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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125002	A. BUILDING ______ B. WING ______	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILO BENIOFF MEDICAL CENTER	1190 WAIANUENUE AVENUE HILO, HI 96720

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance on February 7, 2025. The facility was found not to be in compliance with 42 CFR §483, Subpart B. Survey Dates: January 27, 2025 to January 31, 2025 and February 6, 2025 to February 7, 2025. Census: 50 Sample Size: 19 residents The survey included the following complaints/facility reported incidents: ACTS #HI00011252: Allegation of Resident to Resident Abuse - deficient practice identified ACTS #HI00011348: Accident (Fall with injury) - deficient practice not identified ACTS #H00011229: Allegation of Resident to Resident Abuse - deficient practice identified ACTS #HI00011356: Allegation of Resident to Resident Abuse - deficient practice identified ACTS #HI00011312: Allegation of Resident to Resident Abuse - deficient practice identified	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident	F 550		

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

Electronically Signed

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

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F 550	Continued From page 1 with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on confidential interview and record review, the facility failed to treat each resident with respect and dignity for one of one sampled resident reviewed for dignity. This deficient practice caused the resident distress and affected his mood.	F 550		

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F 550	Continued From page 2 Findings include: Confidential interview was conducted with a resident on 01/27/25 at 11:15 AM. The resident reported that some of the staff are "assholes", treating me bad. Asked how do they treat you badly, resident replied the staff member yells and cusses him/her out. The resident reported that this Certified Nurse Aide (CNA)2 is really loud, screaming and laughing, the resident finds it "very disturbing". The resident reported residents are trying to rest and CNA2 is disrupting. The resident further reported the CNA is so loud it wakes him/her. Further queried whether CNA2 has been physical, resident replied no. The resident further shared that there have been times when, he/she yelled at CNA2 to shut up and used expletives. Then CNA2 will respond, is that how your mother taught you to act? Resident further stated taking offense to this statement as CNA is bringing involving a family member. Resident reported this gets him/her more frustrated and angry. Feels CNA is being antagonistic. Record review was done on 01/30/25 at 08:07 AM. A review of a quarterly Minimum Data Set (MDS) with an assessment reference date of 11/15/24 documents, the resident is cognitively intact and is coded with mood symptoms - having little interest in things, feeling down, moving or speaking slowly, and thoughts of being better off dead. Also reviewed progress which documents the resident's experience with the CNA. The staff member that entered the progress note	F 550		

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F 550	Continued From page 3 documents the CNA the resident identified did not enter the resident's room and was not assigned to the resident.	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		

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F 584	Continued From page 4 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility did not ensure a resident's right to a safe and homelike environment was provided for one of one residents that expressed concern regarding their home environment. This deficient practice affects the resident's comfort and safety. Findings include: On 01/26/25 at 11:23 AM an interview was conducted with Resident (R)29. R29 reported the grab bar next to the toilet is tied up with plastic bags. Following the resident interview, observation of the bathroom found the grab bar to the left of the toilet was anchored with two plastic bags to the bar at the back of the toilet. Also observed a large area of the paint behind the toilet was blistered and peeling. On 01/28/25 at 08:34 AM concurrent observation was done with Licensed Practical Nurse (LPN)1. Inquired why is the bar tied up, LPN1 reported the resident has requested the grab bar to be out of the way to facilitate transfer to the toilet. Further queried whether the grab bar would stay up without it being tied. LPN1 was agreeable to undo the two plastic bags. Upon removal, observed when the grab bar is up and touched, it will disengage and fall. LPN1 was asked if the grab bar was broken, LPN1 responded there may	F 584		

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F 584	Continued From page 5 be something missing that prevents the grab bar from locking in the upright position. LPN1 also confirmed the blistering and peeling paint behind the toilet. On the morning of 01/28/25 observed staff member touching up paint in the East hall. Concurrent observation was done with the staff member. The staff member confirmed the paint is blistering and peeling behind the toilet, as well as, an area by the toilet paper dispenser with peeling paint. The staff member reported the paint is on concrete and with moisture, the paint will peel off the wall. The staff member reported there was a work order regarding the peeling paint. Inquired when was the order submitted, the staff member was not sure. Requested the staff member provide a copy of the work order. The work order was not submitted prior to the survey team's exit.	F 584		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in	F 585		

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F 585	Continued From page 6 accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing	F 585		

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F 585	Continued From page 7 written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the	F 585		

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F 585	Continued From page 8 facility did not ensure the resident was apprised of the progress toward resolution of a filed grievance and prompt efforts were not made to resolve a grievance for one (Resident 1) of one residents that filed a grievance. This deficient practice resulted in the resident being unaware of the outcome of the grievance; therefore, five months have passed and Resident (R)1 continues without knowledge of the results of her grievance and an iPad. Findings include: On 01/29/25 at 01:03 PM, during the resident council interview, Resident (R)1 reported her iPad was damaged by a staff member. R1 shared the Certified Nurse Aides (CNA) was not careful during care, resulting in water damage to the iPad. R1 filed a grievance and reported she had not received a response from the facility on the disposition of the grievance. On 01/30/25 at 08:20 AM an interview was conducted with the Administrator. The Administrator was familiar with the grievance filed by R1 and stated the facility will replace the resident's iPad. Inquired whether the facility informed R1 of the outcome of the grievance. Administrator replied there is no written documentation R1 was notified of the facility's decision to replace the iPad. The Administrator also acknowledged the process for reimbursement is pending the State's accounting department. A review of the "Grievance Form" notes the day of the incident occurred on 08/21/24 at 05:30 AM. R1 reported the CNA was in a rush, accidentally dropped the resident's pitcher of water and when	F 585		

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F 585	Continued From page 9 the CNA moved the over bed table, R1's iPad fell into the puddle of water. The iPad was wiped and R1 attempted to turn it on, but the iPad did not work. Subsequent document, "Grievance Summary Report" notes the grievance was received on 08/28/24. The facility's interview with the CNA notes while moving the bedside table, water spilled, iPad fell to the ground, then did not work. Further noted the recommendation was to replace the iPad and it was documented the grievance was resolved. The date of this document was 10/15/24. A "Claim for Damage or Injury" form was completed on 10/15/24. The amount of the claim for property damage was $205.00. A review of the facility's policy and procedures, "LTC Grievance/Complaint" provided by the facility on 01/29/25 at 03:13 PM notes the following: "Written grievance decisions will be resolved promptly, but no later than 30 days from the filing of the grievance with the facility. Residents/representatives will be notified in writing of any grievance that takes longer than 30 days to resolution due to unforeseen circumstances or the nature of the specific grievance and will be provided an expected time-frame to completion". Further review notes under the facility's procedure, "A summary report (attachment D) of the grievance will be completed in writing and made available to the resident/representative as per this policy. The summary will include:...5. A summary of the pertinent findings or conclusions; 6. A statement as to whether the grievance was confirmed or not confirmed; and 7. Any corrective actions taken or recommended by the facility..."	F 585		

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F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to protect the residents' rights to be free from physical abuse by another resident. The facility did not assure residents with a history of distressed behaviors were identified to be at risk for abuse. The facility did not ensure staff were provided with training to assess potential situations that may result in abuse (Cross Reference to F943 - Abuse, Neglect, and Exploitation Training). The facility did not assure residents with a prior incident were supervised and monitored on the lanai. The facility submitted reports alleging resident-to-resident abuse involving a cognitive resident (Resident 44) that had two incidents as the alleged perpetrator, one with a cognitively impaired resident (Resident 33) and a cognitive resident (Resident 3). There were two incidents involving Resident (R)44 and R33. This deficient	F 600		

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Continued From page 11

practice has the potential to result in psychosocial harm and/or injury.

