STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345008	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Citadel at Myers Park, LLC	300 Providence Road Charlotte, NC 28207

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, Nurse Practitioners (NP) and staff interviews, the facility failed to notify the physician details of a resident abuse incident that caused a resident to fall to the floor and hit his head. After NP #2's assessment a physician's order was provided for transfer to the hospital for evaluation to rule out head trauma, intracranial hemorrhage (bleeding), or other pathology. This occurred for 1 of 1 resident reviewed for notification (Resident #84). The findings included: Resident #84 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease and dementia. The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #84's cognition was severely impaired, and he was not taking anticoagulant or antiplatelet medications and had no history of falls. An incident report dated 1/27/25 at 10:50 AM revealed Nurse #6 observed Resident #84 being tossed out of the room by another resident into the hallway floor landing on his left side and left facial area. Nurse #6 noted there were no injuries observed at the time of the incident and Resident #84 was alert, confused, oriented to person, and ambulatory without assistance. Review of neuro check documentation revealed the first check was started on 1/27/25 at 10:55 AM and indicated Resident #84 refused vital signs, was alert, had a headache, and there were no signs of seizure, ear/nose drainage, or vomiting. Neuro checks continued from 12:16 PM until 5:45 PM and indicated Resident #84 was at the hospital. During a phone interview on 1/30/25 at 11:22 AM Nurse #6 revealed on 1/27/25 she witnessed Resident #64 take both hands and lift Resident #84 off the ground and throw him out of his room and he fell onto the floor. Nurse #6 revealed she heard a noise that sounded like a crack and saw Resident #84's head hit the floor. After the fall she did not see any obvious injuries but Resident #84 told her his left arm and head hurt and would not let her touch or assess him and was guarding his left arm. NP #1 was notified, and she (Nurse #6) was asked to tell what happened and stated she reported Resident #84 was thrown to floor. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 1/29/25 at 5:18 PM with NP #1. NP #1 revealed on 1/27/25 around 11:00 AM he was called and told an aggressive altercation occurred and Resident #84 and was being monitored. NP #1 revealed his guidance was if the nurse thought Resident #84 needed to be evaluated she could send him to the emergency room. NP #1 revealed no specific details were provided about abuse and he was not notified Resident #84 fell and hit his head on the floor. NP #1 revealed if he was notified Resident #84 hit his head on the floor he would have requested the resident be sent to the emergency room for evaluation. During a phone interview on 1/30/25 at 4:12 PM the Administrator revealed she spoke with NP #1 who revealed on 1/27/25 at approximately 11:00 AM or 11:30 AM he was informed of an altercation, but it was not expressed if it was physical or verbal. He spoke with Nurse #6 and was told nothing about a fall or Resident #84 hit his head. NP #1 instructed the nurse if she felt something was wrong to send Resident #84 out for evaluation and use her nursing judgement and let him know if that was what she chose to do. Review of NP #2's follow-up note dated 1/27/25 revealed Resident #84 was reviewed for head injury and arm pain after nursing reported he fell around 10:50 AM. NP #2 noted Resident #84 fell as a result of resident abuse when Resident #64 forcefully lifted him into the air and threw him out of his room. Resident #84 landed on his left side and a cracking sound was heard and he hit his head on the floor. NP #2 noted neuro checks were started and during the evening Resident #84 was arousable but would not open his eyes and minimally responded to questions. NP #2's assessment revealed Resident #84 had no deformities or visible signs of mal-alignment or dislocation and appeared at baseline for the diagnosis of dementia. NP #2 recommended sending him to the emergency department for evaluation to rule out head trauma, intracranial hemorrhage, or other pathology. During an interview on 1/29/25 at 4:48 PM NP #2 revealed she was at the facility around 4:30 PM on 1/27/25 when Nurse #6 told her she saw Resident #84 fall and hit his head on the floor. NP #2 revealed when she assessed Resident #84 on 1/27/25 he was groggy but had no deformities or obvious physical injury, but she was concerned about him being thrown onto the floor and sent him to the emergency department for an evaluation of injury. A review of the emergency department summary revealed on 1/27/25 Resident #84 was evaluated due to a previous fall. A CT (computed tomography) scan (a three dimensional imaging of the body) of the head and neck and a chest x-ray showed no abnormalities or injuries, and Resident #84 was discharged back to the facility in stable condition. A follow-up phone interview was conducted on 1/31/25 at 2:21 PM with the Administrator. The Administrator revealed she expected the same information was shared with NP #1 when he was notified about the resident abuse incident and include Resident #84 fell and hit his head.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews with residents and staff, the facility failed to maintain wheelchairs for 2 of the 2 residents reviewed for mobility device (Resident #38 and Resident #87) and window blinds in good repair in 1 of 8 rooms (room [ROOM NUMBER]) on 1 of 6 halls. The findings included: 1.a. Resident #38 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #38 was coded with moderately impaired cognition and impairment on one side of lower extremity. During an observation conducted on 01/14/25 at 11:12 AM, Resident #38 was seen sitting in a wheelchair in his room wearing a short sleeve shirt. The padded left armrest of the wheelchair had an area of approximately 2 inches by 5 inches of the covering that was torn, cracked, and ripped with sharp edges. Resident #38's left arm was seen contacting the area of disrepair on the armrest during the observation. An interview was conducted with Resident #38 on 01/14/25 at 11:16 AM. He stated he could not recall how long the left armrest of his wheelchair had been in disrepair. He stated it would be nice if someone in the facility could fix it as soon as possible. During a joint observation of Resident #38's wheelchair in conjunction with an interview conducted on 01/15/25 at 1:01 PM with Nurse Aide (NA) #8 and Nurse #5, the left armrest for Resident #38's wheelchair remained in disrepair. Nurse #5 assessed Resident #38's left arm immediately and confirmed the areas of skin exposed to the armrest in disrepair were intact. An interview conducted with NA #8 and Nurse #5 revealed they had provided care for Resident #38 frequently in the past few weeks and did not notice the left armrest of Resident #38's wheelchair was in disrepair. They acknowledged that the left armrest needed to be replaced immediately as it could cause skin irritation. b. The census records indicated Resident #38 had been staying in room [ROOM NUMBER] since he was admitted to the facility on [DATE]. The admission MDS assessment dated [DATE] revealed Resident #38 was coded with moderately impaired cognition and adequate vision. During an observation conducted on 01/14/25 at 11:14 AM, the window blinds in room [ROOM NUMBER] could not be rolled up or down nor flip open or closed as needed as the rod and the cord controlling the blinds were missing. The blinds remained open all the time. An interview was conducted with Resident #38 on 01/14/25 at 11:16 AM. Resident #38 stated the blinds had been in disrepair since he moved into this room last November. He could not control the blinds as it would not roll up and down, or open and close as needed. He felt like someone was watching him when he was in his room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a joint observation of the window blinds in room [ROOM NUMBER] in conjunction with an interview conducted on 01/15/25 at 1:01 PM with NA #8 and Nurse #5, the window blinds in room [ROOM NUMBER] remained in disrepair. An interview conducted with NA #8 revealed she did not notice the window blinds in room [ROOM NUMBER] were broken until the morning of the interview. However, she did not notify any maintenance staff or initiate a work order for the maintenance department. She acknowledged that the window blinds in room [ROOM NUMBER] needed to be replaced immediately. Nurse #5 stated she did not notice the window blinds in room [ROOM NUMBER] were broken and added they needed to be fixed immediately. 2. Resident #87 was admitted to the facility on [DATE]. The admission MDS assessment dated [DATE] revealed Resident #87 was coded with moderately impaired cognition. During an observation conducted on 01/14/25 at 11:49 AM, Resident #87 was seen sitting in the wheelchair in her room. The left side of the wheelchair did not have an armrest in place. Resident #87 was observed resting her left arm on top of the metal frame of the wheelchair while sitting in the wheelchair. An interview was conducted with Resident #87 on 01/14/25 at 11:51 AM. She stated she could not recall how long the left armrest of her wheelchair had been missing. She added it was very uncomfortable for her as she had to rest her left arm on the metal frame of the wheelchair when sitting in it. She wanted the wheelchair to be fixed as soon as possible. During a subsequent observation conducted on 01/15/25 at 9:05 AM, the left armrest of Resident #87's wheelchair remained missing. During a joint observation of Resident #87's wheelchair in conjunction with an interview conducted on 01/15/25 at 1:01 PM with NA #8 and Nurse #5, the left armrest on Resident #38's wheelchair remained missing. An interview conducted with NA #8 and Nurse #5 revealed they had provided care for Resident #87 frequently in the past few weeks, but did not notice the left armrest on Resident #87's wheelchair was missing. They acknowledged that the left armrest needed to be fixed immediately as it could cause skin irritation. An interview was conducted with the Maintenance Director on 01/15/25 at 3:25 PM. He stated he had just assumed his position in the facility about 10 days ago. He walked through the entire building at least once daily on a regular basis to identify repair needs. The Maintenance Director indicated he also depended on the nursing staff to report repair needs either verbally or with work order. He acknowledged that the armrests for Resident #38's and Resident #87's wheelchair and the window blinds for room [ROOM NUMBER] were in disrepair and needed to be replaced immediately. During an interview conducted with the Director of Nursing (DON) on 01/16/25 at 1:57 PM. She expected all the wheelchairs and window blinds to be in good repair all the time to prevent skin irritation and protect residents' privacy. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 01/17/25 at 10:12 AM with the Administrator. The Administrator expected all the staff to be more attentive to the residents' living environment and mobility devices when providing care to ensure all the repair needs would be communicated to the maintenance department in a timely manner. It was her expectation for all the window blinds and wheelchairs to be in good repair all the time.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interviews with the Nurse Practitioners, resident, and staff the facility failed to protect Resident #84's right to be free of physical abuse perpetrated by Resident #64. On 1/27/25 Resident #84, who was cognitively impaired and had wandering behaviors, entered the room of Resident #64 who was also cognitively impaired. Nurse #6 heard Resident #64 yell at Resident #84 to get out of his room followed by Resident #64 taking both of his hands to lift Resident #84 off of the ground and throw him out of his room. Resident #84 fell to the floor hitting his head and Nurse #6 stated she heard a noise that sounded like a crack. Resident #84 reported pain to his left arm and head and was evaluated at the hospital with no acute injuries. There was a high likelihood of Resident #84 suffering serious physical harm as a result of the physical abuse. A reasonable person would have experienced feelings such as fear, intimidation, anxiety, and/or withdrawal as a result of being abused in their home environment. Additionally, the facility also failed to prevent resident to resident abuse when Resident #64 shoved Resident #18. The deficient practice occurred for 2 of 3 (Resident #84 and Resident #18) reviewed for abuse. Immediate jeopardy began on 1/27/25 when the facility failed to protect a cognitively impaired resident right to be free of abuse when Resident #84 wandered into the room of cognitively impaired Resident #64 who used physical force to throw Resident #84 to the floor. Immediate jeopardy remains present and on-going. Example 2 is being cited at a scope and severity of D. The findings included: 1) Resident #64 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (stroke) and cognitive communication deficit. The care plan last reviewed on 11/20/24 revealed Resident #64 had the potential to be physically aggressive related to poor impulse control and had attempted to throw a chair in the dining room. Interventions included analyzing times of day, places, circumstances, triggers, and what de-escalated behavior and document. The quarterly Minimum Data Set (MDS) dated [DATE] assessed Resident #64's cognition was moderately impaired. He had no upper or lower extremity range of motion impairment, did not use a device for mobility, and was able to transfer and walk independently without assistance from staff. Resident #64's height and weight was 68 inches and 184 pounds. There were no physical or verbal behaviors directed towards others during the lookback period. A review of Resident #64's Medication Administration Record (MAR) revealed behaviors were monitored each day, evening, and night shift. Behaviors being monitored included agitation/pacing/yelling, and danger to self or others. From 1/1/25 through 1/26/25 the nurses documented 0 to indicate no behaviors were present. On 1/27/25 day shift Nurse #7 documented 0 to indicate no behaviors were present. