>Record review of the "Proper Name of Police Department Incident Report" dated 6/21/25 revealed an officer responded to the facility for a reported fight between Resident #45 and Resident #50. According to the report, | F0600 | | |

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| F0600 SS = SQC-K | Continued from page 23<br>the responding officer spoke with Resident #45 and advised him that the police department had several calls on him being physical with other residents, and if he continued to be a disturbance actions would be taken.<br><br>Record review of the "Progress Notes" for Resident #45 and Resident #50 on 6/21/25 at 10:52 AM, revealed, "This nurse was notified by housekeeping that Resident #50 was walking by going to the snack machine and Resident #45 started calling out her name. Resident #50 did not respond and walked back to the nurse's station and sat in rollator. Resident #45 followed Resident #50 up to the nurse's station and kicked her foot. That is when housekeeper came and got this nurse. This nurse and activity director went over to separate residents from each other."<br><br>Record review of the "Progress Notes" for Resident #45 and Resident #50 on 6/21/25 at 3:06 PM, revealed, "This nurse was notified by activity director and laundry staff that Resident #50 was coming in from smoke break and physical altercation broke out. Resident #45 hit Resident #50 and then she hit him back. Activity Director and laundry staff separated them."<br><br>Record review of the Interim Director of Nursing witness statement undated, revealed, "While sitting at nursing station making a call the smokers were coming in from smoke break. Resident #50 was coming in using her rollator walker and ran into Resident #45, words were exchanged, and they were separated by aide and myself. While attempting to separate, Resident #50 kept walking toward Resident #45, and Resident #45 struck at her arm with an open hand and rolled away (in wheelchair)."<br><br>An interview with Social Services (SS) on 8/7/25 at 8:50 AM revealed Resident #50 admitted to the facility from home in May 2025. She explained that the resident has a history of an abusive boyfriend and explained that her reaction to other residents that were aggressive or cursing her was "to fight back". She explained that Resident #45 would follow Resident #50 around and provoke, but his cognition was poor, and he could not remember the altercations after they happened. She revealed Resident #50 was sent to Geri psych after the second altercation with Resident #45 and they tried to get Resident #45 transferred out as well, but no one would accept him because he has | F0600 | | |

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| F0600 SS = SQC-K | Continued from page 24<br>Medicaid.<br><br>An interview with the Interim Director of Nursing (DON) on 8/7/25 at 9:10 AM revealed Resident #45 persistently followed Resident #50 around and provoked the resident-to-resident altercations. She revealed Resident #45 has numerous disruptive behaviors and stated, "This is not the place for him." Interim DON revealed the resident has been to every nursing home and been kicked out due to behaviors. She revealed he has consistently exhibited problematic behaviors but none of the facilities will accept him. She revealed they (the facility) have a lot of residents with behaviors spread throughout the building and acknowledged they needed extra aides to help due to the high acuity of the residents.<br><br>Record review of the “Admission Record” revealed the facility admitted Resident #50 on 5/12/25 with a medical diagnosis of Chronic Obstructive Pulmonary Disease.<br><br>Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/18/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 11, indicting Resident #50 was moderately cognitively impaired.<br><br>Removal Plan<br><br>The removal plan below is provided in response to the Immediate Jeopardy (IJ) received on 08/06/2025. The State Agency notified the facility administrator of the IJ on 08/06/2025 at 12:20 PM.<br><br>Brief Description:<br><br>On 08/06/25, the State Agency (SA) identified that the facility had three (3) residents (Residents #45, Resident #46, and Resident #65) with known histories of aggressive behaviors toward other residents and were allowed to abuse other residents over an extended period. Despite repeated incidents of physical, verbal, and mental abuse, the facility failed to implement supervision, behavior monitoring, or protective interventions. The behavior escalated with Resident #65. On 06/30/2025, Resident #65 was in the dining area and became aggressive with Resident #20. Resident #65 then got behind the resident as he sat in the wheelchair and choked Resident #20 until staff could | F0600 | | |