Findings include:

1) ACTS #HI00011229

On 09/26/24 at 12:30 PM, the facility submitted an Event Report regarding an allegation of resident-to-resident abuse involving R44 and R33. R44 was identified as the alleged perpetrator and R33 as the alleged victim. The facility reported on 09/26/24 at 10:45 AM, R44 was observed by staff to wheel out to the lanai and began throwing garden rocks at R33. This was witnessed by two Certified Nurse Aides (CNA) who were eating lunch on the lanai. The CNAs stopped R44 and separated them. R44 accused R33 of taking her papaya the day before. R33 was noted with a bruise to the left forearm.

The residents were separated, and the activities staff calmed R44. R44 requested papaya which was immediately provided by dietary.

Subsequently, R33 noted with bruise (1.5 cm x .4 cm) on left forearm. R33 was unable to recall the event.

Interviews with the staff present found R44 ate alone on the lanai and R33 ate in the dayroom. R33 went out on the lanai after lunch. Staff did not witness R33 taking food from R44 and R33 does not have history of taking food from others.

Residents reportedly were kept apart, and no verbalizations of aggression or anger noted during investigation. In service was provided to

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all staff on abuse and neglect with focus on resident-to-resident altercation. Facility deemed altercation was substantiated as there were witnesses present at the time.

On the morning of 01/27/25 observed R44 was on droplet precautions for the flu. R44 was quarantined to her room. On 01/28/25 at 08:00 AM, attempted to interview R44 at breakfast. R44 was visited at bedside. She was eating hot cereal, introductions were made R44 did not acknowledge my presence. As her mouth was full with cereal, informed her I'd wait until she swallowed her cereal, she looked up, made eye contact and took another spoonful of cereal. Requested an interview, R44 did not respond.

On 01/30/25 at 10:26 AM observed R44 sitting alone on the lanai. It was difficult to see her as she was sitting to the side and could not be seen from across the activity/dining room.

Record review notes R44 was admitted to the facility on 05/30/24 from an acute hospital. Diagnoses include cerebrovascular accident, hemiplegia, and diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) with assessment reference date of 11/12/24 notes R44 is cognitively intact, scored a 15 on the Brief Interview for Mental Status (BIMS).

A review of Section D. Mood, the mood interview was conducted, R44 noted with the presence of the following mood symptoms: little interest or pleasure in doing things; feeling down, depressed, or hopeless, trouble falling or staying asleep or sleeping too much; poor appetite; feeling bad about yourself or that you are a failure or have let yourself or family down; and moving or

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speaking so slowly that other people could have noticed. R44 was not coded for exhibiting behaviors during the assessment period.

R44 was seen by the psychologist on 10/17/24. The psychologist notes R44 tends to become agitated, and hoards (mostly food). R44 reportedly not on psychotropic or have psychiatric history. The recommendation/plan is to continue standard behavioral oversight and interventions to provide resident time to settle into her new placement.

Review of the care plan for behavioral symptoms noted the following interventions, I can be impatient and have history of changing my own briefs while in my bed/room, remind to use call light and educate me on the importance of being patient and the risks of changing my own brief. Following the incident, the care plan was revised (09/26/24) to include, please ensure that I am not seated near resident in E2 (R33) during meals, as I think she stole food from me which made me upset.

R33 was admitted to the facility on 11/29/22, diagnoses include but not limited to vascular dementia with behavioral disturbance, acute subdural hematoma, and insomnia.

A review of the quarterly MDS with ARD of 12/10/24 notes, R33 scored a three (severe cognitive impairment) upon application of the BIMS. R33 noted with no mood or behavioral symptoms.

On 01/27/25 at 01:09 PM interviewed R33 in her room. R33 was unable to recall any incident(s) with fellow residents.

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F 600	Continued From page 14 Review of R33's care plan for behavioral symptoms included intervention when out in the dayroom staff will have visual on me at all times until further notice. Although facility noted R33 does not have a history of taking food from other, the care plan was revised, 09/26/24 to include "I may take food that is left on table unattended, please redirect me." 2) ACTS #HI00011356 On 12/08/24 at 02:41 PM, the facility submitted an "Event Report" regarding an allegation of resident-to-resident abuse. This is second event between R44 and R33 while on the lanai. R44 was identified as the alleged victim and R33 as the alleged perpetrator. Report indicates on 12/08/24 at 12:26 PM, R44 was sitting outside on the facility's lanai. Activities Aide (AA) saw R33 heading out to the lanai on her wheelchair. Ten minutes later, AA heard screaming on the lanai, a Certified Nurse Aide (CNA)11 reportedly ran outside and called for help and upon arrival AA saw R33 pulling R44's hair. CNA11 indicated in the facility's investigation report while separating the residents, R44 turned to pull R33's hair and attempted to hit R33. The residents were immediately separated. R44 had scratch marks at the back of her necks and two small open areas to the right side of her neck. R44 was crying. R33 was assessed by the nurse and found to have one scratch and two open areas to the right hand and a scratch to the left forearm. Registered Nurse (RN)3 reported R44 indicated R33 scratched her when she would not allow her to take her phone and papaya. RN3 noted there	F 600		

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F 600	Continued From page 15	F 600		

was no papaya on the table but saw R44's phone on the table. RN3 indicated R44 told her R33 took her papaya.

The Clinical Coordinator was documented as interviewing R44 on 12/09/24. R44 reported she was sitting her wheelchair on the lanai when another resident tried to grab her phone and took her papaya. R44 reported telling the resident not to take her things but the resident grabbed her by the hair. R44 further stated she had to protect herself and things.

R44 was seen by the psychologist for evaluation on 12/11/24. The psychologist's impression was that the altercation with other resident has resolved but there could be a flare at any time due to the resident's impulsive tendencies and extreme guarding of her possessions. The psychologist recommendations includes watching R44 close for signs of upset with other residents when in common areas, particularly when on the back lanai as this seems to be the location of most conflicts and consider placing her bed to the far wall adjacent to the windows for security/privacy.

R33 was seen for evaluation by the psychologist on 12/11/24. Psychologist noted R33 lacks capacity due to dementia and tends to wander and violate privacy/property of others, thus requiring close supervision. Psychologist further states R33 requires close supervision particularly when away from main common areas, as well as, minimizing interaction with R44.

On 01/27/25 at 01:09 PM interviewed R33 in her room. R33 was unable to recall any incident(s) with fellow residents.

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F 600	Continued From page 16	F 600		

3) ACTS #HI00011312

On 11/09/24 at 04:24 AM, the facility submitted an Event Report of an allegation of resident-to-resident abuse involving R44 and R3. This is R44's third involvement in resident-to-resident abuse. R44 was identified as the alleged perpetrator. The report documents on 11/09/24 at 03:15 AM R3 was on the bedside commode yelling for assistance, the privacy curtain was closed. The RN observed R44 in her wheelchair at the foot of R3's bed. R3 reported R44 threw a plastic mouthwash bottle at her. R44 admitted to throwing the bottle at R3 as she would "not shut up." R3 with no visible injury. R44 was moved to another room. The completed report submitted on 11/18/24 at 03:33 AM notes the RN found the bottle at the side of R3's bed.