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #84 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease and dementia. The admission MDS dated [DATE] revealed Resident #84's cognition was severely impaired, and he had demonstrated physical and verbal behaviors directed towards others, rejection of care, and wandering behaviors for 1 to 3 days during the lookback period. Resident #84's height and weight was 69 inches and 148 pounds. There was no mobility device identified on the MDS and Resident #84 was dependent on staff for walking. The MDS indicated Resident #84 was not taking anticoagulant or antiplatelet medications. The care plan last reviewed on 1/16/25 identified Resident #84 wandered related to being disoriented to place. Interventions included to intervene as needed to protect the rights and safety of others and to remove from situations to another location as needed. A review of Resident #84's MAR revealed behaviors were being monitored each day, evening, and night shift. Behaviors being monitored included agitation/ pacing/yelling, uncooperative, and wandering. On 1/10/25 and 1/13/25 the nurse documented during day shift agitation/pacing/yelling, uncooperative, and wandering behaviors were present. On 1/27/25 during day shift Nurse #6 documented behaviors of agitation/pacing/yelling, uncooperative, and wandering were present. A review Resident #84's current physician orders revealed he was not taking anticoagulant or antiplatelet medications. A review of an incident report dated 1/27/25 at 10:50 AM revealed Nurse #6 observed Resident #84 being tossed out of the room by another resident into the hallway floor landing on his left side and she unable to obtain assessment due to Resident #84 was guarding his body. Nurse #6 noted there were no injuries observed at the time of the incident and Resident #84 was alert, confused, oriented to person, ambulatory without assistance, and the predisposing factor was he wandered. A review of the progress note created on 1/27/25 at 5:29 PM by Nurse #6 revealed she was the assigned nurse for Resident #84 and at 10:50 AM was at the medication cart and observed the door to Resident #64's room was open, and Resident #84 was tossed out of the room. Nurse #6 documented she observed Resident #84 fall to the floor and land on the left side of his body and the left side facial area. Resident #84 landed in front of Nurse #6, and she heard Resident #84's body make an audible sound. The note indicated Nurse #6 told what happened in detail to the Director of Nursing (DON) and Unit Manager #5. Nurse #6 observed Unit Manager #5 contact Nurse Practitioner (NP) #1 by phone and Nurse #6 answered their questions. Neuro checks were implemented and DON assisted Resident #84 with a bed bath and the Unit Manager and DON assumed plan of care. At 4:45 PM Nurse #6 updated NP #2 and a verbal order was provided to transfer Resident #84 to the emergency room for evaluation and rule out possible head trauma. Review of the neuro check documentation for Resident #84 revealed the following: the first check was started on 1/27/25 at 10:55 AM and indicated vital signs were refused, Resident #84 was alert and Nurse #6 was unable to assess his upper and lower extremity motor function. Headache was checked yes, and no was checked for signs of seizure, ear/nose drainage, or vomiting. Neuro checks continued from 12:16 PM until 5:45 PM and indicated Resident #84 was at the hospital. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on 1/30/25 at 11:22 AM Nurse #6 revealed on 1/27/25 she was working on the secured unit on the third floor and witnessed the altercation between Resident #64 and Resident #84. Nurse #6 revealed she heard Resident #64 yell out, Get out my room, I told you to get out. Nurse #6 revealed she saw Resident #64 take both hands and lift Resident #84 off the ground and throw him out of his room and he fell to the floor, and she heard a noise that sounded like a crack and saw Resident #84's head hit the floor. Both residents were separated, and Resident #64 stayed in his room. After the fall she did not see any obvious injuries but Resident #84 told her his left arm and head hurt but would not let her touch or assess him and was guarding his left arm. She revealed Nurse #7 stayed with Resident #84 while she went to find the Administrator or DON. The DON and Unit Manager #5 came to the secured unit on the third floor. Nurse #6 revealed she attempted to administer acetaminophen for pain but Resident #84 spit it out and the DON administered olanzapine (an antipsychotic medication) and took Resident #84 to a room and gave him a bed bath. She revealed Unit Manager #5 notified NP #1 and she (Nurse #6) was asked to tell what happened and stated she reported Resident #84 was thrown to floor. Nurse #6 revealed she heard Unit Manager #5 tell NP #1, the nurse thought the resident was hurt and was thrown on the floor. Nurse #6 revealed when NP #2 came to the facility she updated her on what happened, and an order was provided to send Resident #84 to emergency room for further evaluation. During an interview on 1/29/25 at 11:29 AM Nurse #7 revealed she was working on the secured unit on the third floor where the altercation between Resident #64 and Resident #84 occurred on 1/27/25 but she did not witness the incident. Nurse #7 revealed she was at the opposite end of hallway from Resident #64's room when she heard Nurse #6 scream he threw him on the floor. Nurse #7 revealed when she looked up, she saw Resident #84 on the floor in the hallway by Resident #64's room door. Nurse #7 revealed Resident #84 was scooting himself on the floor and around the corner of the nurse station away from Resident #64's room. Nurse #7 revealed she heard Resident #84 say he broke my arm and would not let anyone touch him. Nurse #7 revealed when she asked Resident #64 what happened he did not say anything about the incident but did say he was okay. During an interview on 1/29/25 at 3:59 PM Nurse Aide (NA) #10 revealed she worked on the secured unit on the third floor where the altercation between Resident #64 and Resident #84 occurred on 1/27/25 but she did not witness the incident. NA #10 revealed she did observe Resident #84 on the floor by the nurse station near the room of Resident #64 and was told by a nurse, she could not recall by name, that Resident #64 picked up and threw Resident #84 to the floor. NA #10 revealed she stood by Resident #84 to ensure there was no contact until the DON, Unit Manager #5, and Nurse #6 assessed the resident. NA #10 described Resident #84 had wandering behaviors prior to the altercation and would wander into other resident rooms and she would redirect him. During an interview and observation on 1/29/25 at 10:54 AM and 3:53 PM the entry door to Resident #64's room was kept closed. Resident #64 was observed sitting on the edge of the bed and was able to self-transfer and walk in and out of his room without assistance from staff. Resident #64 revealed a resident had entered his room and would not leave after he told him, you got to go. Resident #64 revealed the resident did not say anything but would not leave and he used physical force to get him out of his room. Resident #64 demonstrated he used both hands to lift up and throw the resident out of the room onto the floor. Resident #64 revealed the resident he threw was not doing anything to make him feel threatened or afraid and repeated, it was time for him to go. Resident #64 confirmed he did not ask a staff member for help and stated he did not need help from anyone. Resident #64 revealed that if someone came into his room and would not leave when asked, he would use physical force to get them out and did not need help getting someone out of his room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the nurse progress note created on 1/29/25 at 1:43 PM by Unit Manager #5 was a late entry for 1/27/25 at 11:30 AM. The note revealed the Unit Manager #5 was called to the secured unit on the third floor to assess Resident #84. Unit Manager #5 and the DON noted Resident #84 was sitting on the floor near the nurse station and the assigned nurse (Nurse #6) stated Resident #84 had an unwitnessed fall. Unit Manager #5 noted Resident #84 refused assistance from staff and was assessed by the DON. Unit Manager #5 contacted NP #1 and was instructed to notify the assigned nurse (Nurse #6) to send Resident #84 out to the hospital if needed. Unit Manger #5 noted she was instructed to provide additional 30-minute checks for the NA staff and hourly checks for the nurses for Resident #84. An interview was conducted on 1/29/25 at 4:26 PM with Unit Manager #5. Unit Manager #5 revealed she was asked by Nurse #6 to come to the secured unit and when she arrived saw Resident #84 sitting on the floor and he did not want anyone to touch or help him. Unit Manager #5 revealed Resident #84 got up off the floor without help and walked to his room with the DON who provided incontinence care. Unit Manager #5 revealed she was told by Nurse #6, she heard a noise that sounded like a boom but did not see anything. Unit Manager #5 revealed 1/28/25 was the first time she heard Resident #64 threw Resident #84 to the floor. She revealed Resident #84 was not capable of describing what happened and she did assess Resident #64, and he told her he did not want anyone in his room but did not tell what happened. A review of a nurse's progress note created on 1/28/25 at 8:01 PM by the DON was a late entry for 1/27/25 at 11:30 AM. The note revealed the DON was called to the secured unit on the third floor to assess Resident #84. The DON and Unit Manager #5 saw Resident #84 on the floor near nursing station. The DON asked Nurse #6 what happened and was told Resident #84 had an unwitnessed fall to the floor. Resident #84 refused vital signs and assistance from staff. The DON noted Resident #84 eyes were reactive to light, grips were equal, and cognitive status was at baseline with no signs of distress or complaints. Resident #84 got up off the floor without assistance and walked with the DON. The DON noted there were no visible injuries, and no change in physical, emotional, or social state at the time of assessment. During an interview on 1/29/25 at 5:35 PM the DON revealed on 1/27/25 she received a text to come to the third-floor unit immediately during her morning meeting. The DON revealed when she arrived on the unit she saw Resident #84 sitting on his buttocks with his back against the wall and around the corner of the nurse station located near the room of Resident #64. Nurse #6 told her Resident #84 had an unwitnessed fall and she did not know what happened. The DON revealed Resident #84 would not let her touch him but was able to get up from the floor without assistance and walk and appeared at his baseline. The DON revealed when she asked what happened, Resident #84 stated I fell. The DON revealed Resident #84 had a history of wandering behaviors and when she checked on Resident #64, he was sitting on the edge of the bed in his room and she asked Resident #64 if someone had been in his room, and he denied that. The DON revealed she asked Nurse #6 to fill out a statement on 1/27/25 but did not get it before leaving that day. The DON revealed she was not made aware of a physical altercation involving Resident #64 and Resident #84 until 1/28/25 after reviewing Nurse 6's note and incident report during their morning meeting. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on 1/29/25 at 5:18 PM with NP #1. NP #1 revealed on 1/27/25 around 11:00 AM he was called and informed there was altercation between residents and named Nurse #6 was who he spoke with. NP #1 revealed he was told an aggressive altercation occurred and Resident #84 was administered olanzapine and was being monitored and was calm. NP #1 revealed his guidance was if the nurse thought Resident #84 needed to be evaluated, she could send him to the emergency room. NP #1 revealed no specifics were provided about the altercation and he could not confirm Resident #64 threw Resident #84 to the floor. NP #1 revealed he was not notified that a fall occurred during the altercation or that Resident #84's head hit the floor and if told that information he would have requested to send the resident to the emergency room for evaluation. A review Resident #84's medical record revealed NP #2 documented a follow-up note dated 1/27/25 that revealed Resident #84 was being reviewed for head injury and arm pain. NP #2 noted nursing reported around 10:50 AM Resident #84 wandered into another resident's room and was forcefully lifted into the air and thrown from out of the room. Resident #84 landed on his left side and a cracking sound was heard and he hit his head on the floor. NP #2 noted neuro checks were started and during the evening Resident #84 was arousable but would not open his eyes and minimally responded to questions. NP #2 assessed Resident #84 had no deformities or visible signs of malalignment or dislocation and appeared at baseline for the diagnosis of dementia. NP #2 recommended Resident #84 be transferred to the emergency department for evaluation to rule out head trauma, intracranial hemorrhage, or other pathology. A physician's order dated 1/27/25 at 5:00 PM provided directions to send Resident #84 to the emergency room for evaluation to rule out head trauma. A review of the emergency department summary revealed on 1/27/25 Resident #84 was evaluated due to a previous fall. A CT (computed tomography) scan (a three-dimensional imaging of the body) of the head and neck and chest x-ray showed no abnormalities or injuries, and Resident #84 was discharged back to the facility in stable condition. A review Resident #64's medical record revealed NP #2 documented a follow-up note dated 1/27/25 that revealed nursing reported Resident #64 was the aggressor in an incident after Resident #84 wandered into his room. The NP noted Resident #64 forcefully removed Resident #84 from the room. NP #2 noted the incident was isolated and Resident #64 was calm and stable and being monitored by staff with no further incidents with other residents. NP# 2 recommended to continue 1:1 monitoring for 12 hours. During an interview on 1/29/25 at 4:48 PM NP #2 revealed she was at the facility around 4:30 PM on 1/27/25 when she was told the details of an altercation between Resident #64 and Resident #84. NP #2 revealed Nurse #6 told her Resident #84 had wandered into Resident #64's room and Resident #64 threw him out. NP #2 revealed Nurse #6 stated she saw Resident #84 flying out room and was lifted off the floor and she heard a crack and saw Resident #84 hit his head. NP #2 revealed she spoke with Resident #64, and he confirmed he picked Resident #84 up and threw him to the floor. NP #2 stated when she assessed Resident #84 on 1/27/25 he was groggy but had no deformities or any obvious physical injury, but she was concerned about him being thrown onto the floor and sent him out for evaluation of injury. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A phone interview was conducted on 1/31/25 at 2:23 PM with the Administrator. The Administrator revealed she became aware of the physical abuse altercation between Resident #64 and Resident #84 the next morning on 1/28/25 during their clinical morning meeting after reading Nurse #6's notes. The Administrator revealed staff had just received training and were expected to inform her or the DON of any situation between residents and she would start the investigation and determine if abuse occurred. The Administrator revealed based on the information in the medical records it appeared Resident #64 actions were willful. The Administrator was notified of IJ on 02/06/25 at 8:30 PM. The facility provided the following credible allegation of immediate jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. -The facility failed to have an effective system in place to prevent resident to resident abuse and ensure the safety of all residents. -On 1/27/2025 Resident #84 entered the room of resident #64. Per witness documentation from Nurse #6, Resident #64 could be heard saying, I told you to get out of here. Per Nurse #6 documentation, Resident #64 was visualized to take both hands and pick Resident #84 up off the ground and 'throw' Resident #84 to the floor resulting in Resident #84 hitting his head on the floor. Resident #84 was assessed and assisted from the floor to his feet and proceeded to his own room receiving toileting and incontinence care provided by the Director of Nursing (DON). Fall assessments and neuro checks were initiated to be completed by licensed nurse as directed by the Director of Nursing on 1/27/25. Later in the shift Resident #84 was sent to emergency room (ER) for full evaluation per Nurse Practitioner (NP) orders to ensure no physical injury. Resident #84 returned to the facility with no negative findings. It was noted that the nurse's notes stated resident #84 had left arm pain and the hospital had not completed an x-ray of the arm, and an order was obtained for an x-ray. On 1/28/25, the order was changed to stat (now or as soon as possible) as the x-ray company had not yet come. Resident #84 demonstrated unrelated behaviors becoming combative with care resulting in discharge on [DATE] to the hospital for psych evaluation. On 1/29/25 Resident #84 returned to facility and continued to demonstrate escalating behaviors with emergency medical staff and facility staff. Resident #84 again was discharged from the facility for psych evaluation. Resident #84 remains out of the facility at this time. -Police were notified of this resident-to-resident abuse and reported to facility for statements on 01/28/25. No actions were taken by the police. Resident #64 was assessed by police and determined to not be at risk to self or others. -Residents on the dementia unit were assessed for injuries and/or physical indicators of abuse by the DON, Unit Manager, and licensed nursing staff on 1/28/25. Interviewable residents were interviewed by the DON, Unit Manager, and licensed nursing staff on 1/28/25 regarding any witnessed physical altercations, witnessed abuse, and feelings of safety while residing in the facility. No additional findings were identified. Documentation is maintained by the Administrator in the physical copy of the investigation file. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. -Resident #64 was placed on increased monitoring of every 30 minutes via nurse aides and hourly via licensed nurse. This directive was received by the Administrator and Director of Nursing on 1/28/25. Resident #64's orders and care plans were reviewed and updated by the DON and Unit Manager on 1/28/25 to reflect 30-minute checks by nurse aides and hourly checks by licensed nurses. Staff providing care were made aware of aforementioned care plan modification on 1/28/25 by the DON and Unit Manager. Resident #64 remains in need of skilled care related to assistance required with activity of daily living (ADL), inability to self-manage medications, and cognitive impairments that result in behaviors such as wandering completed by the Director of Nursing on 2/8/25. As a result of a secondary resident to resident involving Resident #18, Resident #64 was escalated to a 1 on 1 supervision during wake hours via nurse aide or designee effective 2/1/25. This was directed by the Director of Nursing and Administrator on 2/1/25. This will continue until deemed safe to reduce or eliminate by a psych provider or until discharge. -Education was initiated by Licensed Nursing Home Administrator (LNHA)/designee related to types of abuse including resident to resident altercations, abuse identification, abuse prevention, and maintaining resident safety, with all nursing home staff on 1/28/25. Education included scenarios and quizzes for demonstration of staff competency. Education further included redirecting residents, monitoring for and identifying precipitating behaviors that could lead to possible resident to resident altercations. This education includes agency staff and newly hired employees via the facility orientation process. No staff will work after 2/7/2025 without having had this education. Licensed Nursing Home Administrator (LNHA) or designee will maintain compliance with tracking education requirements. -Additional ongoing whole nursing home staff education is being coordinated by the Regional Director of Operations on 2/8/25 with Telos psych providers or designee related to dealing with difficult behaviors and monitoring interventions, to be completed monthly with all staff. First education in this series will be conducted on 2/17/25. The facility Administrator assumes responsibility for the immediate jeopardy removal plan. The date of the immediate jeopardy removal is 2/9/25. The survey team attempted to conduct a validation of the immediate jeopardy removal on plans on 2/10/25. The facility had failed to update Resident #64's care plan to reflect 30-minute Nurse Aide checks and hourly Nurse checks. The facility failed to collaborate with the psychaitric provider for montly on-going education that was supposed to start on 02/17/25. The facility failed to have Resident #64 assessed by a psychiatric provider before reducing his one-on-one supervision. The immediate jeopardy removal date of 2/9/25 was not able to be validated. 2. Resident #64 was admitted to the facility on [DATE] with diagnoses which included depression and alcohol related dementia (brain damage from alcohol abuse) and adjustment disorder with depressed mood (mental health disorder that can occur as a response to stressful life events). Review of the Electronic Medical Record (EMR) revealed Resident #64 was last seen for psychiatric services (psychotherapy) on 10/29/2024. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #64 was moderately cognitively impaired with no behaviors, rejections of care, or wandering. A care plan dated 1/7/2025 revealed Resident #64 had the potential to be physically aggressive related to poor impulse control. Resident #64 was to have psychiatric/psychogeriatric (mental health services) consulted as needed. Resident #18 was admitted to the facility on [DATE] with diagnoses which included vascular dementia. A quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #18 was severely cognitively impaired. Resident #18 was coded as behavior of this type occurred daily for wandering. Resident #18 had no impairment of her upper and lower extremities and did not utilize assistive devices. Resident #18 was coded as independent for walking. A care plan dated 1/13/2025 revealed Resident #18 was an elopement risk, wanderer, with interventions which included staff were to address wandering behavior by walking with Resident #18 and redirecting Resident #18 from inappropriate areas. A nurse's note dated 2/1/2025 at 12:21 pm, authored by the Unit Manager #4, revealed she was sitting at the nurse's station when she heard Resident #64 saying get out of here, get out of here. As Unit Manager #4 got up to redirect the residents, Resident #64 was observed shoving Resident #18 as she was proximal to Resident #64's door. Unit Manager #4 immediately intervened and stepped between the two residents. Resident #64 went into his room and slammed the door. Unit Manager #4 redirected Resident #18. Resident #18 walked over to the common area then proceeded to walk back towards Resident 64's room. Resident #64 came out of his room as Resident #18 started walking and antagonized Resident #18 by saying walk over here, walk over here with a grin on his face and his fist balled up. Unit Manager #4 continued to redirect Resident #18 and attempted to reeducate Resident #64 on peer-to-peer interactions with no effect. Resident #64 told Unit Manager #4 to yeah go call the police, yeah I will do it again. Unit Manager #4 made the supervisor aware at 12:14 pm, called the Administrator at 12:15 pm, and contacted the Nurse Practitioner (NP) at 12:34 pm. Unit Manager #4 reported the event to Nurse #3 at 1:10 pm. An interview was conducted on 2/10/2025 at 11:19 am with Unit Manager #4. Unit Manager #4 stated she was charting at the nurse's station on 2/1/2025 when she heard Resident #64 say get out of here, get out of here. Unit Manager #4 stated when she went to get up, she witnessed Resident #64 shove Resident #18. Unit Manager #4 was unable to recall if Resident #64 shoved Resident #18 using one hand or two hands. Unit Manager #4 stated the shove did not cause Resident #18 to lose balance or fall. Unit Manager #4 stated the shove seemed as though it was to have Resident #18 go the other way. Unit Manager #4 stated she educated Resident #64 and told him not to place his hands on anyone else. Unit Manager #4 stated Resident #64 was placed on one-on-one supervision immediately. Unit Manager #4 stated she contacted the supervisor, Guardian, and NP as well. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A nurse's note dated 2/1/2025 at 2:14 pm, authored by Nurse #3, revealed she had been notified by another nurse Resident #64 had pushed another resident. Resident #64 was separated and one-on-one care during wake hours was initiated until further notice. One-hour checks were to be completed by the nurse and 30-minute checks were to be completed by Nurse Aides (NAs) while Resident #64 was sleeping. Nurse #3 documented per supervisor, a new order for lorazepam 1 milligram (mg) was to be administered every 6 hours as needed and would be placed in the system by a physician. An initial allegation report dated 2/1/2025, completed by the Administrator, revealed the facility reported an allegation due to resident-to-resident physical altercation involving Resident #64. The facility became aware of the incident on 2/1/2025 at 12:14 pm and notified law enforcement at 12:54 pm. Resident #64 was placed on one-on-one supervision while awake and hourly nursing checks with every 30-minute NA checks while Resident #64 was asleep. A five-day investigation report dated 2/7/2025 revealed the Administrator had completed an investigation and determined Resident #64 pushed Resident #18. Resident #18 was not injured, did not fall, and there were no bruises. An interview was conducted on 2/10/2025 at 11:38 am with NA #10. NA #10 stated she worked on the memory care unit on 2/1/2025 and was on the unit, sitting as a post near the elevators (to watch residents and ensure they did not go down the elevator). NA #10 stated she did not witness the incident between Resident #64 and Resident #18. NA #10 stated she was told by a nurse, name unknown, to sit with Resident #64 one-on-one. NA #10 stated Resident #64 was calm the remainder of the time she was assigned to him and stated she had taken him out to smoke after the incident to help calm his nerves. NA #10 stated she was not aware of any other instances where Resident #64 had been aggressive with other residents. NA #10 stated Resident #64 was able to ambulate independently and made his needs known. NA #10 stated Resident #18 frequently wandered and would attempt to go in other resident's rooms. NA #10 stated Resident #64 would get agitated when other residents would try to wander into his room but stated she had never witnessed him shoving anyone before. An interview was conducted on 2/10/2025 at 11:46 am with Nurse #3. Nurse #3 stated she was not on the memory care unit when the event between Resident #64 and Resident #18 occurred. Nurse #3 stated when she arrived back on the memory care unit, Resident #64 and Resident #18 were already separated. Nurse #3 stated she assessed Resident #18 for pain and injuries following the incident and stated Resident #18 was okay. An interview was conducted on 2/10/2025 at 12:17 pm with NP #2. NP #2 stated she had been called over the weekend by a facility staff member regarding the incident with Resident #64 and Resident #18. NP #2 stated she had made the recommendation to place Resident #18 on one-on-one supervision. An observation was conducted on 2/10/2025 at 3:43 pm of Resident #64. Resident #64 was observed awake, sitting on the side of his bed, and no longer had a one-on-one sitter. Resident #64 appeared calm. An observation was conducted on 2/10/2025 at 11:03 am of Resident #18. Resident #18 was observed lying in bed. Resident #18 did not answer questions. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on 2/10/2025 at 4:19 pm with the Director of Nursing (DON). The DON stated she had made aware of the incident involving Resident #64 and Resident #18 on 2/1/2025. The DON stated Resident #64 was immediately placed on one-on-one supervision. Follow-up interviews have been requested with the Director of Nursing (DON) and have not been successful. An interview was conducted on 2/11/2025 at 1:20 pm with the Administrator. The Administrator stated she was made aware of the incid[TRUNCATED]