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| F0600 SS = SQC-K | Continued from page 25<br>intervene. Resident #20 immediately began to have seizures after the choking incident that lasted three minutes and continued with multiple seizures daily until he was sent out to the hospital on 07/02/2025 for evaluation of a change in condition. The facility failed to protect Resident #5, Resident #20, Resident #21, Resident #34, Resident #41, and Resident #50 from abuse, creating a situation of immediate jeopardy. Resident #46 who had aggressive behaviors had an altercation with Resident #41 on 07/21/2025 when he walked into his room and hit Resident #41 in the eye so hard that it broke the hand of Resident #46. On 07/29/2025, Resident #45 who had sexual and physical behaviors made unwanted sexual advances towards Resident #34, which created an environment of sexual abuse. Residents #5, #20, #21, #34, #41, and #50 were also affected. No signs of distress were noted to be found. Resident #45 had a room change upon return from Geri psych in a semi-private room alone. Resident #46 remains in the same room with no roommate present.<br><br>Immediate Actions taken:<br><br>Resident #65 and Resident #20<br><br>On 06/30/2025 at approximately 4:30 pm, the Administrator was notified that Resident #65 initiated a physical altercation with Resident #20. On 06/30/2025 at 4:40 pm, the Administrator reported the incident to the Mississippi State Department of Health. On 06/30/2025 at approximately 4:42 pm, the Administrator reported the incident to the Local Police department. On 06/30/2025 at approximately 5:07 pm, the Administrator reported the incident to the Attorney General. On 06/30/2025, the Administrator notified Resident #65's RP at 5:09 pm. On 06/30/2025, the Administrator notified Resident #20's RP at 5:15 pm. On 06/30/2025, the Administrator notified the Medical Director (MD) and Ombudsman at 5:11 pm. On 06/30/2025 at 5:23 pm, a full body assessment was performed on Resident #20. The nurse performed a full body audit with no bleeding, swelling, or redness present. The resident was treated with pain reliever medication for the neck pain and as needed (PRN) seizure medication. Beginning 06/30/2025, Resident #65 was put on 1:1 until his discharge date of 07/02/2025. Resident #20 was transferred to the hospital on 07/02/2025 due to multiple seizure behavior and was returned to the facility the same day. Resident #65 was discharged and taken to jail on 07/02/2025.<br><br>1. Upon notification of the IJ citation on 08/05/2025, the Director of Nursing (DON) began an in-service on the Abuse and Neglect Policy, behavior monitoring, | F0600 | | |

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| F0600 SS = SQC-K | Continued from page 26<br>immediate separation, and Resident Rights until 100% is completed. No staff will be allowed to work until in serviced.<br><br>2. On 08/06/2025, the DON began a de-escalation training until at 100% completion. No staff will be allowed to work until in-serviced.<br><br>3. On 08/05/2025, the DON informed all staff to immediately notify the Administrator who is the Abuse Coordinator of any physical altercations for proper handling and reporting purposes.<br><br>4. On 08/06/2025, the facility began a full body audit on all residents for abnormal findings until 100% complete.<br><br>5. On 08/06/2025, Social Services did an interview of signs and symptoms for emotional distress with residents #5, #20, #21, #34, #41, and #50. No signs of distress were noted to be found.<br><br>6. Nursing will monitor all residents for signs of emotional distress every shift for seventy-two (72) hours.<br><br>7. On 08/06/2025, the Administrator implemented supervision protocol for residents who congregate in common areas, including the facility dining room.<br><br>8. On 08/06/2025, the facility implemented additional smoke breaks for residents to decrease physical altercations.<br><br>9. On 08/05/2025, a meeting was held with the Ombudsman if she identifies any additional behavior concerns to immediately get with the Administrator for timely resolutions.<br><br>10. Beginning 08/06/2025, a resident with past aggressive behaviors was relocated to a private room with fewer residents on the hall to decrease the probability of physical altercations.<br><br>11. On 08/06/2025, the interdisciplinary team conducted a comprehensive behavioral and psychosocial assessment on all residents with a history of aggression and behavior toward others.<br><br>12. Beginning 08/06/2025, residents identified as high-risk were flagged in the task list and placed on targeted supervision plans.<br><br>13. The facility found that there were twelve (12) | F0600 | | |

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| F0600 SS = SQC-K | Continued from page 27<br>residents with aggressive behaviors, and they were flagged in the Electronic Medical Record for hourly observation for increased behaviors on the Certified Nursing Aide task list in the Point of Care system.<br><br>14. On 08/06/2025 at 1:40 pm, an emergency Quality Assurance Performance and Improvement meeting was held to review the immediate jeopardy related to Residents Rights, Abuse and exploitation, and physician protocol for behaviors. Attendees included the Nursing Home Administrator (NHA), Director of Nursing (DON), Social Services, Assistant DON/Quality Assurance Nurse, Regional Nurse Consultant, Medical Director, and Regional Director of Operations. No changes were made to the policies. The meeting included immediately putting residents on 1:1 if signs of physical abuse are presented, until the Provider discontinues it.<br><br>The facility alleges that all corrective actions were completed on 08/06/25, and the IJ removed as of 08/07/25.<br><br>The SA validation of the Removal Plan was made on 08/07/25 through interviews, observations, record reviews, and policy reviews. The SA determined all corrective actions were completed on 08/06/25 by the facility and the IJ was removed on 08/07/25. | F0600 | | |
| F0610 SS = G | Investigate/Prevent/Correct Alleged Violation<br><br>CFR(s): 483.12(c)(2)-(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. | F0610 | | |