Subsequent progress notes indicate on 11/12/23 R44 became "furious at dinner time because she was looking for banana and papaya on her dinner plate, but it was not included." Staff explained that they don't have papaya now and R44 calmed down. Approximately 20 minutes later, she was noted to be shouting and crying and when asked what was wrong, she responded she didn't know and showed a video of kids and said, "send me baby."

Another progress note of 11/13/24 documents R44 with behavior while in the day room. R44 was seated at the table with other residents for a resident council meeting and when another resident attempted to back up and ran into R44, they began arguing. The other resident picked up a cup of water and threw it at R44. R44 attempted to take a swing at the other resident.

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This was R44's second incident with another resident. R44 was assessed by the psychologist on 11/23/24. Psychologist notes R44 presenting with status post cerebrovascular accident with aphasia, right hemiplegia (a condition that causes paralysis or weakness on one side of the body), and cognitive deficits. Psychologist notes managing R44's impulsive behaviors have been challenging and further complication includes language barrier English is not her primary language. R44 was happy being placed in a private room and has been provided a cooler to keep her papaya and banana in (related to earlier incident). Psychologist further notes the room reassignment to a private and quiet location has been well received by the resident who has not had an impulsive outburst since then.

The update to the care plan included intervention for an appointment with the psychologist.

R3 was admitted to the facility on 08/05/24 with diagnoses of chronic obstructive pulmonary disease with hypoxia, history of falls and bipolar disorder.

A review of a significant change MDS with ARD of 12/19/24 notes R44 is cognitively intact with a BIMS score of 15. R3 was not coded for exhibiting mood or behavioral symptoms.

Review of the witness statement by Registered Nurse (RN)3 notes she entered the room when she heard R3 screaming for help. Upon entering the room, R3 was on the commode with privacy curtain drawn closed. R44 was at the foot of the bed yelling at R3. R3 reported to RN3 that R44 threw a plastic mouthwash bottle at her.

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The progress note of 11/09/24, created on 11/11/24 notes R44 admitted to throwing the plastic mouthwash bottle at R3 but denies the bottle hit R3.

On 02/06/25 at 11:21 AM a telephone interview was conducted with RN2. RN2 was the Charge Nurse at the time of the incident. RN2 reported by the time she went to the residents' room, R3 was already back in bed. R3 reported having pain to the left arm. RN2 stated the plastic mouthwash bottle was found on R3's bed. RN2 reported there was no history of R44 and R3 not getting along or having a history of incidents.

Interview with the Administrator and Social Services regarding R44's behavior. They reported working on finding placement for this resident and had R44 sign a behavioral contract. On 01/31/25, the facility provided a copy of the "Behavior Contract" for R44. The contract includes the following: 1. I will notify staff immediately when I have a concern regarding another resident here at facility; 2. I will NOT display/demonstrate any physical aggression with any residents here at facility; and 3. I will refrain from ANY negative verbal comments directed at other residents here at facility". The date of signature was illegible. On 02/07/25 at 10:13 AM, the Administrator and DON confirmed the contract was signed on 01/10/25, approximately one month from R44's last incident of 12/08/24.

4) ACTS #HI00011252

On 10/05/24 at 06:50 PM, the facility submitted an Event Report of an allegation of resident-to-resident abuse between R14 and

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F 600	Continued From page 19 R37. A review of the Event Report and facility's staff report notes on 10/05/24 at 05:00 PM, R37 was seated in his wheelchair in the dayroom. R37 could be heard screaming out for help when R14 stood up and yelled at R37 to shut up and punched R37 in the head twice. Review of staff witness report, CNA4 indicates he was assisting another resident with his meal in the dayroom. R37 was seated at a different table with two other residents, including R14. CNA4 saw R37 was done with his meal and began making several loud vocalizations which was noted to be a frequent observed behavior of R37. R37 was attended to, not needing "immediate action." A few minutes later R37 made another series of vocal outbursts. At this time, R14 reportedly began a verbal exchange with R37. R14 was witnessed to stand and strike R37 in the face. R37 was removed and returned to his room. Another witness report by RN3 notes upon completion of assisting a resident with toileting, R37 was heard to call out (repetitive behavior). RN3 told R37 that his CNA would be with him in a few moments and to "hang tight for a little while" which R37 responded "okay". While speaking to another staff member, R37 was heard to call out and RN3 witnessed R14 stand, yell at R37 and immediately hit him. Residents were separated. R14 was admitted to the facility on 08/31/20. Diagnoses include, diabetes mellitus (insulin dependent), anemia, renal insufficiency, coronary artery disease, and anemia. Review of R14's quarterly MDS with ARD of 10/14/24 indicates he is cognitively intact as he scored a 14 on the BIMS. R14 was coded with symptom of mood,	F 600		

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F 600	Continued From page 20 having little or pleasure in doing things over the past two to six days. R14 was not coded with behavior. R14 is coded with severely impaired vision (no vision). Following the incident, R14 was assessed by the psychologist on 10/17/24. The psychologist documents R14 was frustrated and impulsively became aggressive. The psychologist surmised this was an isolated incident, R14 recognized the inappropriateness of his behavior and gave verbal assurance he will address personal issues with staff and not lay hands on another resident. Review of R14's behavioral care plan includes intervention to monitor resident for presence of agitation, frustration, physical aggression, auditory hallucinations and intervene accordingly; updates of 10/10/24 includes when agitated with loud, repetitive stimulation, do not place me near anyone who is making loud, repetitive verbal stimulation, order for psychological consult due to physical altercation with another resident. Interviewed R14 on 01/28/25 at 09:36 AM in his room. R14 was able to recall the incident. He explained the guy yells every time and this time he got disgusted and punched R37. R14 stated that he would not do that again and the staff are aware that should R37 start yelling that they would move him away. R37 further stated that he doesn't like anything about R37 and he just "don't like his ass". R37 shared that he doesn't know why he doesn't like R37 as he gets along with everyone else. A review of R37's record indicates he was admitted to the facility on 06/16/23. Diagnoses include non-traumatic brain dysfunction and	F 600		

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F 600	Continued From page 21	F 600		

dementia. R37 has severe cognitive impairment, scoring a four on the BIMS. He was not coded for mood or behavior.

A review of the psychiatric consult dated 10/01/24 notes diagnosis of dementia with behavioral disturbance - unstable, paranoid, and anxiety of being alone. Psychiatrist documents R37 is a reliable historian, he relayed to the psychiatrist "they want me to stay here" and has been screaming and yelling every day for the past 8 months. R37 noted to be agitated. Follow-up with psychiatrist was done on 10/14/24. R37 is seen for medication management.

R37's care plan revision includes, but not limited to, 10/23/24, please bring me back to my room after meals in order to decrease overstimulation and frustration with noise.

On 02/06/25 at 11:33 AM a telephone interview was conducted with RN3. RN3 reported R14 and R37 does not have a history of not getting along, they are usually "okay" together. RN3 recalled R37 has behavior or yelling and screaming out, he is being seen by a psychiatrist to correct the behavior. RN3 shared R37's behavior is attention seeking so when he calls out, staff need to go over and talk to him.

At the time of the incident RN3 recalled R37 calling out, R37's assigned CNA responded to him. CNA attended to resident and left. RN3 heard R37 calling again, approached him and told him to hold on, his CNA is coming back. RN3 reported CNA4 no longer works at this facility.