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and staff and Resident interviews, the facility failed to implement their abuse policy in the area of protection following an incident of resident-to-resident physical abuse placing 33 of 33 other residents residing on the secured unit at risk of suffering abuse perpetrated by Resident #64. On 01/27/25 Nurse #6 witnessed Resident #64 lift Resident #84 off the floor and throw him out of Resident #64's room. Resident #84 fell to the floor, hit his head, and Nurse #6 heard a noise that sounded like a crack. The facility implemented 30-minute monitoring checks for Resident #64 on 01/28/25. The 30-minute monitoring checks were not effective in preventing further abuse. On 02/01/25 as Resident #18 was ambulating past Resident #64's room, Resident #64 pushed Resident #18. Following the incident, Resident #64 balled up his fist and stated to Resident #18, walk over here and I will do it again. Immediate Jeopardy began on 01/27/25 when protective measures were not immediately implemented to protect other residents from further abuse after Nurse #6 witnessed Resident #64 physically abuse Resident #84. Immediate Jeopardy was unable to be removed and is present and ongoing. The findings included: Review of the facility's Abuse, Neglect and Exploitation policy dated 11/01/2020 indicated the facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. The policy listed examples of protection that included: increased supervision of the alleged victim and residents; and room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator. The policy specified that protection was not limited to those examples. Resident #64 was admitted to the facility on [DATE]. A review of Resident #64's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident's cognition was moderately impaired and did not use a device for mobility and was able to transfer and walk independently without assistance from staff. A review of an Incident Report dated 01/27/25 at 10:50 AM revealed Nurse #6 observed Resident #84 being tossed out of the room by another resident (Resident #64) into the hallway floor landing on his left side. Nurse #6 noted there were no injuries observed at the time of the incident and Resident #84 was alert, confused, oriented to person, and ambulatory without assistance. During a telephone interview on 01/30/25 at 11:22 AM Nurse #6 revealed on 01/27/25 she was working on the secured unit on the third floor and heard Resident #64 yell out, Get out my room, I told you to get out. Nurse #6 revealed she saw Resident #64 take both hands and lift Resident #84 off the ground and throw him out of his room. Resident #84 fell to the floor, and she (Nurse #6) heard a noise that sounded like a crack and saw Resident #84's head hit the floor. Both residents were separated, and Resident #64 stayed in his room. She revealed Nurse #7 stayed with Resident #84 while she went to find the Administrator or the Director of Nursing (DON). DON and Unit Manager #5 came to the secured unit on the third floor. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 01/29/25 at 11:29 AM and 02/10/25 at 12:45 PM Nurse #7 revealed she was working on the memory care unit where the incident between Resident #64 and Resident #84 occurred on 01/27/25. The Nurse reported after the incident she stayed with Resident #84 who was still in the floor outside of Resident #64's room while Nurse #6 went downstairs to get the DON and Administrator. Nurse #7 stated while she was with Resident #84, Resident #64 did not come out of his room. The Nurse explained that she did not know what system was put in place immediately following the incident to monitor Resident #64 but stated around 3:00 PM that same day the DON came up to the unit and asked where the papers were (meaning the hourly monitoring sheets) for Resident #64. Nurse #7 informed her (the DON) that she did not know anything about Resident #64 being on hourly monitoring and initiated the hourly monitoring sheets herself at that time. An interview was conducted with Nurse Aide (NA) #10 on 02/07/25 at 1:11 PM who reported after the incident with Resident #84 on 01/27/25, Resident #64 was on every 30-minute checks. During an interview on 01/29/25 at 5:35 PM and 02/06/25 at 3:40 PM the DON revealed on 01/27/25 Nurse #6 told her Resident #84 had an unwitnessed fall and she did not know what happened. The DON revealed she was not made aware of a physical abuse incident involving Resident #64 and Resident #84 until 01/28/25 after reviewing Nurse #6's note and incident report during their morning meeting. The DON indicated that after administration found out about the incident on 01/28/25, they decided to include Resident #64 in on every 30-minute observation checks done by the nurse aides and hourly checks done by the nurses to protect the other residents from Resident #64. During an interview on 01/29/25 at 10:54 AM and 3:53 PM Resident #64 demonstrated how he used both hands to lift and throw Resident #84 out of the room onto the floor. Resident #64 revealed that if someone came into his room and would not leave when asked he would use physical force to get them out and did not need help getting someone out of his room. A nurse's note dated 2/1/2025 at 12:21 pm, authored by the Unit Manager #4, revealed she was sitting at the nurse's station when she heard Resident #64 saying get out of here, get out of here. As Unit Manager #4 got up to redirect the residents, Resident #64 was observed shoving Resident #18 near to Resident #64's door. Unit Manager #4 immediately intervened and stepped between the two residents. Resident #64 went into his room and slammed the door. Unit Manager #4 redirected Resident #18. Resident #18 walked over to the common area then proceeded to walk back towards Resident 64's room. Resident #64 came out of his room as Resident #18 started walking and antagonized Resident #18 by saying walk over here, walk over here with a grin on his face and his fist balled up. Unit Manager #4 continued to redirect Resident #18 and attempted to reeducate Resident #64 on peer-to-peer interactions with no effect. Resident #64 told Unit Manager #4 to yeah go call the police, yeah I will do it again. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with Unit Manager #4 on 02/06/25 at 11:13 AM she confirmed she witnessed the incident between Resident #64 and Resident #18 on 02/01/25. The Unit Manager explained that as she was charting at the nursing desk, she heard Resident #64 say get out of here twice. When she looked up, she saw Resident #64 standing in the doorway to his room facing the hallway and saw Resident #18 walk past the doorway in front of Resident #64. She continued to explain that Resident #64 put his hand(s) (she could not remember if he used one or two hands) out as if to redirect Resident #18 from going into his room. The Unit Manager reported that Resident #18 did not lose her balance or fall she was just redirected. When the Unit Manager was asked why she wrote shoving in her nurses' notes the Unit Manager stated, I guess I should not have used that word. The Unit Manager stated after the incident she made sure Resident #18 was redirected and she instructed Resident #64 not to put his hands on the other residents. She stated she reported the incident to the administration and Resident #64 was put on one to one (1:1) supervision and he was still on the 1:1 monitoring. During an interview with NA #10 on 02/07/25 at 1:11 PM she reported that she was assigned to stay with Resident #64 for a 1:1 monitoring for that current shift. She explained that the 1:1 monitoring started on 02/01/25 after the incident with Resident #18. The NA also reported Resident #64's roommates were moved to other rooms after the incident on 02/02/25 with Resident #18. Multiple observations were made of ambulatory residents on the secured Memory Care Unit on 02/06/25 at 12:45 PM, 02/07/25 at 1:08 PM, 02/10/25 PM at 1:20 PM and 02/10/25 at 2:15 PM. Ambulatory residents were walking about the unit in the hallways and in and out of resident rooms. There were residents around Resident #64's room but they were being monitored by the nursing staff. On every observation, Resident #64 was either lying on his bed and or he was being monitored with a 1:1 observation from a nurse aide. An interview was conducted with the Administrator and Director of Nursing on 02/06/25 at 3:40 PM. The DON explained that after the incident on 01/27/25 between Resident #64 and Resident #84 they included Resident #64 in the already established routine monitoring checks for the wandering residents for every 30-minute checks by the nurse aides and hourly checks by the nurses. When asked how the incident happened if all the wandering residents (that would include Resident #84) were being monitored that frequently, and the DON stated the aides must have been busy giving patient care and the Nurse must not have been watching. The DON continued to explain that Resident #64 was currently under 1:1 supervision since the 02/01/25 incident with Resident #18 and both of Resident #64's roommates were moved to other rooms. Both the DON and the Administrator were asked how the second incident between Resident #64 and Resident #18 happen if Resident #64 was being monitored every 30 minutes and every hour by the staff and the Administrator stated during the first incident on 01/27/25 she felt the intervention was appropriate to include Resident #64 in the every 30 minute and hourly checks but, in retrospect, she indicated she should have put Resident #64 on 1:1 monitoring on 01/28/25 after she was more informed of the incident between Resident #64 and Resident #84 on 01/27/25. The Administrator was notified of Immediate Jeopardy on 02/07/25 at 11:51 AM. The facility provided the following Credible Allegation of immediate jeopardy removal. o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- The facility failed to follow their policy about protecting residents and ensuring safety from Resident #64 from 1/27/25 through 2/1/25. - Resident #64 was placed on every 30-minute checks on the morning of 1/28/25 due to physical abuse with resident #84 in which it was reported that that he picked up and threw resident #84 resulting in a fall. The abuse altercation occurred when resident #84 who has wandering behaviors entered Resident #64's room and Resident #64 yelled at him to get out. The hourly checks were initiated by the Director of Nursing (DON) and nursing assistants were assigned on 1/28/25 mid-morning. - On 2/1/25, the Licensed Nursing Home Administrator (LNHA) and DON were notified at 12:15 pm by the Unit manager (UM) of the resident-to-resident abuse in which resident #64 pushed resident #18. - The Nurse Practitioners (NP's) for Residents #64 and #18 were each notified at 12:34 pm by the UM of physical altercation between resident #64 and resident #18. The on-call NP for resident #64 was further updated by his assigned nurse at approximately 1:10 pm. A new order was received for Resident #64 from the NP for as needed (PRN) Ativan to be used for any additional/further signs of agitation. - Resident #18 was assessed by her assigned nurse for any skin or pain concerns and no concerns were identified. Both assessments were completed by Resident #18's assigned nurse on 2/1/25 and documented into the EMR at approx. 2:40 pm by her assigned nurse who completed the assessments. - Residents on the dementia unit were assessed for injuries and/or physical indicators of abuse by the DON, Unit Manager, and licensed nursing staff on 2/1/25. Interviewable residents were interviewed by the DON, Unit Manager, and licensed nursing staff and/or designees on 2/1/25 regarding any witnessed physical altercations, witnessed abuse, and feeling of safety while residing in the facility. No additional findings were identified. Documentation is maintained by the Administrator in the physical copy of the investigation file. o Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete - At approximately 12:15 pm on 2/1/25, Resident #64 was placed on 1:1 supervision via nurse aides or designee during wake hours until further notice and 1-hour checks by nurse and 30-minute checks by nursing assistant or designee to be completed while resident is sleeping. - On 2/5/25, a follow up call to the NP for resident #64 was placed by the DON and new orders were received for labs and psych consult due to escalated behaviors over the past week. On 2/5/25, the NP for resident #64 also started the resident on Seroquel (antipsychotic medication) 25 mg daily for behavior management and diagnosis of adjustment disorder with depressed mood. The psych consult remains pending due to the physician being out with illness, however, his following Nurse Practitioner has seen and assessed Resident #64 on 2/3/25, 2/4/25, 2/5/25 and again 2/8/25. A follow-up call will be made regarding the psych consult to determine the date they will be in to further evaluate. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A Root Cause Analysis was completed on 2/3/25 by the LNHA and the DON with input from Interdisciplinary Team (IDT) and consultants in an effort to determine the cause for resident #64's behaviors that escalated beginning 1/27/25. With the initial incident, it was felt that the resident was angry that resident #84 wandered into his room and did not leave when he told him to. With the second incident on 2/1/25, resident #18 was walking past resident #64's doorway when he yelled at her to stay out of his room and pushed her. A request was made to the NP for acute work-up i.e. labs, psych consultation for resident #64 to determine if any acute illness may be process and to determine if any type of psychosis may be occurring that needed to be further addressed as well. It was discussed with resident #64 regarding placing a stop sign banner across his doorway that could possibly hinder other residents from entering his room, but he refused for this intervention. It was determined that resident #64 became agitated with other residents he did not know and/or whom he felt were entering his room. Failure of staff to redirect wandering residents resulted in abuse situation. Resident #64 was placed on 1:1 supervision on 2/1/25 at 12:15 pm by his nurse. This supervision was assigned to nursing assistant or designee with oversight by the resident's assigned nurse daily and the DON monitoring that 1:1 supervision is assigned and in place daily until such a time that Medical Doctor (MD) deems that resident #64 is no longer a risk for physical altercation. The facility's policy titled Abuse, Neglect, and Mistreatment was reviewed by the administrator on 1/28/25 with no changes indicated at that time. The abuse policy was reviewed again by the LNHA and the regional clinical consultant on 2/7/25 and no changes were made at that time. The clinical consultant reviewed the abuse policy again on 2/8/25 and corrected verbiage in section VI, section C to alleged perpetrator. The abuse policy is specific to protection as noted: VI. Protection of Resident The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation. B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed. C. Increased supervision of the alleged perpetrator and residents. D. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator. E. Protection from retaliation. F. Providing emotional support and counseling to the residents during and after the investigation, as needed. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Verbal education was provided by the Regional Director of Operations and Regional Clinical Consultant on 1/28/25 to LNHA and DON regarding procedures of thoroughly completing an investigation of alleged abuse, unusual events, monitoring for and identifying precipitating behaviors that could lead to possible resident to resident altercations and ensuring protection for all residents. This education also included the importance of thorough communication with the team, adequately obtaining of timely statements, and appropriate use of IDT meetings to review any incidents and/or concerns that may have occurred during the day. Nurse aides and licensed nurses received education from the Licensed Nursing Home Administrator/Designee on 02/08/25 that included direction to stay with the aggressive resident to promote and maintain safety for other residents within the facility. No nurse aide or licensed nurse will work after 2/8/25 without having had this education. The Licensed Nursing Home Administrator will be responsible to track the completion of this education. - On a phone call on 2/3/25, The regional director of operations and the regional clinical consultant reiterated to the LNHA and the Director of Nursing the responsibility that is expected for monitoring and ensuring safety and protection to the facility residents. Understanding was verbalized by the LNHA and Director of Nursing. - Immediate verbal education was initiated by LNHA/designee related to types of abuse including resident to resident altercations, abuse identification, abuse prevention, abuse reporting, and maintaining resident safety, with all nursing facility staff on 1/28/25. Education included scenarios and quizzes for demonstration of staff competency. Education further included redirecting of residents, monitoring for and identifying precipitating behaviors that could lead to possible resident to resident altercations. Education further reiterated the responsibility of the staff to promote and protect each resident. This education is for all nursing facility staff and includes agency staff and newly hired employees via the facility orientation process. No staff will work after 2/7/2025 without having had this education. The LNHA will be responsible to track the completion of this education. - Additional ongoing whole nursing home staff education is being coordinated by the Regional Director of Operations on 2/8/25 with psych providers or designee related to dealing with difficult behaviors and monitoring interventions, to be completed monthly with all staff. First education in this series will be conducted on 2/17/25. The facility administrator assumes responsibility for the immediate jeopardy removal plan. The alleged date of the immediate jeopardy removal is 2/9/25. The facility's credible allegation of Immediate Jeopardy was unable to be validated on 02/10/25. The facility was unable to explain why the Ativan order that was ordered after the resident-to-resident abuse on 02/01/25 was never entered into Resident #64's electronic health record. The Ativan was never entered as an order or received by Resident #64 at the facility. The facility failed to provide evidence that the Regional Director of Operations collaborated with the psych provider or designee to coordinate training on 02/08/25. The Administrator stated that the collaboration had not occurred and would not occur until at least 02/13/25. Resident #64 was not seen by a psychiatry provider due to illness and the following medical visits on 02/03/25, 02/04/25, 02/04/25 and 02/06/25 were not done by a psych provider. They were done by a medical nurse practitioner. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility did not have sufficient evidence to remove the immediate jeopardy, and it remains present and ongoing.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff and the resident the facility failed to implement their abuse policies and procedures in the area of reporting immediately to the Administrator an allegation of resident abuse, after Nurse #6 witnessed a resident (Resident #64) use physical force to remove another resident (Resident #84) from his room resulting in fall; and failed to include an accurate date of when the facility became aware of the incident on the initial 24-hour report; and failed to identify resident abuse occurred and provide details of the incident that caused Resident #84 to fall in the initial 24-hour report. The facility also failed to follow their abuse policy and procedure by not immediately reporting an allegation of resident-to-resident sexual abuse to the Administrator (Resident #82 and Resident #88). The deficient practice affected 2 of 3 residents reviewed for abuse. The findings included: 1. Review of the facility's Abuse, Neglect, and Exploitation policy dated 11/01/20 included reporting all alleged violations to the Administrator within specified timeframes immediately but no later than two hours after the allegation was made, if the events that caused the allegation involve abuse. The policy and procedures did not include to provide sufficient information and details describing the allegation when preparing the initial 24-hour report. Resident #64 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (stroke) and cognitive communication deficit. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #64's cognition was moderately impaired. Resident #84 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease and dementia. The admission MDS assessment dated [DATE] revealed Resident #84's cognition was severely impaired. a. During an interview on 1/29/25 at 10:54 AM Resident #64 revealed he used both hands and physically picked up a resident (Resident #84) and threw him out of his room and onto the floor. A progress note created on 1/27/25 at 5:29 PM by Nurse #6 revealed at 10:50 AM she observed Resident #64's room door was open and saw Resident #84 being tossed out of the room. Resident #84 fell to the floor and land on the left side of his body and the left side of his face. The note indicated Nurse #6 told the Director of Nursing (DON) what happened. During a phone interview on 1/30/25 at 11:22 AM Nurse #6 revealed on 1/27/25 she witnessed Resident #64 use physical force and throw Resident #84 onto the floor causing him to fall and hit his head. Nurse #6 revealed she reported to the DON Resident #84 was thrown to the floor by Resident #64. Nurse #6 stated she received abuse training and was told to report immediately and that's what she did. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/29/25 at 5:35 PM the DON revealed on 1/27/25 while in her morning meeting she received a text from Nurse #6 to immediately come to the secured memory care unit. The DON revealed when she arrived on the unit she saw Resident #84 sitting on the floor and was told by Nurse #6 he had an unwitnessed fall, and she did not know what happened. The DON revealed she was not aware of the details about an abuse incident that Resident #64 used physical force to remove Resident #84 from his room had caused the fall until 1/28/25, after reviewing Nurse #6's documentation of the incident. She revealed Nurse #6's statement was put under the Administrator's door after hours and the incident report signed after hours on 1/27/25 at 6:08 PM and she saw those notes on 1/28/25 during the morning meeting. The DON revealed Nurse #6 should have reported resident abuse at the time she was asked about the fall on 1/27/25. During a phone interview on 1/30/25 at 4:12 PM the Administrator revealed she asked Nurse #6 why she did not report the allegation of resident abuse immediately to her. She revealed staff recently received education to immediately report abuse and aware they need to contact the Administrator first and if she cannot be reached notify the DON. The Administrator revealed Nurse #6 told her she followed the chain of command. b. A review of the initial 24-hour allegation fax cover sheet revealed the report was sent to the State Agency on 1/28/25 at 11:15 AM. The allegation report revealed the date the facility became aware of the incident was 1/27/2025 at 11:12 AM. A phone interview was conducted on 1/30/25 at 4:12 PM and 5:41 PM with the Administrator. The Administrator confirmed the date she became aware of the details of the abuse incident involving Resident #64 and Resident #84 was on 1/28/25 during the morning meeting. The Administrator revealed the date on the initial 24-hour allegation report indicating the facility became aware on 1/27/25 was incorrect and an error on her part and should have been 1/28/25. c. A review of the initial 24-hour allegation report revealed it did not identify resident abuse occurred. The report was completed by the Administrator and indicated a resident to resident physical altercation occurred without details describing Resident #84 was physically thrown by Resident #64 causing Resident #84 to fall and hit his head on the floor. During an interview on 2/7/25 at 12:38 PM the Administrator revealed after reading nurses' progress notes she should have identified resident abuse on the initial 24-hour report. The Administrator revealed the initial 24-hour report did not contain sufficient details describing the incident of resident abuse because she did not want to be late in reporting to the State Agency. 2. An undated facility policy titled, Abuse, Neglect and Exploitation, read in part: all alleged violations will be reported to the Administrator within specified timeframes: a) Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. Resident #82 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS) dated [DATE] assessed Resident #82 as severely cognitively impaired. Resident #88 was admitted to the facility on [DATE]. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly Minimum Data Set (MDS) dated [DATE] assessed Resident #88 as severely cognitively impaired. A nursing progress note dated 10/16/24 at 10:54 PM written by Nurse #1 in Resident #88's electronic medical record (EMR) revealed Resident #82 was discovered in Resident #88's room. Resident #88's pants were all of the way down to his ankles; Resident #82 was leaned over onto Resident #88's lap. The note revealed the Nurse Aide (NA #1) was not aware of what took place because the lights were off when she entered the room. NA #1 separated both residents and redirected Resident #82 back to her room. A nursing progress note dated 10/16/24 at 10:54 PM written by Nurse #1 in Resident #82's (EMR) revealed Resident #82 was discovered in another resident's room during rounds sitting on the bed fully clothed with no signs of distress. She was redirected and taken to her designated sleeping area. Review of Resident #82 and Resident #88's EMR revealed there was no indication that the Director of Nursing (DON) and/or Administrator were notified. On 01/17/25 at 8:45 AM a telephone interview was conducted with Nurse #1. Nurse #1 stated it was difficult to remember the situation due to the length of time that had passed since the incident on 10/16/24. She stated she did recall a Nurse Aide (NA #1) coming to her and stating Resident #82 was found in Resident #88's room and Resident #88's (male resident) pants were down but the female resident (Resident #82) was fully clothed. Nurse #1 stated she told NA #1 to leave a statement, but NA #1 left the next morning without writing a statement for the facility. Nurse #1 thought she had called the former Director of Nursing to let her know about the incident but didn't think she was supposed to let the Administrator know. Nurse #1 stated she did not recall any more details about the incident and stated, I wrote a note about what happened. The interview revealed she had since taken care of both Resident #82 and Resident #88 following the incident and had not witnessed any sexual behaviors from either resident. On 01/17/25 at 9:55 AM a telephone interview was attempted with Nurse Aide (NA) #1. The surveyor did not receive a return phone call. NA #1 was an agency employee and no longer worked in the facility. On 01/16/25 at 2:12 PM an interview was conducted with the Social Worker. She stated she was unaware of any incident on 10/16/24 involving Resident #82 and Resident #88. On 01/17/25 at 9:37 AM a telephone interview was attempted with the former Director of Nursing. The surveyor did not receive a return phone call. On 01/17/25 at 10:04 AM an interview was conducted with the Administrator. During the interview she stated she was unaware of any incident involving Resident #82 and Resident #88. After reviewing the nursing progress note's written by Nurse #1 on 10/16/24 the Administrator stated Nurse #1 should have immediately notified her of the incident and an investigation should have been initiated into what had occurred. The Administrator stated the facilities abuse prevention policy was not followed because she was unaware of the situation. She stated the nursing progress note had been missed during nursing audits and not discussed in interdisciplinary team meetings.