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| WEST POINT COMMUNITY LIVING CENTER | 2056 N ESHMAN AVENUE , WEST POINT, Mississippi, 39773 |

| (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) COMPLETION DATE |
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| F0610 SS = G | Continued from page 28<br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to investigate a resident's allegation of sexual abuse by another resident for one (1) of six (6) residents reviewed for abuse. The facilities failure to investigate and implement protective interventions made the resident feel angry, violated, and unsafe, and lead him to avoid leaving his room for fear of being watched by the alleged perpetrator. This failure placed Resident #34 at risk for further abuse, emotional distress, and significant harm to his sense of safety and well-being. Resident #34<br><br>Findings Include:<br><br>Review of the facility policy titled, “Abuse, Neglect, Exploitation and Misappropriation Prevention Program” with a revision date of 10/22 revealed under, “8. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. 9. Investigate and report any allegations within timeframes required by federal requirements. 10. Protect residents from any further harm during investigations…”<br><br>An observation and interview with Resident #34 on 8/04/2025 at 10:30 AM revealed he was sitting in his wheelchair in his room. He explained that he was admitted to the facility in February 2025 and his only concern was another male resident residing in the facility had been making sexually inappropriate statements to him asking him to "Suck his d***" and telling him he wanted to have sex with him. He stated the encounter happened in July near 100 hall but he could not remember the exact date. He explained that he told the staff after the incident and the resident named the Administrator (ADM) and Registered Nurse (RN) # 1 as the staff members he told. The resident stated, "I'm not gay and I'm not down for that s***." The resident explained that after the incident he came back to his room and could not get it off his mind. He stated it made him angry, and he felt violated. The resident explained that the incident occurred with other residents and staff around. He stated he wanted to handle things by “stabbing him” because if he did not do anything to the perpetrator, he felt as though it made him “look like a punk “(in the eyes of people who may have witnessed the event).He stated after he reported the incident to the ADM, he came away with the feeling nothing would be done. He revealed he called the Long-Term Care Ombudsman, and she came out to talk to him on July 29th. He stated, "I still don't know | F0610 | | |

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| F0610 SS = G | Continued from page 29<br>what was done about it." He revealed the perpetrator's name was (Resident #45). He revealed Resident #45 had not said anything else to him since the incident, but stated," He always watches me, and I don't like that s***." The resident stated, "I went up to him and stuck my finger in his eye and told him, I am not like that and to stop staring at me." The resident explained that he did not want to be the one that might go to jail because he retaliated against another resident. He stated Resident #45 made him uncomfortable and he did not want to come out of his room. He stated they have a lot of resident-to-resident interactions in the facility and stated that administration did not do anything about the resident's behaviors of cursing, threats, and aggression when they first start and wait until things are out of control before they react. When asked whether he felt safe in the facility and felt as though the staff would protect him, he stated, "I will protect myself."<br><br>A telephone interview with the Long-Term Care Ombudsman on 8/4/25 at 1:36 PM revealed Resident #34 called her to come out and speak with him and she did so on 7/29/25. She explained it was regarding another male resident that was making obscene sexual comments to him. She stated the resident reported he had notified the Administrator (ADM) previously about the incident, but he felt that nothing was going to be done, so he called me. She revealed she spoke with the ADM on 7/29/25 and was told they had other complaints about the perpetrator, and she would be sending the resident out to Geri psych. She revealed Resident #34 never told her the name of the alleged perpetrator.<br><br>An interview with the Administrator (ADM) on 8/05/25 at 1:42 PM confirmed Resident #34 came and reported an incident to her regarding Resident #45. She explained that Resident #34 stated that Resident #45 "threatened to interact with him sexually" and Resident #34 had inquired whether Resident #45 was gay. She confirmed the Ombudsman did come by and speak with her, but she thought it was just a misunderstanding. She explained that she did not investigate or do anything about Resident #34's concerns and stated, "He keeps changing his story." The ADM revealed Resident #34 had told the Interim Director of Nursing, 'He did not know these types of things (male to male sexual interactions) happened in a nursing home.' She revealed they tried to send Resident #45 out to Geri psych, but they could not find anyone to accept him.<br><br>An interview with Registered Nurse (RN) #1 on 8/06/25 at 8:15 AM revealed Resident #34 did report to her the | F0610 | | |