5) The facility's policy and procedure titled, "Freedom from Abuse/Neglect/Exploitation Long

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F 600	Continued From page 22 Term Residents" was reviewed. The purpose of the policy and procedure is to keep residents free from abuse, neglect and corporal punishment of any kind, including involuntary seclusion, by any person. The type of abuse includes resident to resident abuse which notes cognitive impairment or mental disorder does not preclude a resident from being abusive; facility will assess the resident and care plan interventions to address resident behaviors that may indicate a risk for abusive, aggressive interaction (e.g. physical, sexual or verbal aggression; taking, touching or rummaging through another's property; wandering into another's rooms/space). The policy for training and maintaining staff's knowledge by providing education upon hire and at least annually includes but not limited to: "Understanding behavioral symptoms of residents that may increase the risk of abuse and how to respond, including: i. aggressive and/or catastrophic reactions or residents; ii. Wandering or elopement-type behaviors; iii. Resistance to care; iv. Outbursts or yelling out; and v. difficulty in adjusting to new routines or staff. Also noted for preventing abuse, staff will be informed of the individual residents' care needs and behavioral symptoms, staff will identify, assess, and develop care plan interventions and monitor residents with needs and behaviors which may lead to conflict or neglect; and staff supervision will help to identify staff behaviors that may indicate potential for abuse or neglect". On 02/06/25 at 11:21 AM interviewed RN2 via telephone. Inquired what kind of training is	F 600		

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F 600	Continued From page 23 provided regarding abuse. RN2 reported administration provides training on abuse and recently handouts were provided. Further queried what information was provided in the handouts. RN2 recalled it was a review of the process when there is suspected abuse, who to contact and to complete a report to the State Agency. Telephone interview with RN3 was done on 02/06/25 at 11:33 AM. RN3 was asked if she received training after the incident, she witnessed between R14 and R37 on 10/05/24. RN3 recalled they received training. Further queried what did she learn from the training, RN3 responded to round a little more, check on everybody, and assess before it gets worst. Further queried whether the facility provided training for providing care to residents with dementia or cognitive disabilities. RN3 recalled upon hire, training was done. Presently, RN3 stated she learns from other nurses on how to address behaviors. On 02/05/25 at 12:50 PM an interview was conducted with CNA5. Inquired what kind of training she received regarding abuse. CNA5 responded that she received in service training, which included review of the facility's policy and procedure. Further asked if the facility provided training on how to identify situations or behaviors that could lead to abuse. CNA5 responded, they were taught to remain calm and approach residents in a nice way. CNA5 is aware that if R37 becomes loud to take him back to his room. CNA5 also shared if residents become combative, they will inform the charge nurse, the resident may need medication. On 02/07/25 at 08:45 AM an interview was conducted with CNA1. CNA1 reported the facility	F 600		

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F 600	Continued From page 24 has provided training on how to prevent abuse. CNA1 was asked what she looks for, CNA1 responded give resident water or something they want. Further asked how you ensure residents are not going to fight, CNA1 responded when they do you need to separate them. Requested documentation of the training that was provided to staff regarding abuse/neglect. The facility provided a copy of their policy and procedure, "Freedom from Abuse/Neglect/Exploitation Long Term Care Residents with an attached staff sign-in form. Interview with Administrator was done on 02/07/25 at 10:28 AM. Administrator reported training is ongoing and includes review of the facility's policy and procedures. Further queried what kind of training is provided to staff to recognize behaviors that may put residents at risk for resident-to-resident abuse. Administrator explained residents' behaviors are discussed in their "huddles" meeting with the psychologist. Administrator was asked what if staff aren ' t' present. Administrator reported communication with the charge nurses are sent via email. Discussions are among the clinical staff.	F 600		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-	F 655		

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(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and interview, the facility failed to develop a baseline care plan that provided effective and person-centered care for 1 of 4 new admissions

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in the sample. Specifically, despite identifying that Resident (R)151 had psychotropic medication (medications that affect the mind, emotions, and behavior) needs, the facility failed to develop and implement a behavior-monitoring care plan. As a result of these deficient practices, the facility placed R151 at risk for avoidable declines or injury.

Findings include:

Resident (R)151 is a 91-year-old female admitted to the facility on 01/10/25 for long-term care. A review of her electronic health record (EHR) noted she was admitted with diagnoses that include, but are not limited to, dementia with behaviors, generalized anxiety disorder (GAD), and cerebral atherosclerosis (when the arteries in the brain become hard, thick, and narrow due to the buildup of plaque (fatty deposits) inside the artery walls). As a result, R151 was admitted on Quetiapine Fumarate (an antipsychotic) 25 milligrams (mg) twice a day for agitation, and Escitalopram (an antidepressant) 10 mg daily for GAD.

Observations made on 01/27/25 at 11:15 AM, 12:00 PM, 01:00 PM, 01:30 PM, and 02:15 PM, then again on 01/28/25 at 10:15 AM and 12:00 PM, noted R151 to be excessively sleepy.

Review of her EHR noted her Psychotropic Drug Use Care Plan was created on 01/16/25 and included the following intervention:

"Complete behavior monitoring sheet every shift."

Review of the Behavior Monitoring Flowsheet noted that it did not start until 01/27/25.

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F 655	Continued From page 27 On 01/30/25 at 12:59 PM, an interview was done with the Director of Nursing (DON) in the conference room. DON confirmed that the behavior monitoring flowsheet was created on 01/27/25 but should have been created upon admission on 01/10/25. On 01/30/25 at 01:26 PM, an interview was done with the Clinical Coordinator (CC) in the conference room. CC acknowledged that the Psychotropic Drug Use care plan, along with the Behavior Monitoring Flowsheet, should have been created upon admission on 01/10/25.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657		

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F 657	Continued From page 28 or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to review and revise the Comprehensive Care Plan (CP) for 1 of 1 resident (R) sampled for falls. Despite experiencing an unwitnessed fall with major injury, the facility failed to thoroughly revise R21's care plan to ensure his safety when alone. As a result of this deficient practice, R21 remained at risk for another fall. Findings include: The state agency (SA) received a facility-reported incident (FRI) regarding an unwitnessed fall with major injury for Resident (R)21. On 01/27/25, the SA entered the facility to investigate this event. Review of R21's electronic health record (EHR) noted that on 11/25/24, while attempting to ambulate unassisted to the bathroom, R21 fell and sustained a head laceration. The facility assessed him and transferred him to the emergency department where it was found that he had experienced the following injuries: an acute subarachnoid hemorrhage (bleeding in the space between the brain and the membrane that covers it), and small frontal lobe hemorrhages. R21 was admitted to the acute care hospital for seven days as a result. A review of the facility's fall report revealed it was unclear what caused the fall. A review of R21's current fall care plan revealed that despite being identified with impulsive behavior and repeatedly not calling for assistance out of bed, there was no intervention	F 657		

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F 657	Continued From page 29 to ensure R21's bed was kept in the lowest position and with the wheels locked at all times. On 01/31/25 at 12:39 PM, an interview was done with the Director of Nursing (DON) in her office. DON acknowledged that keeping a resident's bed in the low and locked position is an important intervention for all residents, but especially for a resident at risk for falls. DON confirmed that the intervention was not a part of R21's care plan but should be. DON also confirmed that given his recent fall with major injury, the intervention should have been added if not already there. 2) Cross Reference to F692 (Nutrition Status Maintenance) and F710 (Resident's Care Supervised by a Physician). The facility failed to revise R10's care plan to reflect individualized preferences for foods and snacks. Record review found R10 had a significant weight loss. On 01/31/25 at 10:50 AM an interview was conducted with the Registered Dietitian (RD). RD confirmed significant weight loss occurred. Following identification of significant weight loss, RD reported she met with the resident to inquire what are his food and snack preferences are and discussed the use of dietary supplement. RD acknowledged the care plan was not updated to include the resident's preference as well as the interventions that were discussed.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		

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F 677

Continued From page 30

services to maintain good nutrition, grooming, and personal and oral hygiene;
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility did not assure one (Resident 10) of one resident who is unable to carry out activities of daily living (ADL) receives the necessary services to keep his fingernails clean. This deficient practice has the potential to result in unsanitary practice which may lead to infections.

