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F 000 ✓ ok/CP	INITIAL COMMENTS Correction date: December 19, 2024 The following deficiencies resulted from the facility's Annual Recertification survey and investigation of Complaints #119225-C, #119437-C, #123747-C and Facility Reported Incident #123854-I, #124941-I, #124942-I, #124943-I, #124944-I, and #124946-I conducted November 4, 2024 to November 19, 2024. Complaint #119225-C, #119437-C, and #123747-C were substantiated. Facility Reported Incident #123854-I, #124941-I, #124942-I, #124943-I, #124944-I, and #124946-I were substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: LNHA | TITLE: Administrator | (X6) DATE: 12/20/24

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

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review, and facility policy review, the facility failed to ensure residents were treated in a manner to preserve dignity and respect for 1 of 2 residents reviewed for dignity (Resident #20) when staff failed to ensure residents had been kept clean and free from odors following episodes of incontinence in a timely manner (Resident #20), made unkind comments in the presence of residents in the dining room, and staff interview revealed concerns with a staff member being unkind. The facility reported a census of 26 residents.	F 550		

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Findings include:

1. The Quarterly Minimum Data Set (MDS), dated 10/09/24, revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicated moderate cognitive impairment. Resident #20 required substantial to maximal amount of staff assistance for toilet hygiene and frequently incontinent of urine. Diagnoses included non-traumatic brain dysfunction, non-Alzheimer's dementia, heart failure, depression, and psychotic disorder.

The Care Plan, revised on 9/27/24 revealed Resident #20 had impaired cognitive function evidenced by short and long term memory deficits, impaired decision making, and impaired ability to understand others related to a diagnosis of dementia with mood disturbance. Resident #20 at risk for impaired skin, Urinary Tract Infections, and irritation in perineal area related to incontinence of bowel and bladder. Interventions instructed staff to encourage fluids, provide prompt voiding responses, and provide perineal cares twice per day and as needed with each episode of incontinence.

Review of Resident #20's Hospice Provider Visit Notes, revealed the following documented entries:
1. On 8/26/24 during a visit from a Hospice Provider, Resident #20 found to be incontinent of large amount of urine with strong odor. Resident noted to be very lethargic and weak.
2. On 9/04/24, during a visit from a Hospice Provider, Resident #20 found laying in bed, flat on back, with lunch plate on her abdomen. Provider observed Resident #20 eating from plate with

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fingers while laying flat on back. Note indicated Hospice Provider removed food from Resident #20's hair and noted a very strong urine odor. Resident #20 assisted to bathroom and Provider saw that Resident #20 was wearing both a tabbed brief and pull up type incontinent product, and had both saturated in urine and stool incontinence.

On 11/13/24 at 10:00 AM, Nurse for Hospice stated it seemed like for a while every time they would come in to visit Resident #20, she would be saturated in urine with dirty brief on and when asked, facility staff would report Resident #20 had refused cares. Hospice Nurse reported during more recent visits, Resident #20 had been clean, and her room had been cleaner.

On 11/13/24 at 12:03 PM, Social Worker for Hospice reported during a recent visit, Resident #20 found laying in bed at approximately 9:00 AM, with gown falling off, and appeared as if morning cares had not yet been completed as resident had not been dressed for the day. Social Worker informed this was reported to facility staff who then assisted Resident #20 with cares.
2. A dining observation conducted 11/5/24 revealed the following:

On 11/5/24 at 11:24 AM during a dining observation with residents present in the dining room, Staff C, Certified Nursing Assistant (CNA) heard to say the following to a resident: Slow down, look at all that food in your mouth. When something dropped to the floor, Staff C stated, Every day. Staff C also heard to say the following during a dining observation: It's not a race...smaller bites.

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F 550	Continued From page 4 On 11/19/24 at 2:37 PM during an interview with the facility Administrator about the above observation, the Administrator explained it would depend on the tone and how was said. Per the Administrator, sometimes became more like buddies than caretakers, and not malicious, and described as banter. 3. On 11/18/24 at 11:31 a.m., via phone, Staff K Certified Nursing Assistant(CNA) stated Staff C CNA could be kinder with her demeanor and a little more compassionate. On 11/19/24 at 11:59 p.m. via phone, the Director of Nursing(DON) of a sister facility stated staff should treat residents as they would treat their own mothers and fathers. They should be kind and compassionate. The facility policy "Resident Rights", revised January 2019, directed employees to treat all residents with kindness, respect, and dignity.	F 550		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		

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§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure consistent documentation of code status to indicate whether to perform Cardiopulmonary Resuscitation (CPR) or Do Not Resuscitate (DNR) status for one of three residents reviewed for advanced directives (Resident #22). The facility reported a census of 26 residents.