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| F0610 SS = G | Continued from page 30<br>incident with Resident #45. She explained that she did not overhear anything, but Resident #34 had told her that Resident #45 made sexually inappropriate statements to him. She also stated that she saw Resident #34 telling a housekeeper about it, but she could not recall who the housekeeper was or the details of the incident and stated, "I have a lot to do." RN #1 confirmed she did not document or report it to anybody and acknowledged what Resident #34 reported was resident to resident abuse.<br><br>Record review of the “Abuse and Neglect” sign in sheet dated 6/30/25 revealed Registered Nurse #1 was in attendance for the in-service.<br><br>Record review of the “Admission Record” revealed the facility admitted Resident #34 on 2/26/25 with a medical diagnosis of Multiple Sclerosis.<br><br>Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/26/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #34 was cognitively intact. | F0610 | | |
| F0645 SS = D | PASARR Screening for MD & ID<br><br>CFR(s): 483.20(k)(1)-(3)<br><br>§483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.<br><br>§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:<br><br>(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,<br><br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br><br>(B) If the individual requires such level of services, whether the individual requires specialized services; or<br><br>(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State | F0645 | | |

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| F0645 SS = D | Continued from page 31<br>intellectual disability or developmental disability authority has determined prior to admission-<br><br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br><br>(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.<br><br>§483.20(k)(2) Exceptions. For purposes of this section-<br><br>(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.<br><br>(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-<br><br>(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,<br><br>(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and<br><br>(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.<br><br>§483.20(k)(3) Definition. For purposes of this section-<br><br>(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).<br><br>(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.<br><br>This REQUIREMENT is NOT MET as evidenced by: | F0645 | | |

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| F0645 SS = D | Continued from page 32<br>Based on staff interview, record review, and facility policy review, the facility failed to follow the requirements for obtaining a Preadmission Screen (PAS) for a resident in the facility for greater than 30 days for one (1) of five (5) residents reviewed. Resident #10<br><br>Findings include: Record review of facility policy titled, "Admission Criteria", dated 4/10/23, revealed, "...9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID), or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process..." During an interview on 8/6/25 at 8:20 AM, the Social Worker stated Resident #10 was admitted to the facility for therapy with plans to be discharged home within 30 days, but her therapy was extended. She acknowledged the resident had diagnoses of bipolar disorder and anxiety disorder. She confirmed the Pre-Admission Screening (PAS) process evaluated residents for proper placement in nursing facilities and she confirmed the facility failed to submit a PAS for a resident that was admitted in the facility for greater than 30 days. An interview with the Administrator on 8/6/25 at 9:00 AM, revealed a PAS was part of the process to help ensure residents were appropriate for nursing home care. She acknowledged that Resident #10 had diagnoses of bipolar disorder and anxiety disorder. She confirmed the facility failed to complete the required PAS for a resident in the facility for greater than 30 days. Record review of Resident #10's "Admission Record" revealed she was admitted to the facility on 6/17/25. Her diagnoses included bipolar disorder and anxiety disorder.<br><br>Record review of Minimum Data Set (MDS) Section C dated 6/24/25, revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. | F0645 | | |
| F0656 SS = D | Develop/Implement Comprehensive Care Plan<br><br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br><br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan | F0656 | | |

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| F0656 SS = D | Continued from page 33<br>must describe the following -<br><br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br><br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br><br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br><br>(iv)In consultation with the resident and the resident's representative(s)-<br><br>(A) The resident's goals for admission and desired outcomes.<br><br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br><br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br><br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(iii) Be culturally-competent and trauma-informed.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observations, resident and staff interviews, record review, and facility policy review, the facility failed to develop a comprehensive person-centered care plan for a resident with a diagnosis of post-traumatic stress disorder (PTSD) (Resident #5), Bipolar and anxiety disorder (Resident #10), and failed to implement a care plan for a resident receiving nectar thickened liquids (Resident #27) for three (3) of 22 care plans reviewed. Resident #5, #10, #27 | F0656 | | |