Findings include:

Resident (R)23 was admitted to the facility on 12/12/24. Diagnoses includes but not limited to depression, anxiety, acute hypoxemic respiratory failure, chronic shortness of breath, and chronic obstructive pulmonary disease.

Review of the admission Minimum Data Set (MDS) with assessment reference date of 12/16/24 notes R23 is cognitively intact. In Section GG. Functional Abilities, R23 was coded as requiring substantial/maximal assistance for personal hygiene. Helper does more than half the effort.

R23 has a care plan for potential for decrease in ADL with the goal to maintain/improve ADLs. The intervention for personal hygiene is for staff to assist resident.

On 01/27/25 at 01:45 PM observed R23's left hand with reddish/brownish substance under his fingernails. Interviewed R23 on 01/27/25 at 02:14 PM. R23 reported a lady comes to help with nails but he hasn't seen her. R23 looked at his nails

F 677

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F 677	Continued From page 31 and started to pick the substance out from under his nails. R23 stated he was not sure what this was.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews, the facility did not ensure a resident receives appropriate treatment and services to prevent further decrease in range of motion (how far a joint or muscle can be moved in various directions) for one (Resident 2) of four residents in the sample for residents with limited range of motion. The facility failed to apply soft posey splint and did not have an individualized program to perform passive range of motion. This deficient practice affects the resident's ability to obtain and maintain his highest functional goal.	F 688		

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F 688	Continued From page 32	F 688		

Findings include:

On 01/27/25 at 10:51 AM observed Resident (R)2 lying in bed wearing headphones with laptop on his over bed tray. Both arms were drawn up to his chest and both hands were in a fisted. On 01/28/25 at 08:05 AM an interview was conducted with R2. R2 was wearing his headphones and was unable to raise his arms up to push it aside or remove them. A staff member assisted in removing the headphones.

R2 was asked if he has a splint (device used to prevent and correct contractures, a permanent shortening of muscles, tendons, or ligaments, resulting in reduced range of motion). R2 replied he does not have splints. Further queried whether R2 receives range of motion (ROM) services (a type of therapy that helps people regain or maintain their ability to move their joints - active ROM, the resident will move the joint using their own muscles and passive ROM, another person will move the joint). R2 responded, it's "useless."

Record review was done on 01/30/25 at 12:59 PM and 02/06/25 at 09:52 AM. R2 was admitted to the facility on 05/31/21 with diagnoses which includes but not limited to quadriplegia (partial or total loss of function in all four limbs and the torso) due to a diving accident, decubitus ulcer to sacrum (injury to skin and underlying tissue resulting from prolonged pressure on the skin), and diabetes mellitus. R2 was hospitalized from 06/06/24 to 06/26/24 for bowel obstruction. He was readmitted to the facility on 06/26/24.

A review of the quarterly Minimum Data Set

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F 688	Continued From page 33 (MDS) with an assessment reference date of 10/22/24 notes R2 is cognitively intact. In Section GG. Functional Abilities, R2 is coded with functional limitation in range of motion to both sides of his upper and lower extremities. In Section O. Special Treatments, Procedures, and Program R2 was coded as not receiving restorative nursing services for passive ROM, active ROM, and splint or brace assistance in the last seven calendar days. A review of R2's care plan for prevention of skin breakdown includes the following, nursing staff to apply splints to my bilateral arms as recommended, and ROM to my upper extremities to be performed before putting them on. The care plan did not include specific interventions to address R2's limited range of motion/contractures. On 02/06/25 at 10:00 AM, an interview was conducted with Certified Nurse Aide (CNA)10. CNA10 works the night shift. Inquired whether she performs ROM for R2. CNA10 replied that ROM is performed when resident is dressed, and ROM is performed to both legs and hands. Further queried whether there is a program that specified what is required for R2's ROM exercises. CNA10 responded she exercises R2's legs and hands. CNA10 was asked how she knows what exercises are required for R2. CNA10 stated nobody has taught her, she goes by the years of experience. Inquired whether R2 has soft posey brace. CNA10 stated she doesn't know whether R2 has a brace. Accompanied CNA10 to R2's room to look for the brace. CNA10 stated she does not think R2 has a brace. On 02/06/25 at 08:55 AM, interview and	F 688		

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F 688	Continued From page 34 concurrent record review was done with the Director of Nursing (DON). The DON reported R2 has Podus boots (a device designed to prevent and manage heel pressure ulcers by suspending the heel off the surface it rests on). Also noted a care plan for potential for decrease in activities of daily living which includes interventions for soft posey elbow extension brace end of evening shift and to remove start of day with monitoring for discomfort (dated 11/03/23) and assist to do ROM twice a day and PRN (as needed) to all extremities as tolerated (dated 12/02/24). Review of the electronic health record (EHR) with the DON documented ROM was being provided twice a day. Further queried whether R2's care plan included specific ROM or passive ROM for the aides to perform. Also, inquired whether R2 has the soft posey splints for his arms. DON was agreeable to follow up. On 02/06/25 at 12:10 PM, DON reported when R2 returned from the hospital in June 2024 there were no soft posey braces. DON also stated she would request a physical therapy screen for R2.	F 688		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte	F 692		

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F 692	Continued From page 35	F 692		

balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to assure one (Resident 10) of two residents reviewed for significant weight loss was evaluated by his physician and his care plan was revised to include person-centered interventions. This deficient practice has the potential to result in continued weight loss and the inability of the resident to maintain acceptable parameters of nutritional status.

Findings include:

Cross Reference to F710. The facility did not ensure Resident (R)10's physician was notified of the significant weight loss to further evaluate the resident and contribute to the care plan.

Cross Reference to F657. The facility did not ensure R10's care plan was revised to include individualized interventions to maintain his current nutritional status.

On 01/27/25 at 11:11 AM, observed R10 lying in bed. R10 immediately waved his hand at surveyor and said he was "not interested". Subsequent observation on 01/28/25 at 09:33 AM

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F 692	Continued From page 36 found the privacy curtains were drawn closed. On 01/28/25 at 12:35 PM observed R10's lunch tray to consist of coffee, chocolate Ensure, entrée (covered), ground fruit, soup, and chocolate ice cream. A review of the facility's matrix noted R10 with unplanned excessive weight loss. Record review was done on 01/28/25 at 03:54 PM and 01/29/25 at 04:09 PM. R10 was admitted to the facility on 04/17/24. Diagnoses includes but not limited to anemia; renal failure; arteriovenous malformation of brain, and squamous cell carcinoma of base of tongue. R10 was discharged from the facility on 10/15/24 to an acute hospital for aspiration pneumonia. He was readmitted to the facility on 10/25/24. Review of the hospital record from 10/15/24 to 10/25/24, noted R10 weighed between 154 to 143 pounds (lbs.). Record review done on 01/28/25 at 03:38 PM found documentation on 10/25/2024, R10 weighed 159.6 lbs. On 11/30/2024, the resident weighed 135.2 pounds which is a 15.29 % Loss. Review of the facility's Registered Dietician (RD) progress note of 11/01/24 in the electronic health record (EHR) R10 was hospitalized for the past 10 days (10/15/24 to 10/25/24) for aspiration pneumonia and speech therapy assessment. The speech therapist recommended minced and thin liquids with Ensure (dietary supplement) one can two to three times a day. At this time, the RD's recommendation was to continue monitoring. R10 was assessed at low nutritional risk. The Weekly Skin/Weight Condition Review of 11/19/24 documents R10's weight ranged from	F 692		

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F 692 | F 692

Continued From page 37
136 to 166 lbs. over the last six months, possibly due to scale discrepancy and poor food intake. RD noted R10 with 25% intake and seven meal refusals.