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and staff interviews, the facility failed to update a care plan to indicate do not resuscitate (DNR) status (Resident #25) and failed to update a care plan to reflect the use of an electronic wander guard alarm (a device that residents wear to trigger an alarm in unsafe areas) (Resident #63) for 2 of 3 residents reviewed for care plans. The findings included: 1. Resident #63 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, heart failure and seizure disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #63 had severe cognitive impairment and wandering behaviors were not indicated on the MDS. The MDS indicated a wander/elopement alarm was used daily. A review of Resident #63's physician orders dated [DATE] revealed an order to check electronic monitoring device via testing machine every shift and to visually check electronic monitoring device every shift. Resident #63's wandering care plan last revised on [DATE] did not include the use of the electronic monitoring device as an intervention. During an interview with the MDS Coordinator on [DATE] at 3:05 PM the Coordinator explained that she was responsible for adding the new interventions to the care plans which would go over onto the Kardex (a care guide) for the nurse aides to see and follow. She indicated the wander guards were normally care planned. The MDS Coordinator reviewed Resident #63's care plan and acknowledged the wander guard was not on the care plan and stated he did have a wandering care plan. The Coordinator stated she did not remember discussing a wander guard for Resident #63. On 3:43 PM on [DATE] interviews were conducted with Nurse Aide #3 and Nurse Aide #13 simultaneously. The Nurse Aides were asked how they knew when a new intervention was started for the residents, and they explained that when an intervention was added to the care plan it automatically comes over to the Point of Care (Kardex) charting system for the Nurse Aides to see and sign off on. An interview was conducted with the Director of Nursing (DON) on [DATE] at 5:25 PM. The DON indicated that Resident #63 had severe cognitive impairment and was a wanderer on the Memory Care Unit. She explained that he needed a wander guard alarm to keep him safe. When the DON was informed that the wander guard was not on Resident #63's care plan she stated she did not know that it was not on there and it needed to be added to the care plan. During an interview with the Administrator on [DATE] at 6:10 PM she stated Resident #63 was a wanderer and needed a wander guard alarm which should be care planned. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and staff interviews, the facility failed to update a care plan to indicate do not resuscitate (DNR) status for 1 of 3 residents reviewed for care plans (Resident #25). The findings included: 2. Resident #25 was admitted to the facility on [DATE]. His diagnoses included cerebral infarction due to unspecified occlusion or stenosis of bilateral carotid arteries, diabetes mellitus due to an underlying condition with hypoglycemia, and chronic obstructive pulmonary disease. A review of Resident #25's electronic medical record (EMR) nursing progress note revealed he transitioned to Hospice/end of life care on [DATE] and his code status was changed from a CPR/Full Code to DNR on the same date. A review of Resident #25's physical Do Not Resuscitate (DNR) revealed the form was signed on [DATE]. A review of the most recent quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #25 was severely cognitively impaired. There was no current care plan indicating do not resuscitate. An interview was completed with the MDS Nurse on [DATE] at 10:32 AM revealed she did not update the care plan when a resident code status changed. She explained that the Social Worker (SW) was tasked with updating the care plan. An interview with the SW occurred on [DATE] at 9:55 AM. She explained she was tasked with updating care plans quarterly or whenever they needed to be updated. The SW indicated the care plans used to be updated by the MDS Nurse and the process had changed many months ago. She stated she attempted to schedule a care plan meeting for Resident #25 last quarter but was unable to explain why she was unsuccessful. The SW stated she was aware a change in code status and transition to Hospice care was discussed for Resident #25, but she was not informed by nursing that the change had been made, and the care plan was not revised or updated. An interview with the DON on [DATE] at 11:32 AM revealed Resident #25's care plan should have been updated when his code status changed from CPR/Full Code to DNR by the SW. An interview with the Administrator on [DATE] at 2:07 PM revealed she expected Resident #25's care plan to be updated timely.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Citadel at Myers Park, LLC	300 Providence Road Charlotte, NC 28207

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, resident and staff interviews, the facility failed to provide nail care for 1 of 3 residents (Resident #65) reviewed for activities of daily living. The findings included: Resident #65 was admitted to the facility on [DATE] with diagnoses which included cerebrovascular accident (stroke), diabetes mellitus, dementia, and Alzheimer's disease. Resident #65's Care Area Assessment for activities of daily living (ADL) dated 07/16/24 revealed she needed assistance from staff with all activities of daily living due to her diagnoses of dementia and Alzheimer's disease. Staff were to anticipate the needs of the resident. Resident #65's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was severely cognitively impaired and required substantial to maximal assistance with all activities of daily living (ADL) except eating in which she required set up. There were no behaviors, and no rejection of care noted on her assessment. Resident #65's care plan last revised on 10/22/24 revealed she had a focus area for an ADL self-care performance deficit related to recent hospitalization, decline in functional transfers, ADL and mobility. The goal was for Resident #65 to improve ability to safely and efficiently perform eating tasks with supervision or touching assistance to ensure adequate nutrition, hydration, perform upper and lower body dressing with supervision or touching assistance by the next review date of 04/14/25. The interventions included in part: - Encourage resident to participate to the fullest extent possible with each interaction. - Encourage the resident to use the call bell to call for assistance. - Monitor/document/report prn any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. - Praise all efforts at self-care. - Therapy evaluation and treatment as per Medical Doctor orders. An observation on 01/14/25 at 3:07 PM of Resident #65 revealed her sitting in the dining area in her wheelchair coloring and watching TV. The resident was oriented to person only and her nails on both hands were noted to have brown colored debris under all nails on both hands. The resident was unable to answer when the last time she washed her hands or had her hands washed by staff. An observation on 01/15/25 at 1:37 PM of Resident #65 revealed her sitting in the dining area in her wheelchair at a table with another resident watching TV. The resident's nails on both hands were noted to have brown colored debris under all nails on both hands. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 01/16/25 at 2:31 PM with Nurse Aide (NA) #4 revealed she had assisted with care for Resident #65 on 01/15/25. She stated she had not noticed the resident having brown debris under the resident's nails. NA #4 did not offer to clean Resident #65's fingernails. An observation on 01/16/25 at 2:39 PM of Resident #65 revealed her sitting in the dining area in her wheelchair working on a puzzle. The resident's nails on both hands were noted to have brown colored debris under all nails on both hands. An interview on 01/16/25 at 2:45 PM with NA #2 revealed she was assisting with care for Resident #65 during the 7:00 AM to 3:00 PM shift on 01/16/25 and had assisted with her care on 01/14/25 during the 7:00 AM to 3:00 PM shift. NA #2 stated she had not noticed Resident #65 having brown colored debris underneath her fingernails. She further stated Resident #65 received her showers on the 3:00 PM to 11:00 PM shift on Mondays and Thursdays and she was not responsible for her shower today. NA #2 did not offer to clean Resident #65's fingernails. An observation and interview was conducted with Unit Manager #1 on 01/16/25 at 3:15 PM. UM #1 confirmed she was assigned to care for Resident #65 during the 7:00 AM to 3:00 PM shift on 01/16/25 and when shown the resident's dirty fingernails she stated that she had already seen them and discussed with NA #3 they needed to give her a good shower on the 3:00 PM to 11:00 PM shift today (01/16/25). UM #1 stated Resident #65's fingernails were dirty and needed to be cleaned and stated she had already discussed with NA #3 that they would give her a good shower on the 3:00 PM to 11:00 PM shift. UM #1 stated when she noticed things like dirty fingernails or long fingernails or any issue with the residents she tried to get them taken care of right away. UM #1 did not offer to clean the resident's fingernails prior to her scheduled shower on 2nd shift. An interview on 01/17/25 at 9:40 AM with NA #3 revealed she had taken care of Resident #65 during the 3:00 PM to 11:00 PM shift on 01/16/25. She stated she and Unit Manager (UM) #1 had given Resident #65 a shower and had trimmed and cleaned her fingernails on both hands. NA #3 said UM #1 had noticed her fingernails being dirty while she was caring for her on 01/16/25 and had asked if NA #3 would assist her in giving Resident #65 a good shower on 01/16/25 during the 3:00 PM to 11:00 PM shift. NA #3 further stated she had not noticed Resident #65's dirty fingernails until UM #1 had brought it to her attention and stated she had not offered to clean her fingernails when it had been brought to her attention because she knew she and UM #1 were going to be giving Resident #65 a shower on 2nd shift. An interview on 01/17/25 at 12:53 PM with the Director of Nursing (DON) revealed she promoted daily grooming of residents when possible. The DON stated sometimes residents on the 300-hall were not able to be redirected for care and that was why they were utilizing an extra NA on the hall to help with redirecting residents that wandered and refused care. She further stated she expected all refusals to be documented and communicated to UM #1 so she can reapproach the residents. The DON indicated she expected all staff to make sure the residents were groomed daily. An interview on 01/17/25 at 2:30 PM with the Administrator revealed she could not understand why the residents were not being groomed immediately when issues of grooming were identified by staff. She stated they had provided education to all staff, and she expected the staff to be diligent with daily care of the residents especially on the 300-hall given their dementia and inability of most of them to care for themselves.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4. Resident #63 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, heart failure and seizure disorder. Resident #63 resided in the Memory Care Unit which is a secured unit on the third floor of the facility. The care plan revised on 06/06/24 revealed Resident #63 was a wanderer due to being disoriented to place. The goal that he will be safe would be attained by utilizing interventions such as distracting the Resident by offering distraction with activities, ensuring the areas that the Resident is wandering in is safe and monitoring for fatigue and weight loss. There was no wander guard monitoring device on the care plan. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #63 had severe cognitive impairment and wandering behaviors were not indicated on the MDS. The MDS also indicated the Resident ambulated independently and wander/elopement alarm was used daily. A review of Resident #63's physician orders dated 01/29/25 revealed an order to check electronic monitoring device via testing machine every shift and to visually check electronic monitoring device every shift. A review of Resident #63's Medication Administration Record (MAR) for 01/2025 indicated an order dated 01/29/25 to visually check the electronic monitoring device right ankle every shift and check electronic monitoring device via testing machine every shift. The MAR indicated the electronic monitoring device was checked as present every day and every shift. A review of Resident #63's MAR for 02/2025 indicated an order dated 01/29/25 to check the electronic monitoring device right ankle every shift and check electronic monitoring device via testing machine every shift. The MAR indicated the electronic monitoring device was checked as present every day and every shift except day shift on 02/06/25. An interview and observation were made of Resident #63 on 02/07/25 at 1:08 PM. The Resident was standing in the middle of the floor in his room. Resident #63 answered to his name being called but could not follow verbal command. Observation of both ankles and wrists revealed there was no wander guard alarm on the Resident. An observation was made on 02/10/25 at 1:15 PM of a sign posted on the back wall in the Providence Road elevator (one of two elevators that leads up to the Memory Care Unit) that stated STOP in a red stop sign and verbiage underneath the sign that stated PLEASE SEE THE NURSE BEFORE ALLOWING OUR SECURED RESIDENTS ON THE ELEVATOR in black capital letters. There was no sign posted on the front door of the elevator about the precaution. An observation was made of the outside door and inside back wall of the Dartmouth Road elevator which leads up to the Memory Care Unit on 02/10/25 at 2:12 PM. There were signs posted that stated STOP in a red stop sign and verbiage underneath the sign that stated PLEASE SEE THE NURSE BEFORE ALLOWING OUR SECURED RESIDENTS ON THE ELEVATOR in black capital letters. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/10/25 at 12:45 PM during an interview with Nurse #7 the Nurse reported that she was working on the second floor on 02/10/25 when around 7:39 AM she observed Resident #63 wandering around on the second floor near the nurses' station alone with no one attending him. The Nurse explained she sent a text message to the Director of Nursing (DON) to report her observation then called Nurse #5 who was working the Memory Care Unit at that time and reported her observation to the Nurse in which she responded that she would send a staff member down to get Resident #63. Nurse #7 continued to explain that approximately 5 minutes later Nurse Aide (NA) #11 who was scheduled to work on the Memory Care Unit came to the second floor nurses' station and assisted Resident #63 back upstairs to the Memory Care Unit. The Nurse reported that a few minutes after the NA left with Resident #63, the DON came to the second floor to collect statements from staff about Resident #63 being downstairs unattended. The Nurse stated she informed the DON that Resident #63 was observed to be walking up the long hall from the area of the Providence Road elevator. When asked how the Nurse thought Resident #63 got unattended to the second floor she indicated if his wander guard alarm did not sound on the Memory Care Unit then he could have ridden the elevator down with someone who did not know that the Resident should not be left unattended. The Nurse reported that there were a lot of new people at the facility and there were signs posted outside the elevator doors about patient safety. On 02/10/25 at 1:16 PM during an interview with Nurse Aide #12, the NA was working on the Memory Care Unit on first shift on 02/10/25 who explained that he was off the Unit when Resident #63 was found downstairs on the second floor. The NA continued to explain that a Hospice staff was on the Unit earlier that morning and the Resident could have rode the elevator down with that person. NA #12 stated Resident #63 had since had the wander guard placed on his ankle and was on a 1:1 monitoring with NA #11. An observation of Resident #63 was made on 02/10/25 at 1:19 PM. The Resident was alert and walking up the hallway while being monitored by Nurse Aide #11. The NA asked Resident #63 to lift his pant leg up and the Resident could not follow through with the request. The NA had to lift the Resident's left pant leg to expose the wander guard was present on his ankle. An interview and observation were conducted with Nurse Aide #11 on 02/10/25 at 1:20 PM. The NA was monitoring Resident #63 for the 1:1 protocol and explained that she went downstairs earlier that morning and as soon as she stepped off the elevator on the second floor the Resident was walking toward her and had already passed the nurses' station. The NA continued to explain that she asked Nurse #7 how Resident #63 got down to the second floor but neither of them knew how the Resident got downstairs by himself. NA #11 reported when she returned to the Memory Care Unit with Resident #63, she was told that she was changing assignments to monitor the Resident 1:1 for the rest of the shift. Soon afterwards the NA had to take Resident #63 to the podiatry clinic downstairs and one of the Unit Managers placed a wander guard on the Resident's left ankle. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with Nurse #5 on 02/10/25 at 1:35 PM the Nurse explained that earlier that morning she received a phone call from Nurse #7 who was working on the second floor, she found Resident #63 wandering around by himself and Nurse #5 needed to send someone down to get the Resident. The Nurse stated she notified Nurse Aide #8 who was the Resident's assigned care giver that day, that Resident #63 was found on the second floor, and she needed to go downstairs and get the Resident. NA #8 informed the Nurse that she had just sat Resident #63 down in the dining room and he was watching TV when she went to the supply closet to obtain some supplies to continue her morning care of the residents. The Nurse stated as the NA went to the Dartmouth Road elevator to obtain the Resident, she observed Nurse Aide #11 and Resident #63 getting off the elevator. Nurse #5 explained that she notified the Director of Nursing that Resident #63 was found downstairs on the second floor and the DON came to the Memory Care Unit when it was discovered that Resident #63 did not have his wander guard on either ankle. The Nurse reported that the staff searched the Resident's room and could not find the wander guard. Nurse #5 stated a new wander guard was placed on Resident #63 by one of the Unit Managers and he was placed on 1:1 monitoring with Nurse Aide #11. Nurse #5 continued to explain that she worked on the Memory Care Unit on Saturday 02/08/25 first shift and Resident #63 had his wander guard on during that shift. When Nurse #5 was asked how she thought Resident #63 got to the second floor she explained that since the wander guard alarm did not sound for the Resident, he must have ridden the elevator down with someone who did not know that the Resident could not be without attendance of staff. The Nurse reported only one person was on the unit that day which was a Hospice Aide, and she thought the DON had already obtained a statement from her about the incident. On 02/10/25 at 1:45 PM an interview was conducted with Nurse Aide #8 who confirmed she was assigned to Resident #63 and explained that she had just sat Resident #63 down in the dining room to watch TV and went to the supply closet to obtain supplies to continue her care of the residents. She stated that approximately 5-7 minutes later when she opened the door to come out of the supply room Nurse #5 informed her that Resident #63 was found on the second floor by himself unattended and asked the NA to go downstairs and bring him back up but as she approached the Dartmouth Road elevator she saw that NA #11 had already brought Resident #63 back to the Unit. NA #8 reported that the Resident was supposed to have a wander guard on, but he did not have a wander guard on when he was brought back to the Unit. She stated if Resident #63 had a wander guard on then he would not have been able to get on the elevator because of the alarm sounding as he approached the elevator. The NA stated the Resident was put on 1:1 monitoring with NA #11 and the wander guard was replaced later that morning. NA #8 reported that she did not know how Resident #63 got downstairs unattended, but he should have had a wander guard on because of his wandering behavior. An interview was conducted with Unit Manager #4 on 02/10/25 at 3:30 PM. The Unit Manager explained that the Director of Nursing notified her earlier that day to put a wander guard on Resident #63 when he was at the podiatry clinic which she did. She stated the DON did not tell her why to put the wander guard on the Resident. The Unit Manager stated that she did not know that Resident #63 was found on the second floor earlier that morning unattended. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted with the Director of Nursing on 02/10/25 at 5:25 PM. The DON was asked what she knew of Resident #63 being found downstairs on the second floor earlier that day and the DON explained that she was notified that Resident #63 was wandering around and he had to have his wander guard replaced that day. The staff informed her that they were looking for his wander guard because he was wandering in and out of the rooms and near the doors and when they noticed it off, they replaced it. The DON stated she told someone through a text message circle to replace it and left one at the Reception Desk and told the receptionist to give it to whoever comes to get it, and Unit Manager #4 ended up replacing it. The DON reported Resident #63 was not found on the second floor because that would indicate he was lost. She stated the facility had a procedure when a resident was (missing) and it was to call a color code and there was not a code called that day to indicate a missing resident. When the DON was asked what the color code was for missing residents, she indicated she did not know and would have to get back with that information. The DON continued to explain that she was informed that Resident #63 was with an agency aide, but the DON found out later that it was a Hospice Aide because the Hospice Aide was the only non-staff member up on the Memory Care Unit earlier that day. She reported she had already called the Hospice Aide because the Hospice Aide was on the Memory Care Unit to get briefs to give care and she was the last person out of any doors from the Unit. The DON continued to explain that when she called the Hospice Aide the Aide informed her that there was no one on the elevator with her when she left the Memory Care Unit, that she was by herself. The DON was asked how was it possible that Resident #63 got to the second floor by himself without the wander guard alarm sounding to alert the staff and the DON explained that since Resident #63 did not have a wander guard on he must have went down the elevator but that he had to have been with someone who knew the code to the elevator because he was not cognitively intact to manage the code of the elevator, know the code of the elevator or push button #2 on the elevator to go to the second floor. She stated, he just don't have it. At 4:25 PM on 02/10/25 during an interview with the Hospice Aide she explained that she was up on the Memory Care Unit earlier that morning but when she went back down in the elevator there was no one with her on the elevator. An interview was conducted with Nurse #8 on 02/11/25 at 1:04 PM. The Nurse confirmed she worked on the Memory Care Unit on third shift (11:00 PM - 7:00 AM) on 02/07/25 and 02/08/25. Nurse #8 explained that she checked both nights for the wander guard on Resident #63's ankle (could not remember which ankle) and the wander guard was on his ankle. The Nurse continued to explain that Resident #63 was usually awake and up all night walking the halls and often removed the wander guard. The Nurse reported it was not uncommon for her to have to replace the wander guard because Resident #63 often removed it from his ankle. The Nurse explained that she had reported it to the previous Unit Manager (who no longer worked at the facility), and she was trying to come up with a different plan for the Resident. Nurse #8 reported everybody was aware that Resident #63 removed the wander guard, even the Director of Nursing (DON), but she had not personally spoken to the DON about it. The Nurse explained that the only explanation she would have about how Resident #63 was found on the second floor unattended was that the Resident was not wearing the wander guard when he approached the elevator to sound the alarm or if he did not have the wander guard on, he must have road the elevator down to the second floor with someone who knew the code. The Nurse indicated Resident #63 was not cognitively intact enough to know the elevator code or to input the code by himself. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with Nurse # 3 on 02/11/25 at 4:45 PM the Nurse reported that she recently worked on the Memory Care Unit on 02/06/25 first shift (7:00 AM - 7:00 PM) and worked with Resident #63. She stated Resident #63 wandered around the unit independently and was easily redirected. Nurse #3 explained that when she checked the Resident's wander guard (monitoring device) during the shift, the wander guard was not on the Resident. She stated she did not report it, nor did she replace it because everybody knew, even the administrative staff. The Nurse stated she had mentioned it in the past to the Director of Nursing (DON) about not having the wander guards and the reply she got was I will take care of it. The Nurse continued to explain that it was her understanding that there were not enough straps for the wander guards for everyone who needed them to have one. Nurse #3 stated she was not aware of whether Resident #63 was able to remove his wander guard. On 02/10/25 at 6:10 PM and 02/11/25 at 1:20 PM interviews were conducted with the Administrator who explained that she was not aware that Resident #63 had been found on the second floor wandering around unattended until this interview. The Administrator continued to explain that someone asked her for a wander guard, and she contacted the Maintenance Director to obtain a strap for the wander guard from a sister facility that was approximately 2 miles away and he was able to get one and they put it on him. She stated she found out who it was for, and she told the staff to put him on 1:1 monitoring until the wander guard got to the facility. The Administrator stated she did not know how Resident #63 got downstairs on the second floor. The Administrator indicated in the follow-up interview that she was still investigating how Resident #63 was able to get downstairs to the second floor because he can not press the buttons by himself. She stated as far as she knew the Resident was not unattended. Based on observations, record review, review of the transportation van training tutorial, and resident, Transportation Driver #1, Transportation Administrator, staff, and Nurse Practitioner interviews, the facility failed to ensure that Resident #336 who was cognitively intact, received dialysis services and was prescribed an anticoagulant, was safely transported back to the facility following dialysis on 01/21/25. Transportation Driver #1 who drove through a contract transportation company failed he failed to secure the lap and shoulder belt around Resident #336. During the transport, Transportation Driver #1 hit bumps in the road and Resident #336 was thrown from his wheelchair to the floor of the van. In addition, Transportation Driver #1 did not contact Emergency Medical Services for Resident #336 to be evaluated and when he was unable to assist Resident #336 back into his wheelchair, Transportation Driver #1 made the decision to leave Resident #336 on the floor of the van and transport him back to the facility. Resident #336 stated he was not injured. When Transportation Driver #1 returned to the facility Nurse #24 assessed Resident #336 for injuries and none were noted. Failing to secure the lap and shoulder belt around Resident #336 during transport and transporting Resident #336 back to the facility while he was on the floor of the van had the high likelihood of causing serious harm, or serious impairment. The facility also failed to complete an accurate safe smoking assessment for Resident #39 and have electronic monitoring devices in place for Resident #29 and Resident #76. In addition, the facility failed to provide supervision to Resident #63 who resided on the locked unit on the third floor of the facility and had a history of wandering from getting on the elevator unattended and going to the second floor of the facility where staff found him and returned him to the secured unit on the third floor. The deficient practices affected 5 of 5 residents reviewed for supervision to prevent accidents (Resident #336, Resident #39, Resident #29, Resident #76, and Resident #63). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediate jeopardy began on 01/21/25 when Resident #336's lap and shoulder belt was not secured around him prior to transportation and he was thrown to the floor after Transportation Driver #1 hit bumps in the road. Immediate jeopardy is present and ongoing. Examples #2, 3a, 3b, and 4 are being cited a lower scope and severity of E. The findings included: 1. Per the restraint system used on the transportation van training tutorial, in order to properly secure a resident in a wheelchair with the restraint system, Transportation Driver #1 needed to lock the resident's wheelchair after loading Resident #336 followed by utilizing the retractable securing hooks to Resident #336's wheelchair and ensuring that they are locked and prevented Resident #336's wheelchair from moving. Transportation Driver #1 should have then placed the lap and shoulder belt over Resident #336, ensuring the lap belt was snug across Resident #336's lap and the shoulder belt was across the front of Resident #336. Resident #336 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease. Resident #336's admission Minimum Data Set assessment dated [DATE] revealed him to be cognitively intact with no delusions, behaviors or rejection of care. Resident #336 was coded as dependent on others for transfers and had impairments on both sides of his lower extremities. Resident #336 was also coded as taking an anticoagulant medication and receiving dialysis services. Resident #336's physician orders revealed Eliquis Oral Tablet - 5 milligrams - Give one tablet by mouth two times a day for history of stroke. This physician order was dated 01/20/25. Resident #336's care plan dated 01/20/25 revealed a care plan for receiving hemodialysis related to end stage renal disease. Resident was scheduled for dialysis on Tuesdays, Thursdays, and Saturdays. The facility's fall incident report dated 01/21/25 at 6:00 PM revealed the following: Transport Driver arrived stating resident had fell out of wheelchair and asking for assistance. Un-witnessed fall. Resident lying on right side in the floor of the transport van. Resident was laying beside his wheelchair in back. No signs of visual injury. Resident had complaints of right knee discomfort. Resident stated he did not hit his head. Aided resident back into his chair with the help of driver. This nurse asked driver to come in and write a statement and driver left without doing so. Resident stated upon returning to facility from dialysis, driver went over a speed bump when he got dispositioned in his wheelchair. Resident stated before he could get himself straightened back up in wheelchair, the driver then [stomped] on the brakes and resident fell forward out of wheelchair on transport van floor. Resident stated his right leg was slightly bent when he landed on the floor. Resident stated his seat belt was anchored around his wheelchair and not him. Resident stated van driver made an attempt away from premises to pick him up off the floor but was unsuccessful. An additional review of the incident report revealed Resident #336's vital signs were taken and were within normal limits. Per the incident report a complete body check was completed on Resident #336 and there were no signs of injury. Nurse #24 offered Resident #336 an ice pack, but he declined. The incident report was written by Nurse #24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345008	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Citadel at Myers Park, LLC	300 Providence Road Charlotte, NC 28207

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with Resident #336 on 02/07/25 at 12:16 PM revealed he remembered the incident. He reported he had gone to dialysis and was supposed to be picked up around 4:00 PM on 01/21/25. He stated Transportation Driver #1 first loaded another resident (Resident #337) and then loaded him onto the transportation van. He stated when Transportation Driver #1 loaded him on the transportation van, he locked the wheels of his wheelchair, but instead of placing the lap belt around his body, he placed it around his wheelchair. Resident #336 stated he did not question Transportation Driver at that time because, I thought he knew what he was doing. Resident #336 continued, stating as Transportation Driver #1 proceeded on to the facility, it felt as though Transportation Driver #1 hit a bump which jarred him from his wheelchair. Resident #336 stated before he could get resituated in his wheelchair. Transportation Driver #1 hit another bump which resulted in throwing him from the wheelchair onto the floor of the van. Resident #336 reported he called out for help and Transportation Driver #1 pulled over and unsuccessfully attempted to get him back into his wheelchair. Resident #336 stated Transportation Driver #1 then proceeded to tell him that they were only about 10 minutes from the facility and that he would get him off of the floor of the van when they returned to the facility. Resident #336 stated he remained on the floor of the van for the remainder of the drive and when they arrived back at the facility, a staff member came out and helped him get back into his wheelchair. Resident #336 reported that he was not injured in the event but reported he really did not like being left on the floor of the van while it was returning to the facility and that it was not a good first-time experience being transported by the transportation company. Resident #337's admission Minimum Data Set assessment dated [DATE] revealed he was cognitively intact. An interview with Resident #337 on 02/07/25 at 3:43 PM revealed he was on the transportation van the day Resident #336 fell. Resident #337 reported that Transportation Driver #1 loaded him [Resident #337] into the transportation van first and secured his wheelchair with four straps to his wheelchair and then placed a lap and shoulder belt over his midsection. He stated since he was loaded first, he could not see how Transportation Driver #1 loaded and secured Resident #336 in the transportation van. He stated at some point during transport, he heard Resident #336 state, Help, I need help. Resident #337 reported when he heard Resident #336 call out for help, he asked Resident #336 if he was okay, and Resident #336 replied that he needed help. Resident #337 reported he could not see Resident #336 due to their placement in the van, so he relayed that message to Transportation Driver #1. Resident #337 stated Transportation Driver #1 pulled the van into a bank parking lot and checked on Resident #336 but was unable to either get Resident #336 resituated into his wheelchair or get him off of the floor, so Transportation Driver #1 got back into the driver's seat of the van and continued on to their destination. Resident #337 indicated he did not realize Resident #336 was in the floor of the van until Transportation Driver #1 got to the facility and retrieved a staff member to come out and assist him in getting Resident #336 back into his wheelchair. Resident #337 reported he did not feel any significant bumps in the road but that there were a few times where Transportation Driver #1 applied the brakes a little hard. (continued on next page)

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	345008	A. Building B. Wing	02/12/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with Transportation Driver #1 on 02/10/25 at 11:09 AM via telephone revealed he was the transportation driver for Resident #336 and Resident #337 on 01/21/25. Transportation Driver #1 reported he loaded Resident #337 onto the van first, secured his wheelchair with four straps and then placed the lap belt around Resident #337's midsection and then loaded Resident #336 onto the van and repeated the same process. He reported he was driving both residents back to the facility and when he pulled into the facility's parking lot, he was notified by Resident #337 that Resident #336 needed assistance. Transportation Driver #1 stated he stopped and went to check on Resident #336 and noted that he had started to slide out of his seat. Transportation Driver #1 reported he attempted to resituate Resident #336 back into his wheelchair but was unsuccessful. He stated he unlatched the lap belt and when he did, Resident #336 slid out of his wheelchair to the ground. Transportation Driver #1 stated Resident #336 landed on his bottom but could not recall if he was leaning to one side or the other. Transportation Driver #1 insisted that he was not aware of the issue until he was pulling into the facility's parking lot and denied pulling into any other parking lots or that Resident #336 was transported while he was on the floor. He continued, stating once he realized he could not get Resident #336 back into his wheelchair, he went and retrieved assistance from a staff member in the facility. Transportation Driver #1 reported he received in-service trainings and was tested on competencies a couple times a year and had been reminded daily to ensure that when he was transporting clients, that their wheelchairs and the clients were secured before transporting them to their destinations. Transportation Driver #1 indicated if a client were to fall during transportation, he was supposed to immediately pull over and contact his supervisor. He also stated once he retrieved assistance from a facility staff member, they were able to get Resident #336 back into his wheelchair and off of the transportation van. He reported once Resident #336 was safely back into the facility, he knew he had to contact his supervisor but noticed that his phone was dead, so he immediately left the facility so he could charge his phone and contact his supervisor. He indicated he was unaware that the facility requested him to stay and complete a written statement of the incident. Review of Transportation Driver #1's training revealed he was trained on defensive driving, along with how to secure resident's for transportation and the processes and policies in the event of an emergency. Transportation Driver #1's written statement that was received by the facility on 01/22/25 at 12:00 PM, via email, to the attention of the Administrator read, in part: I am writing to provide an account of an incident that occurred at [facility]. I arrived at the facility between 5:15 PM and 5:30 PM. As I was pulling into the driveway, [Resident #337] informed me that [Resident #336] had slid out of his wheelchair. I did not hear about or observe the incident myself but immediately inquired about [Resident #336's] condition. I then entered the facility to request assistance. The nursing staff promptly responded and assisted in helping [Resident #336] back into his wheelchair. Once [Resident #336] was safely secured in his wheelchair, the nurse wheeled him back inside. I took [Resident #337] out of the van and subsequently left to notify my manager about the situation. Unfortunately, the office was closed, and my phone battery was dead. I made haste to get home so I could inform my manager, [Transportation Administrator], of the incident as quickly as possible. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the Transportation Administrator via telephone on 02/10/25 at 11:27 AM revealed she was made aware of the incident on 01/21/25 later that evening when Transportation Driver #1 contacted her. She said he reported to her that Resident #336 had slid out of his chair during transportation. She said she could not recall if Transportation Driver #1 reported he had slid completely out of the wheelchair or if he was only partially out of the wheelchair. She stated they provide training to all of their transportation drivers including proper securement of the clients and what to do in the event a client had a fall during transport. She stated her staff were trained to secure clients by hooking up four locking straps to the client's wheelchair and then placing the lap and shoulder belt over the client. Once that was complete, she expected her employees to wiggle the wheelchair to ensure it was fully secure. She continued, stating that if a client were to fall or have an emergency during transportation, she expected them to immediately pull over somewhere safe, check on the client, contact emergency services, and then notify her of the incident. She indicated she did not know if Transportation Driver #1 contacted emergency services at the time he was made aware that Resident #336 had slid out of his wheelchair. An interview with Nurse #24 on 02/10/25 at 2:26 PM, revealed she was working on 01/21/25 and was near the lobby of the facility when Transportation Driver #1 entered the facility and stated Help, help, a resident just fell in the van. She stated she ran outside and found Resident #336 who was lying flat on his side on the floor in the back of the transportation van. She questioned Transportation Driver #1 on how Resident #336 ended up in the floor and he reported to her that when he was trying to get Resident #336 out of the van, he slid out of his wheelchair and onto the floor. She stated his left leg was slightly bent and was between the wheels of his wheelchair underneath the seat. She stated she assessed and questioned Resident #336 who stated he had fallen during transport but was not injured and that he had not hit his head. She stated he did complain of some slight discomfort in his left foot or leg when she removed the wheelchair in order to get him off of the floor. She stated once she got Resident #336 off of the floor of the van and into his wheelchair, she questioned him as she took him into the facility, and he stated he had fallen during transport and was left on the floor of the van until they arrived at the facility. She stated he also informed her that Transportation Driver #1 had placed his lap belt around his chair and not his person, which resulted in him falling. Once she spoke with Resident #336 and ensured he was comfortable in his room, she immediately reported the fall to the Administrator. She reported she went back out to get a statement from Transportation Driver #1, but he refused and got into the transportation van and left the facility. An interview with Nurse Practitioner #1 on 02/10/25 at 5:08 PM via telephone call revealed Resident #336 was taking anticoagulant medication and there was a higher risk for internal bleeding following a fall. An interview with the Director of Nursing on 02/10/25 at 3:21 PM revealed all she could remember of the incident was she was completing h[TRUNCATED]