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| F0656 SS = D | Continued from page 34<br>Findings Include:<br><br>Resident #5<br><br>Review of the facility policy titled “Care Plans, Comprehensive Person-Centered” reviewed 10/2022, revealed under, “Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident’s physical, psychosocial and functional needs is developed and implemented for each resident..."<br><br>Record review of Resident #5’s Care Plans revealed a care plan was not developed for past traumatic events or potential triggers.<br><br>On 8/4/25 at 10:52 AM, an observation and interview with Resident #5 revealed he was lying in bed with the curtains closed and the room dark. The resident stated he suffered from depression and took an antidepressant. He explained that he served in the Marine Corps for 17 years and was diagnosed with post-traumatic stress disorder (PTSD). He stated that having to kill people during his service deeply affected him. He reported trouble sleeping due to nightmares and said almost everything bothers him, including crowded areas, noise, and loud environments.<br><br>An interview with Social Services (SS) #1 on 8/6/25 at 8:45 AM confirmed Resident #5 did not have a care plan for post-traumatic stress disorder. She revealed the care plan should be developed because staff need to know the residents' triggers and the things that cause the resident distress such as loud noises so they can better care for him.<br><br>On 8/7/25 at 9:10 AM, an interview with the Interim Director of Nursing revealed Resident #5 was a veteran and confirmed he should have a care plan to address his triggers so that staff were aware of the things to avoid.<br><br>Record review of the “Admission Record” revealed the facility re-admitted Resident #5 on 4/7/24 with medical diagnoses of post-traumatic stress disorder dated 1/9/25 and schizophrenia affective disorder, bipolar type.<br><br>Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/24/25 revealed under Section C, a Brief Interview for Mental Status | F0656 | | |

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| F0656 SS = D | Continued from page 35<br>(BIMS) summary score of 15, indicating Resident #5 was cognitively intact.<br><br>Resident #27<br><br>Record review of Resident #27's "Care Plans" revealed under, "Focus: I have a nutritional problem or potential nutritional problem r/t (related to) my dysphagia mechanical soft diet restrictions." Also revealed under, "Interventions: Provide, serve diet as ordered."<br><br>A record review of the "Order Summary Report" revealed the following diet order dated 5/19/25: "Dysphagia mechanical soft texture, nectar consistency, add ground meats."<br><br>On 8/4/25 at 11:20 AM, during an observation of Resident #27's lunch meal, she was provided a carton of 2% milk (non-thickened) with a straw inserted.<br><br>A record review of Resident #27's meal ticket dated 8/7/25 revealed the following note: "Nectar liquids, nectar milk, nectar water."<br><br>On 8/4/25 at 11:28 AM, an observation and interview with Dietary Staff #1 confirmed Resident #27 was served the wrong consistency milk.<br><br>An interview with the MDS Nurse on 8/7/25 at 8:38 AM revealed the purpose of the care plan was to alert staff of what care to provide for the residents. She confirmed the care plan was not followed for Resident #27 in relation to the nectar thickened liquids.<br><br>Record review of the "Admission Record" revealed the facility re-admitted Resident #27 on 6/16/25 with medical diagnoses that included Dementia with Anxiety, Dysphagia, and Conversion Disorder with Seizures or Convulsions.<br><br>A record review of the MDS with an ARD of 6/30/25 revealed under Section C, a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment.<br><br>Resident #10 | F0656 | | |

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| F0656 SS = D | Continued from page 36<br><br>During the record review of Resident #10's care plan, it was revealed that the resident did not have a care plan for her diagnoses of anxiety disorder and bipolar disorder.<br><br>During an interview with the Licensed Practical Nurse (LPN) MDS Coordinator on 8/6/25 at 10:05 AM, it was revealed that care plans guide the residents' care and preferences for the staff to follow. She acknowledged Resident #10 had diagnoses of bipolar disorder and anxiety disorder and the care plan failed to include the individualized care plan for these mental health diagnoses. She confirmed she was responsible for developing the care plan and due to an oversight, she failed to develop the care plan for her mental health diagnoses.<br><br>An interview with the Administrator on 8/6/25 at 10:15 AM, revealed the care plan offers a guide for each resident's care and Resident #10 did not have a care plan developed for her diagnoses of bipolar disorder and anxiety disorder. She confirmed the facility failed to develop care plan for a resident's mental health diagnoses.<br><br>Record review of Resident #10's "Admission Record" revealed she was admitted to the facility on 6/17/25. Her diagnoses included bipolar disorder and anxiety disorder.<br><br>Record review of MDS Section C dated 6/24/25, revealed resident had a BIMS score of 15 which indicated the resident was cognitively intact. | F0656 | | |
| F0699 SS = D | Trauma Informed Care<br><br>CFR(s): 483.25(m)<br><br>§483.25(m) Trauma-informed care<br><br>The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on resident and staff interviews, record review, | F0699 | | |