Subsequent entry of 12/07/24 notes R10 with a 15.2% weight loss in one month and a 9.6% weight loss in six months (not significant). The recommendation was to continue current diet, honor resident preferences, continue to monitor weights monthly, and nutrition related labs per protocol.

A review of the quarterly Minimum Data Set (MDS) with an assessment reference date of 12/02/24 notes R10 was 70 inches in height and weighed 140 lbs. R10 was coded for weight loss (5% or more in last month or 10% or more in last 6 months) and not on physician-prescribed weight-loss regimen.

A review of the care plan for Nutrition Risk with goal for no significant weight change documents the following interventions: provide diet as ordered and food consistency as best tolerated, provide preferences as verbally or observed; monitor monthly and prn weights, discuss in interdisciplinary team meeting as needed; and notify physician and RD of significant weight loss and assess possible cause of weight loss. There was notation care plan reviewed 12/04/24.

On 01/31/25 at 10:50 AM concurrent record review and interview was conducted with the facility's RD. RD acknowledged R10 had a significant weight loss. Inquired what contributed to the resident's weight loss. RD responded R10 is "cranky" about being weighed and has pain with poor appetite and poor intake. R10's diet

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F 692 | F 692

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order is minced and moist and he receives supplement. RD reviewed supplement consumption and reported intake ranges from 25% to 100% with many refusals.

The care plan was reviewed with the RD. The interventions included: provide diet as ordered and food consistency as best tolerated, provide preferences as verbally or observed, monitor monthly and prn weights, discuss in IDT meeting as needed, and notify physician and RD of significant weight loss. RD noted the documentation that the care plan was reviewed on 12/10/24. Inquired if there were care plan revisions. RD was not aware of any changes and the history of the interventions. RD reported following identification of R10's weight loss, she visited the resident weekly to ask about food/snack preferences and supplement intake. RD confirmed there is no documentation in the care plan of the resident's food/snack preferences. RD noted R10's ideal body weight is 166 lbs.

RD stated R10's weight loss started on readmission from acute hospital in October, then there was further loss in November and December. Further queried whether R10's physician was notified of the significant weight loss. RD replied she did not notify the resident's physician; nursing may have notified R10's physician.

On 01/31/25 at 11:18 AM interview was conducted with the Director of Nursing (DON). Inquired whether R10's physician was notified of the significant weight loss. The DON reported residents are discussed in weekly meetings with the physician. The DON confirmed there is no

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F 692	Continued From page 39 documentation R10's physician was notified of the significant weight loss.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review the facility failed to label resident's nasal cannula with a date when first used for one of one resident in the sample. This failure has the potential to result in illness due to bacterial/viral buildup in the plastic tubing. Findings include: On 01/27/25 at 11:09 AM, Resident (R)23 was asleep. R23 was wearing a nasal cannula (a thin, flexible tube that goes around the head and into your nose to deliver oxygen). There was no label on the nasal cannula to document when the nasal cannula was changed and/or first used. Second observation on 01/27/25 at 01:19 PM staff were transferring resident from bed to wheelchair. R23 was connected to an oxygen canister. Did not observe the nasal cannula was labeled with a date. Resident interview was conducted on 01/26/25 at 01:44 PM on the lanai. Inquired how often does the staff change the nasal cannula	F 695		

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F 695	Continued From page 40 tubing. R23 responded once a month the facility changes the whole thing. Third observation on 01/28/25 at 10:12 AM observed no date label on the nasal cannula. At 10:20 AM concurrent observation was done with Licensed Practical Nurse (LPN)1. LPN1 confirmed the nasal cannula was not labeled with a date to indicate when it was changed. LPN1 reported the nasal cannula is changed weekly or if it is "gunky". On 01/30/25 at 11:10 AM the Director of Nursing (DON) was interviewed in her office. Inquired when is nasal cannula changed? DON reported she will need to follow up. Further queried why is it important to change the nasal cannula, DON responded to prevent infection and ensure it doesn't get dirty. Requested a copy of the facility's policy and procedure for oxygen use. On 01/30/25 at 12:05 PM, the DON provided a copy of the policy and procedure, "Oxygen Administration". DON reported the nasal cannula is to be changed weekly. The policy and procedure did not include procedures to label nasal cannula with the date it was changed and how often to change it.	F 695		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's	F 710		

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F 710	Continued From page 41 immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to notify the resident's physician of a significant weight loss for one (Resident 10) of two residents sampled for significant weight loss. This deficient practice resulted in the lack of physician oversight to evaluate and manage causes of the resident's weight loss, inability to contribute to the resident's assessment and care planning, and ensure resident is maintaining acceptable parameters of nutritional status. Findings include: Cross Reference to F657. The facility did not revise the resident's care plan to ensure person-centered interventions were implemented. Cross Reference to F692. The facility failed to ensure a resident maintained acceptable parameters of nutritional status as evidenced by significant weight loss. Record review done on 01/28/25 at 03:38 PM found documentation on 10/25/2024, Resident (R)10 weighed 159.6 lbs. On 11/30/2024, the resident weighed 135.2 pounds which is a -15.29	F 710		

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F 710	Continued From page 42 % Loss. On 01/31/25 at 10:50 AM concurrent record review and interview was conducted with the facility Registered Dietitian (RD). RD noted R10's weight loss started on readmission from acute hospital in October, then there was further loss in November and December. Further queried whether R10's physician was notified of the significant weight loss. RD replied she did not notify the resident's physician; nursing may have notified R10's physician. On 01/31/25 at 11:18 AM interview was conducted with the Director of Nursing (DON). Inquired whether R10's physician was notified of the significant weight loss. The DON reported residents are discussed in weekly meetings with the physician. The DON confirmed there is no documentation R10's physician was notified of the significant weight loss.	F 710		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph	F 756		

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F 756	Continued From page 43	F 756		

(d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review and interviews, the facility failed to ensure the pharmacy recommendations were addressed for one (Resident 27) of five residents reviewed for unnecessary medication when the physician did not respond to the pharmacist's recommendation for dose reduction of psychotropic medications. This deficient practice could potentially result in residents receiving unnecessary medication.

Findings include:

Record review done on 01/31/25 at 09:01 AM notes Resident (R)27 was admitted to the facility

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on 05/20/21. Diagnoses includes but not limited to anemia; dementia, senile delusions; emotional lability, mood disorder; metabolic encephalopathy; and major depressive disorder, recurrent severe without psychotic features. A review of the medication orders noted R27 is prescribed with bupropion (anti-anxiety), Prozac (antidepressant) and risperidone (antipsychotic).