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Findings include:

Review of the Minimum Data Set (MDS) assessment for Resident #22 dated 9/18/24 revealed the resident scored 00 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition.

Review of the Resident's Care Plan did not address the resident's code status.

On 11/5/24, review of Resident #22's chart revealed an Iowa Physician Orders for Scope of Treatment (IPOST) form dated 6/19/24 which directed CPR/Attempt Resuscitation. The resident was noted to have a DNR order in the resident's electronic orders.

Review of the Physician Order dated 10/15/24 revealed, DNR (DO NOT RESUSCITATE).

On 11/5/24 at 10:14 AM, Staff B, Licensed Practical Nurse (LPN) showed the resident's IPOST in the resident's paper chart. Staff B explained, oh wait, that's not right. Per Staff B, the resident went DNR after hospice services. The IPOST in the resident's chart observed to be dated 6/19/24. Staff B further explained she (Staff B) was present when the resident admitted to hospice, and looked in the hospice book and acknowledged did not see one in there. When queried where Staff B's go to spot would be to see code status, Staff B explained the computer.

Review of the resident's Hospice IDG Comprehensive Assessment and Plan of Care Update Report revealed the resident started hospice services on 9/19/24, with IDG meeting held 10/1/24. Hospice Paperwork for Resident

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#22 revealed, Do Not Resuscitate Comfort Measures Only.

On 11/6/24 at 9:57 AM, observation of the first page of the resident's paper chart revealed an IPOST for Resident #22 dated 6/19/24 with CPR/Attempt Resuscitation selected.

On 11/06/24 at 3:10 PM, the Director of Nursing (DON) explained she would reach out to hospice.

On 11/13/24 at 12:40 PM, review of the first page of the resident's paper chart revealed an IPOST for CPR/Attempt Resuscitation.

On 11/13/24 at 3:16 PM, the DON explained had a verbal order in in the hospice chart DNR. The DON explained if something happened now, would be stuck with CPR, and would need to call [Family] right away to tell [facility] to stop. Per the DON, hospice said had a verbal order mailed for allow natural death to family, and were waiting on wet signature. Per the DON, facility waiting to see who signed and got back to the building first to have the most up to date one.

Observation on 11/14/24 at 11:58 AM revealed [Resident #22] in tilted back broda chair in the common area/television area.

On 11/19/24 at 2:41 AM during an interview with the facility's Administrator, the Administrator explained as collaboration with the company and hospice, should be resolved, and was a very important component.

Review of the Facility Policy titled Emergency Procedure-Cardiopulmonary Resuscitation dated 2001, revised 1/19, revealed the following: 6. If a

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F 578	Continued From page 8 resident's DNR status is unclear, CPR will be initiated until it is determined that there is a DNR or a physician's order not to administer CPR.	F 578		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State	F 583		

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law.
This REQUIREMENT is not met as evidenced by:
Based on observation, facility policy, and clinical record review, the facility failed to safeguard the resident ' s personal and medical information. The facility reported a census of 26 residents.

Findings Include:

On 11/06/24 between 08:23a.m. -8:26 a.m., State Agency (SA) observed the computer left on and no one at the nurses desk with the point click care system (electronic charting software) open to document on residents and several names displayed.

On 11/06/24 between 09:22 a.m. -11/06/24 09:31 a.m. when the computer timed out, the point click care (PCC) was open with several residents ' names displayed and no one sitting at desk.

On 11/06/24 at 12:54 p.m., PCC system was open on a resident ' s chart and no one was sitting at the desk.

On 11/06/24 at 02:25 p.m., Staff D, LPN walked away and left the resident chart open. Staff D, LPN Went to grab something in a different room and came back to the computer.

Resident Rights Policy Statement with revised date of January 2019, directed staff as follows; The unauthorized release, access, or disclosure of resident information is prohibited. All release, access, or disclosure of resident information must be in accordance with current laws governing privacy of information issues. All inquiries concerning the release of resident information

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F 583	Continued From page 10 should be directed to the Health Insurance Portability and Accountability Act (HIPAA) Compliance Officer. .	F 583		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from sexual abuse for two of twelve residents reviewed for abuse (Resident #12, Resident #19). Resident #12, was a severely cognitively impaired resident with a previous history of unsolicited sexual touching. On 10/26/24, Resident #12, was touched on the breast underneath her clothing by Resident #19. On an unknown date, Resident #19 touched Resident #12 on the buttock. On an unknown date, staff reported Resident #19 grabbed/groped Resident #12. Resident #12's family explicitly	F 600		

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instructed the facility staff that they did not consent to Resident #12 engaging in sexual contact with another resident. This deficient practice resulted in an Immediate Jeopardy (IJ) to the health and safety of residents.