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| F0699 SS = D | Continued from page 37<br>and facility policy review, the facility failed to assess and identify potential triggers for a trauma survivor for one (1) of three (3) residents reviewed for post-traumatic stress disorder (PTSD). Resident #5<br><br>Findings Include:<br><br>Review of the facility policy titled “Trauma-Informed and Culturally Competent Care,” revised 8/22, revealed under “Purpose: To guide staff in providing care that is culturally competent and trauma-informed in accordance with professional standards of practice, and to address the needs of trauma survivors by minimizing triggers and/or re-traumatization.”<br><br>An observation and interview with Resident #5 on 8/4/25 at 10:52 AM revealed he was lying in bed with the curtains closed and the room dark. The resident stated he suffered from depression and took an antidepressant. He explained that he served in the Marine Corps for 17 years and was diagnosed with post-traumatic stress disorder (PTSD). He stated that having to kill people during his service deeply affected him. He reported trouble sleeping due to nightmares and said almost everything bothers him, including crowded areas, noise, and loud environments.<br><br>Record review of Resident #5’s “Psychiatry Note” dated 1/9/25 revealed: “In Marine Corps for 17 years; when I first got out of the military, I stuck a gun in my mouth, then had to go to a mobile mental health center; nightmares every now and then-last one about a week ago (revisiting the past).” The resident was diagnosed with PTSD.<br><br>Record review revealed the facility did not complete a trauma assessment for Resident #5.<br><br>An interview with Social Services (SS) #1 on 8/5/25 at 4:01 PM revealed she was responsible for conducting trauma-informed care assessments. She learned in January 2025 that Resident #5 had post-traumatic stress disorder (PTSD) after the nurse practitioner saw the resident. She confirmed no assessment had been completed and stated it should have been done to inform staff about his PTSD and potential triggers that could cause re-traumatization. | F0699 | | |

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| F0699 SS = D | Continued from page 38<br>An interview with the Interim Director of Nursing on 8/7/25 at 9:10 AM revealed Resident #5 was a veteran. She stated that trauma assessments should be conducted quarterly to ensure his psychosocial needs and mental well-being were met.<br><br>Record review of the “Admission Record” revealed the facility re-admitted Resident #5 on 4/7/24 with medical diagnoses of post-traumatic stress disorder dated 1/9/25 and schizophrenia affective disorder, bipolar type.<br><br>Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/24/25 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #5 was cognitively intact. | F0699 | | |
| F0759 SS = D | Free of Medication Error Rts 5 Prcnt or More<br><br>CFR(s): 483.45(f)(1)<br><br>§483.45(f) Medication Errors.<br><br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not 5 percent or greater;<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, staff interview, record review, and facility policy review the facility failed to maintain a medication error rate of less than 5% by ensuring that residents received all physician-ordered medications for three (3) of 28 medication administration opportunities observed during medication pass. The medication error rate was 10.71%.<br><br>Review of the facility policy titled, “Medication Administration” dated November 1, 2008 revealed, “Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so … B. Administration … 2) Medications are administered in accordance with written orders of the attending physician...”<br><br>On 8/06/2025 at 9:35 AM, a medication administration observation with Registered Nurse (RN) #1 revealed a | F0759 | | |

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| F0759 SS = D | Continued from page 39<br>medication administration to Resident # 5. The medications administered were Diazepam tablet 5 mg (milligrams), Linzess oral capsule 145 mcg (micrograms) Prednisone tablet 5 mg (3 tablets) Pantoprazole Sodium tablet delayed release 40 mg, Keppra tablet 500 mg, Gabapentin capsule 100 mg, Imuran tablet 150 mg, Eliquis tablet 5 mg, and Glycolax powder (polyethylene Glycol 3350) 17 grams. The total number of medications administered to Resident #5 was nine (9).<br><br>During medication reconciliation, a record review of the “Order Summary Report and Medication Admin Audit Report” revealed that Resident #5 did not receive three (3) medications that were prescribed by the Physician to be given during that medication administration time. Medications omitted were Metformin HCl Tablet 500 mg, Oxybutynin Chloride ER (extended release) tablet 24-hour 10mg, and Risperdal tablet 0.5 mg.<br><br>Review of the Medication Admin Audit Report revealed that the three omitted medications were documented as given under the “administration time” as 09:38 and the “documented time” as 09:40 during the medication observation with RN #1.<br><br>During an interview on 8/6/25 at 11:10 AM the interim Director of Nurses (DON) revealed it is our expectation that our nurses administer to the residents all of the medications that the physician has ordered. She revealed that not giving a resident their medications is not acceptable, and if a medication is unavailable, the nurse must call the physician and notify the DON.<br><br>In an interview on 8/6/2025 at 1:30 PM, RN #1 revealed she returned after the Medication administration pass and later gave Resident #5 the other medications. SA inquired why the medications were not given simultaneously with the other morning medications listed on Resident #5's physician orders. RN #1 revealed she needed some time and exited the room where the interview was being held.<br><br>A record review of the facility “Admission Record” revealed Resident #5 was admitted to the facility on 04/07/2024 with diagnoses that included Type 2 Diabetes Mellitus, Post-Traumatic Stress Disorder, Schizoaffective disorder, Bipolar type, and Overactive bladder.<br><br>A record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of July 24, 2025, revealed a Brief Interview for Mental Status | F0759 | | |