The pharmacist Medication Regimen Review (MRR) documents from 12/12/23 to 01/10/25 were reviewed. There was a note for 08/13/24 the MRR was completed and see report. Requested a copy of the report. On 01/31/25 at 11:28 AM, the Director of Nursing (DON) provided a copy of the "Consultant Pharmacist's Medication Regimen Review" dated for recommendations created between 08/01/24 and 08/13/24. The pharmacist notes, R27 has been taking the antipsychotic Risperidone, 1 mg, daily since 07/20/23 for diagnosis of paranoid delusions. Further noting it is time for documentation of an annual review of this psychotropic medication and to consider a dose reduction. There was no documentation of a response from R27's physician.

Review of the quarterly Minimum Data Set with an assessment reference date of 10/18/24 notes in Section N. Medications, R27 coded as receiving an antipsychotic and antidepressant on a routine basis. Also noted, a gradual dose reduction was not attempted and there is no documentation by the physician a gradual dose reduction would be clinically contraindicated.

Subsequent interview with Director of Nursing (DON) on 01/31/25, the DON confirmed there is no documentation of physician's response to

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F 756	Continued From page 45 document need for dose reduction or to indicate a dose reduction would be clinically contraindicated.	F 756		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review, the facility failed to ensure all medications used in the facility were labeled in accordance with professional standards. In addition, the facility failed to ensure all medications used in the	F 761		

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F 761	Continued From page 46 facility were securely stored in locked compartments in 3 of 4 medication carts. Proper storage and labeling of medications is necessary to promote safe administration practices, and to decrease the risk of medication errors and diversion of resident medications. Findings include: 1) On 01/30/25 at 08:37 AM, an inspection was done of the North Pink medication cart. Observation was made of an insulin glargine pen in the cart for Resident (R)152. The pen was not marked when it had been opened. A concurrent interview with Registered Nurse (RN)6 confirmed that the insulin pen should have been labeled when it was opened, otherwise there was no way to tell when it should be discarded. RN6 also confirmed that she had used the insulin pen that morning and had not noticed that it was missing an opened date. At 08:40 AM, observation was made of a Fluticasone nasal inhaler for R13 that had not been marked when it was opened. Concurrent interview with RN6 confirmed that it should have been labeled with an open date so that the discard date could be determined. When asked, RN6 stated that she was unsure how long the inhaler was good for after opening. A review of the manufacturer's insert revealed that Fluticasone nasal inhalers should be discarded thirty days after opening, or when the inhalation counter reaches zero, whichever comes first. 2) On 01/27/25 at 10:39 AM, observation was made that the North Pink medication cart had been left unlocked outside Room 2. Within two minutes, RN7 returned to the cart and validated	F 761		

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F 761	Continued From page 47 that he should not have left it unlocked. On 01/27/25 at 02:29 PM, observation was made that the North Green medication cart had been left unlocked. At 02:34 PM RN7 walked by the cart without noticing that it had been left unlocked. At 02:35 PM RN3 locked it. On 01/31/25 at 08:06 AM, observation was made of Licensed Practical Nurse (LPN)1 unlocking the East #2 medication cart then walking away into room 9 after a staff member called her, leaving the cart unlocked. Upon her return a minute later, LPN1 acknowledged that she should not have left the cart unlocked.	F 761		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control 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 communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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	F 880		

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F 880	Continued From page 48 conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	F 880		

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F 880	Continued From page 49 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure appropriate protective and preventive measures for communicable diseases and infections were implemented. This is evidenced by the facility failing to ensure staff followed transmission-based precautions (additional infection control measures used when patients already have confirmed or suspected infections) by wearing the proper personal protective equipment (PPE) and adhered to standard precautions by performing proper hand and glove hygiene. In addition, the facility failed to have a surveillance plan for infections acquired outside of the facility. As a result of these deficient practices, staff and patient safety was compromised. Findings include: 1) On 01/27/25 at 11:14 AM, observed Droplet Precautions (transmission-based precautions for patients known or suspected to be infected with pathogens transmitted by respiratory droplets) signage outside of North room 7. The signage displayed the following instructions: "EVERYONE MUST Clean hands, before entering & when leaving the room. Don gloves and gown BEFORE entering the room.	F 880		

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Make sure their eyes, nose & mouth are fully covered before entering the room."

Concurrent interview with Registered Nurse (RN)7 and Certified Nurse Aide (CNA)14 revealed beds A and C were on droplet precautions for the flu, and beds B and D were not. When asked what PPE would be appropriate when entering room 7, both responded that they would don (put on) full PPE (an N95 respirator, eye protection, a gown, and gloves) only for beds A and C. It was observed at this time, and confirmed by RN7 and CNA14, that beds A and C were the beds closest to the door. When asked for clarification, CNA14 reported that if she were entering room 7 for the residents in bed B or D, she would not need to don full PPE although she would be walking past beds A and C to get there. It was observed at this time that the privacy curtains around beds A and C were not drawn completely, they were drawn only enough to allow visual privacy from the beds next to them (horizontally). When asked what would be considered appropriate eye protection, CNA14 responded that it could be a face shield, goggles, or her eyeglasses (which were placed at the top of her head at the time).

On 01/27/25 at 11:24 AM, observed Droplet Precautions signage outside of North room 4. Concurrent interview with RN7 was done. RN7 stated that the resident (R) in bed A (R7) was on droplet precautions for the flu and was the only resident in the room (as far as he had received in report) that was on any type of transmission-based precautions (TBP). While interviewing RN7, observed CNA14 enter room 4 and approach the resident in bed C (R25) after donning an N95 respirator, gown, and gloves, with her eyeglasses still sitting on the top of her

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F 880	Continued From page 51 head. When asked about her PPE, CNA14 stated she had donned it and entered the room to see R7, however R25 had called her over as soon as she entered. CNA14 confirmed that she had received report that morning and was not told that R25 was on any type of TBP. After helping R25 reposition in bed, observed CNA14 doff (take off) her gown in the room, carry it out of the room, cross the hallway, and discard it in a trash bag hanging on the North pink medication cart. On 01/27/25 at 12:10 PM observed staff enter Resident (R)44's room. There were signs posted at the door to notify staff R44 is on droplet precautions. Certified Nurse Aide (CNA)1 was observed entering the room wearing a medical mask. From the door, observed CNA2 standing at R44's bedside. CNA1 then grabbed a blue gown from the dispenser and returned to R44's bedside, holding the gown in the crook of her arm. CNA1 was observed talking to the resident, then the resident handed her cellular phone to the CNA. CNA1 returned the phone to R44, walked over to the gloves. No hand hygiene was observed prior to putting on the gloves. While standing at bedside, CNA put on the blue gown. CNA1 pulled the privacy curtain and could be heard asking R44 if she wanted to call her daughter. CNA could be seen, she was wearing glasses and removed them to hook onto her scrub, then put glasses back on. CNA1 was also observed to place glasses atop her head. CNA1 requested assistance from Registered Nurse (RN)1 RN1 found there were no gowns in the drawer. RN1 rolled a cart from across the hall and placed it next to R44's door. RN1 was wearing medical mask, donned gloves, gown, and was wearing	F 880		

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glasses. RN1 assisted R44. Upon exit, RN1 confirmed her glasses were eye protectors; however, CNA1 was wearing her regular glasses. RN1 confirmed CNA should have donned personal protective equipment (PPE) prior to entering R44's room. RN1 confirmed signage on the wall noted resident on droplet precaution (positive for the flu).