The facility failed to protect the resident's right to be free from resident to resident physical abuse for 5 of 15 residents reviewed for abuse(Residents #11, #12, #13, #21, #77). Resident #22 hit Resident #77, grabbed and scratched Resident #12, slapped Resident #11, slapped and pinched Resident #13, and grabbed the arm of Resident #2.

The IJ was determined on 11/14/24 at 1:57 PM. The IJ began on 10/26/24. The IJ immediacy was removed on 11/18/24 at 12:27 PM. The Facility Staff removed the Immediate Jeopardy on 11/18/24 through the following actions:

a. Care Plan revision for Resident #12 and Resident #19.
b. All staff education about abuse.
c. An ad-hoc Quality Assurance Performance Improvement (QAPI) meeting completed 11/14/24.

The scope lowered from "K" to "E" at the time of the survey after ensuring the facility implemented education and their policy and procedure.

Findings include:

1. Review of the Quarterly Minimum Data Set (MDS) assessment for Resident #12 dated 9/13/24 revealed the resident scored 5 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired

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cognition. Per this assessment, the resident cognitive patterns were documented as inattention which fluctuated and had behaviors described as having delusions.

Review of Medical Diagnoses for Resident #12 included Wernicke's encephalopathy, dementia with psychotic disorder, dementia with mood disturbance, restlessness and agitation, and delusional disorders.

Review of Resident #12's Care Plan dated 7/5/23 revealed the following: Trauma Informed Care: [Resident #12] is at risk for alterations in my psycho-social well being related to: Allegation of abuse. History of being recipient of unsolicited sexual touching.

Review of Resident #12's Care Plan dated 7/7/24 revealed, [Resident #12] has a Mutual friendship with a resident of the opposite sex. Interventions per the Care Plan included the following:

a. (Created 7/7/24, revised 9/10/24): Do not shame or embarrass [Resident #12] for her friendship.
b. (Created 7/7/24, revised 9/10/24): If [Resident #12's] friendship escalates beyond hugging/hand holding/sitting together, please redirect in a calm manner and we will re-assess the plan with staff, family and medical advice.
c. (Created 7/7/24, revised 9/10/24): Mild affection (hugging/hand holding/sitting together) is acceptable for both families.
d. (Created 10/28/24): Per POA: hand holding, sitting together, resident sitting on other male resident's lap, and a gentle kiss on the lips is within her scope for approval of behavior. Please separate residents if behaviors become more

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sexual in nature such as touching of one another's private areas
e. (Created 7/7/24, revised 9/10/24): Report interactions as needed to Charge Nurse.
f. (Created 7/7/24, revised 9/10/24): This friendship is acceptable if [Resident #12] is safe and happy.

Review of Progress Notes for Resident #12 revealed the following:

The Nursing Note dated 7/4/24 at 6:10 PM revealed, [Name Redacted] POA (Power of Attorney) aware of this resident engaging in activities of hand holding, hugging et (and) sitting together with another male resd (resident), POA consents to above activity continuing in public settings, not behind closed doors.

Review of the Care Conference note dated 9/3/24 at 3:10 PM revealed, in part, [Resident #12] is declining in mental status. She is becoming increasingly confused and aggressive with cares. [Resident #12] is no longer able to take her medications whole, as she pockets them, or becomes confused by what to do with them and puts them in cups, bowls, or anywhere that she no longer can see them...[Resident #12] is increasingly confused. She is sleeping more and spending a significant amount of time in her room. She no longer sits in the common area or with the cat.

The Nursing Note dated 10/26/24 at 5:56 PM revealed, CNA (Certified Nursing Assistant) reports to this nurse that at around 1555 (3:55 PM) a male resd reached up this resd (resident) shirt et groped her lt (left) breast while she was standing next to him. These 2 resd are care

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planned to have a friendly relationship that involve holding hands et hugging. This nurse witnessed female resd approach male resd seated in lobby, they proceeded to hold hands before this nurse had left to attend another resd. CNA separated the 2 resd. CNA reports that resd was asking where male resd went? CNA redirected et kept them apart. When female resd asked by this nurse if the male resd had touched her breast she states "No." Administrator made aware. Called x 2 numbers for POA (Power of Attorney) with no answer et (and) left message.

Review of a Nursing Note dated 10/28/24 at 8:04 AM revealed, Spoke with POA [name redacted] regarding potential incident from 10/26 where male friend may have touched resident's breasts. [POA name redacted] verbalizes that hand holding, sitting together, resident sitting on other male resident's lap, and a gentle kiss on the lips is within her scope for approval of behavior. She states to please separate residents if behaviors become more sexual in nature such as touching of one another's private areas. Care plan updated.

On 11/13/24 at 12:06 PM, Resident #12 observed in her room in bed.

On 11/18/24 at 2:10 PM, Resident #12 observed standing up by the nurses station near the lobby area of the facility.