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| F0759 SS = D | Continued from page 40<br>(BIMS) score of 15, which indicated Resident #5 is cognitively intact. | F0759 | | |
| F0808 SS = D | Therapeutic Diet Prescribed by Physician<br><br>CFR(s): 483.60(e)(1)(2)<br><br>§483.60(e) Therapeutic Diets<br><br>§483.60(e)(1) Therapeutic diets must be prescribed by the attending physician.<br><br>§483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, staff interview, and record review, the facility failed to serve a therapeutic diet as ordered for one (1) of six (6) residents reviewed for the dining task. Resident #27<br><br>Findings Include:<br><br>An interview with the Administrator on 8/7/25 at 10:06 AM revealed the facility did not have a policy regarding serving diets as ordered.<br><br>An observation of Resident #27's lunch meal on 8/4/25 at 11:20 AM revealed she received a meal in the dining room consisting of cornbread dressing with cranberry sauce, rice with gravy, diced carrots, a roll, milk, and apple cobbler. The resident was provided with a carton of 2% milk (non-thickened) with a straw inserted. She was observed feeding herself.<br><br>A record review of Resident #27's meal ticket revealed the following note: "Nectar liquids, nectar milk."<br><br>An observation of Dietary Staff #1 on 8/4/25 at 11:28 AM revealed she brought a carton of nectar-thickened milk to Resident #27's meal tray and removed the regular consistency milk. In an interview, Dietary Staff #1 confirmed that the resident had been served regular milk. She explained she came out of the kitchen to get another resident a sausage and noticed the error at that time. She stated the resident was supposed to | F0808 | | |

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| F0808 SS = D | Continued from page 41<br>be on nectar liquids and said, “I caught it; I don’t think she drank any of it.” She acknowledged that aspiration was a possible risk. She also explained she had a new tray line server who was still in training but emphasized that the server should be reading the tray cards before sending trays to the dining room.<br><br>A record review of the “Order Summary Report” revealed the following diet order dated 5/19/25: “Dysphagia mechanical soft texture, nectar consistency, add ground meats.”<br><br>An interview with the interim Director of Nursing (DON) on 8/7/25 at 9:10 AM revealed her expectation was for certified nurse aides to check the meal ticket against the food provided at mealtime to ensure the correct diet was served. She confirmed Resident #27 was on nectar liquids and acknowledged that the resident could have choked, aspirated, and developed an infection.<br><br>An interview with the Speech Therapist (ST) on 8/7/25 at 9:49 AM revealed Resident #27 was on the speech therapy caseload due to poor dentition and a history of aspiration pneumonia. She stated she had trialed thin liquids with the resident but decided to maintain thickened liquids because the resident’s condition fluctuated and she experiences seizure episodes.<br><br>Record review of the "Admission Record" revealed the facility re-admitted Resident #27 on 6/16/25 with medical diagnoses that included Dementia with Anxiety, Dysphagia, and Conversion Disorder with Seizures or Convulsions.<br><br>A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/30/25 revealed under Section C, a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. | F0808 | | |
| F0880 SS = E | Infection Prevention & Control<br><br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br><br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of | F0880 | | |

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| F0880 SS = E | Continued from page 42<br>communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or<br><br>infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br><br>(iv)When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br><br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br><br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. | F0880 | | |