On 01/27/25 at 11:29 AM, a second interview was done with RN7 regarding which residents in room 4 were on what type of TBP. Additional signage observed outside the room seemed to indicate there were at least two residents in the room on droplet precautions and one resident in the room on contact precautions (intended to prevent transmission of infectious agents spread by direct or indirect contact with the patient or the patient's environment). RN7 agreed that the signage outside the room was confusing, and he was not sure himself which residents were on TBP. After walking away and having a discussion with RN3, RN7 returned and confirmed that both R7 and R25 were on droplet precautions for the flu, and R8 had been placed on droplet precautions because she was at an increased vulnerability for the flu.

On 01/27/25 at 12:12 PM, an interview was done with the Director of Nursing (DON) in her office. DON confirmed that eyeglasses were not acceptable eye protection. DON also confirmed that because droplet precautions were for airborne particles, they applied to the entire room, not specific residents within a room. DON agreed that full PPE should be applied before entering a room on droplet precautions, regardless of which resident within the room was being seen.

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F 880	Continued From page 53 On 01/27/25 at 12:59 PM, observation was done of CNA14 in North room 4, assisting R25 with no eye protection worn. On 01/28/25 at 07:20 AM, observation was done of CNA2 about to exit North room 4 with only a surgical mask on, no gown, and no eye protection. When asked where her PPE was, CNA2 stated that she was in the room only to assist R8, and so did not need to don the full PPE. On 01/28/25 at 04:10 PM, observation was done of CNA12 in North room 4 standing within 6 feet of R25 with only a surgical mask on. After exiting the room, asked CNA12 if he should be wearing full PPE in that room. CNA12 responded that he had only gone in the room to turn off R25's call light, and since he "did not touch the patient," he did not need to don full PPE. On 01/29/25 at 10:25 AM observed housekeeping staff enter R44's room. Housekeeper was wearing a face mask and holding a spray bottle. At 10:29 AM, Housekeeper exited the room, did not change her mask, and was holding a plastic bin of cleaning of supplies. Queried whether she received infection control education, Housekeeper stated, yes. Asked when she received education, Housekeeper responded upon hire. Housekeeper reported she had cleaned the bathroom. Inquired whether she saw the sign by the door regarding droplet precautions. Housekeeper apologized and stated she did not see the sign. 2) On 01/28/25 at 10:45 AM, observed CNA2 and CNA14 performing pericare for R5. Following pericare, observed CNA2 touching R5's drawers,	F 880		

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F 880	Continued From page 54 bedside table, and belongings, and brushing his hair, wearing the same pair of gloves used for pericare. On 01/30/25 at 10:12 AM, observed CNA11 performing pericare for R7. During pericare, observed CNA11 got stool on the gloves she was wearing. CNA11 wiped the gloves on the disposable underpad beneath R7 and proceed with finishing pericare. Following pericare, observed CNA11 touch R7's privacy curtains, and bedside table wearing the same pair of soiled gloves she used for pericare. RN6 was present at this time, applying medicated ointment to R7's perineal area. On 01/30/25 at 10:26 AM, an interview was done with RN6 at R7's bedside. RN6 confirmed that she would expect any CNA to change their gloves when going from dirty to clean. On 01/31/25 at 09:45 AM, an interview was done with DON at the nurses' station. When asked about monitoring of infection control practices, especially relating to PPE use and hand hygiene practices, DON reported that "spot checks" are done by the Charge Nurse and Clinical Coordinator as needed only. DON clarified that spot checks were usually done if they had an outbreak or if a breech in hand hygiene was observed and was documented on their "Focus Rounds." The State Agency (SA) requested documentation of the Focus Rounds at this time. On 01/31/25 at 12:08 PM, an interview was done with DON in her office. DON stated that she could find no infection control practice monitoring logs, and that there was no documentation that Focus Rounds for hand hygiene or PPE checks had	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 55	F 880		

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been done since the last COVID outbreak at the end of May 2024.

Review of the facility policy and procedure, LTC: Infection prevention and control program, last revised 6/2024, revealed the following:

"Change gloves during resident care if the hands will move from a contaminated body site to a clean body site."

3) On 01/31/25 at 09:45 AM, an interview was done with DON at the nurses' station. A concurrent review of the facility matrix noted that 32 of 50 residents had been marked as being on an antibiotic but only 12 had been marked for infection. When asked about infection surveillance for infections obtained prior to admission, or outside the facility, DON stated that she was unsure how the facility monitored that but would check.

On 01/31/25 at 12:08 PM, an interview was done with DON in her office. DON reported the facility had two current influenza infections in the facility, and one resident on antibiotics, confirming that the facility matrix was incorrect. DON also confirmed that the facility currently had no surveillance plan for infections acquired outside the facility, but agreed this was important for a complete picture of the infections in the facility at any given time.

Review of the facility policy and procedure, LTC: Infection prevention and control program, last revised 6/2024, revealed the following:

"When there is a confirmed or suspected outbreak (2 or more ill residents) ... such as

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125002	A. BUILDING ______ B. WING ______	02/07/2025

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F 880	Continued From page 56 influenza: 1. Conduct daily active surveillance for at least 1 week after the last confirmed case occurred."	F 880		
F 943 SS=F	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility did not assure staff members received training for dementia management and resident abuse prevention, understanding expressions or indications of distress of residents to prevent abuse from occurring. This deficient practice has the potential to place at risk of resident-to-resident or staff to resident abuse. Findings include: Cross Reference to F600 - Free From Abuse and Neglect. The facility submitted event reports alleging resident-to-resident abuse, there were	F 943		

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F 943	Continued From page 57	F 943		

incidents of residents striking out, throwing items, and engaging in altercations related to inability to cope with other residents' behaviors of distress.

A review of facility reported incidents found four allegations of resident-to-resident abuse. These incidents were investigated during the survey. The incidents occurred between 09/26/24 and 12/08/24. Resident (R)44 and R33 were involved in two incidents. The first documented incident occurred on 09/26/24 when two staff members on lunch witnessed R44 throwing rocks at R33. The second documented incident occurred on 12/08/24. R44 was seated on the lanai and R33 was seen going out to the lanai. Later, staff heard screaming and found R44 and R33 engaged in a physical altercation with R33 identified as the alleged perpetrator.

R44 was also involved in another incident on 11/09/24. R3 is a cognitive resident and was screaming for help at 03:15 AM. R3 reported R44 threw a plastic mouthwash bottle at her. Registered Nurse (RN)3 documented R44 admitted to throwing the bottle at R3 as she "would not shut up".

An incident on 10/05/24 involves R37 and R14. Residents were seated in the dining room, R37 started making loud vocalizations, staff intervened, and he stopped. R37 started again, R14 reported he got irritated and ended up punching R37.

Interviewed RNs and CNAs regarding staff training for abuse. Some staff members were able to recall having training recently, unable to specify the date as training reportedly is ongoing. Although staff were able to confirm they received

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F 943	Continued From page 58 training, they were unable to identify behaviors and provide examples of interventions that may prevent resident-to-resident abuse. Upon request of the latest training staff received for abuse/neglect, the facility provided the policy and procedure for "Freedom from Abuse/Neglect/Exploitation Long Term Residents". Interviewed Administrator on 02/07/25 at 10:28 AM. Administrator reported part of the staff training included a review of the facility's policy and procedure. Further queried whether other training was provided. Administrator reported training is ongoing and provided during their "huddle" with the psychologist. This information is shared with the charge nurse via email. Inquired whether the CNAs and other staff are involved in this communication. Administrator was unable to confirm the information is shared with other staff members.	F 943		