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| F0880 SS = E | Continued from page 43<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br><br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br><br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, staff interviews, record review, and facility policy review, the facility failed to prevent the possibility of the spread of infection during medication administration as evidenced by failing to ensure Enhanced Barrier Precautions (EBP) were utilized and ensuring a multi-use glucometer was properly cleaned and disinfected for two (2) of four (4) medication observations. Resident #21, Resident #40<br><br>Findings include:<br><br>Record review of the facility policy titled, “Enhanced Barrier Precautions” with no revision date revealed “Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. …3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: … g. device care or use (…feeding tube)..."<br><br>Record review of the facility policy titled, “Blood Sampling-Capillary (Finger Sticks)” undated, revealed “Purpose: The purpose of this procedure is to guide the safe handling of capillary-blood sampling devices to prevent transmission of bloodborne diseases to residents and employee. Equipment and Supplies: 6. Approved EPA registered disinfectant for cleaning of sampling device. General Guidelines 1. Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses..."<br><br>Resident #21 | F0880 | | |

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| F0880 SS = E | Continued from page 44<br><br>An observation on 8/6/2025 at 8:20 AM revealed Personal Protective Equipment (PPE) hanging on Resident #21's room door. Licensed Practical Nurse (LPN) #1 entered Resident #21's room to provide medications through a Percutaneous Endoscopic Gastrostomy (PEG) tube. LPN #1 administered the medications through the PEG tube without donning a gown.<br><br>During an interview on 8/06/2025 at 8:35 AM, LPN #1 revealed that any residents with wounds or PEG tubes are under enhanced barrier precautions. She confirmed that Resident #21 is under EBP due to having a PEG tube and acknowledged that she failed to wear a gown, and she should have protected herself and the resident from potential exposure to bodily fluids and infections.<br><br>During an interview on 08/07/2025 at 10:45 AM, the interim Director of Nurses (DON) revealed that she had conducted in-services on infection control January 2025, which included EBP requirements. She revealed that LPN #1 and all nursing staff were trained to wear the proper PPE while providing care to any resident under enhanced barrier precautions. She confirmed Resident #21 is under enhanced barrier precautions, and a gown should have been worn by LPN #1 while administering his PEG medications.<br><br>Record review of Resident #21's "Admission Record" revealed an admission date of 02/20/2025 with medical diagnoses that included Dysphagia following Cerebral Infarction.<br><br>Record review of Resident #21's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of July 10, 2025, revealed, under "Section C' that the resident is rarely/never understood.<br><br>Resident #40<br><br>An observation and interview on 8/06/2025 at 8:45 AM, revealed Registered Nurse (RN) #1 performed an Accu-Check on Resident #40 using a multi-use glucometer. After using it, she placed the glucometer on the medication cart, then put it into a blue basket in the top drawer without disinfecting it. The State Agent (SA) inquired if she needed to clean the glucometer. The nurse stated, "Oh yeah." RN #1 opened | F0880 | | |

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| F0880 SS = E | Continued from page 45<br>the bottom right drawer on the medication cart, and a white container with a blue top was observed. The nurse looked down and then shut the drawer. She picked up an alcohol swab from the top of the medication cart, briskly cleaned the glucometer, and placed the glucometer back into the top-drawer basket. RN #1 revealed she may not have cleaned the glucometer correctly, but they were out of disinfectant wipes, and she just cleaned with what she had, which was an alcohol swab. The SA prompted RN #1 to look in her bottom drawer again. RN #1 opened the right bottom drawer of her medication cart, and the same white container with a blue top, labeled “Micro-kill bleach Germicidal Bleach Wipes,” was noted. RN #1 stated, "Oh yeah, there are some disinfectant wipes here.” She removed the glucometer from the top-drawer basket, wiped it briskly with the disinfectant wipe, and then laid the glucometer back on top of the medication cart, not utilizing a clean barrier.<br><br>During an interview on 8/7/2025 at 11:00 AM, the interim Director of Nurses revealed that usually each diabetic resident has their own personal glucometer that is kept in their room; however, Resident #40 is relatively new and doesn’t have her personal glucometer yet. She revealed that regardless of whether she did not have her own glucometer, the glucometer on the cart was available for her use, and it should have been cleaned and disinfected appropriately. She confirmed it is never an acceptable nursing practice to clean with only alcohol swabs, and the nursing staff knows that is not acceptable. She revealed it is our expectation and practice to clean and disinfect the multi-use glucometer with the Germicidal bleach wipes, and leave it wet for two to three minutes on a clean barrier to ensure it is thoroughly disinfected.<br><br>Record review of Resident #40’s “Admission Record” revealed an admission date of 06/12/2025 with medical diagnoses that included Type 2 Diabetes Mellitus.<br><br>Record review of Resident #40’s Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of June 18, 2025, revealed, under “Section C’ a Brief Interview Mental Status (BIMS) score of 11, which indicated the resident was moderately cognitively impaired. | F0880 | | |