2. Review of the Minimum Data Set (MDS) assessment for Resident #19 dated 10/9/24 revealed Resident #19 scored 14 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition.

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Review of diagnoses for Resident #19 included schizophrenia and dementia with anxiety.

Review of Resident #19's Care Plan dated 7/4/24 and revised 7/5/24 revealed, [Resident #19] has a Mutual friendship with a resident of the opposite sex. Interventions per Resident #19's Care Plan included the following:

a. (Initiated 7/5/24, Revised 9/10/24): Do not shame or embarrass [Resident #19] regarding this relationship.
b. (Initiated 7/5/24, Revised 9/10/24): If [Resident #19's] friendship escalates beyond hugging/hand holding/sitting together, please redirect in a calm manner and we will reassess the plan with staff, family and medical advice.
c. (Initiated 7/5/24, Revised 9/10/24): Mild affection (hugging/hand holding/sitting together) is acceptable for both families.
d. (Initiated 10/28/24): POA (Power of Attorney) [Name Redacted] verbalizes that hand holding, sitting together, female resident sitting this resident's lap, and a gentle kiss on the lips is within his scope for approval of behavior. He states to please separate residents if behaviors become more sexual in nature such as touching of one another's private areas. [POA name redacted] also requests to be made aware if resident's behaviors with female friend appear to become inappropriate and not reciprocated.
e. (Initiated 7/5/24, Revised 9/10/24): Report interactions as needed to Charge Nurse.
f. (Initiated 7/5/24, Revised 9/10/24): This friendship is acceptable as long as [Resident #19] is safe and happy

Review of Progress Notes for Resident #19 revealed:

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The Communication-with Family/NOK/POA dated 7/4/24 at 6:07 PM revealed, [Name Redacted] POA aware of this resident engaging in activities of holding hands, hugging et sitting together with another female resd, POA consents to above activity continuing in public settings, not behind closed doors.

The Nursing Note dated 10/26/24 at 5:43 PM revealed, CNA reports to this nurse that at around 1555 (3:55 pm) this resident (resd) reached up a female resd shirt and groped her breast while she was standing next to him. These 2 resd are care planned to have a friendly relationship that involve holding hands et hugging. This nurse witnessed female resd approach male resd seated in lobby, they proceeded to hold hands before this nurse had left to attend another resd. No other resd in lobby witnessed event when asked. [Resident #19] was confronted and asked if anything happened when female resd approached him? resd states "No." when asked if they were holding hands? He states "yeah we were holding hands." Resd was asked if he touched female resd anywhere else? states "her back side a little." Resd asked if he reached up female resd shirt? States "no." Administrator made aware. POA [POA Name Redacted] made aware.

The Nursing Note dated 10/28/24 at 8:12 AM revealed, Spoke with POA [Name Redacted] regarding potential incident from 10/26 where resident may have touched female friend resident's breasts. [Name Redacted] verbalizes that hand holding, sitting together, female resident sitting this resident's lap, and a gentle kiss on the lips is within his scope for approval of

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behavior. He states to please separate residents if behaviors become more sexual in nature such as touching of one another's private areas. [Name Redacted] also requests to be made aware if resident's behaviors with female friend appear to become inappropriate and not reciprocated. Care plan updated.

The Behavior Note dated 11/1/24 at 2:22 PM revealed, Resd inappropriately touched activity director, when confronted that it is not appropriate to touch staff like that, resd becomes upset, made rude comment regarding situation to activity assistant er ignored activity director.

On 11/6/24 at 9:23 AM, Incident Reports for Resident #19 for the last six months requested via email to the facility's Administrator and Director of Nursing (DON). The Incident Report received did not address any interactions between Resident #12 and Resident #19.

On 11/6/24 at 1:12 PM, Staff B, Licensed Practical Nurse (LPN) queried if had any residents who were boyfriend and girlfriend. Staff B responded they said that Resident #12 and Resident #19 were allowed to touch, kiss, and said I'm not really sure. Per Staff B, she had not seen them touch each other or speak word to each other. When queried how to know what was appropriate, Staff B responded she believed the POA said ok to do those things for both of those two.

On 11/12/24 at 11:47 AM during an interview with Staff E, Registered Nurse (RN), Staff E explained Resident #12 and Resident #19 were not a couple, and were friends. Per Staff E, up until recently the residents had no notice of each

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other. Resident #19 started talking to Resident #12, and Resident #12 talking, not daily. Staff E explained they would hold hands, nothing had happened, and Staff E didn't think Resident #12 would let it as Resident #12 was very prim and proper. Per Staff E, one day she was working second or day shift, and Resident #19 went down to Resident #12's room. Staff E responded to situation, and Resident 19 exited. When queried if ever heard of touching over or under clothes, Staff E responded no.

On 11/12/24 at 2:27 PM, Staff D, Licensed Practical Nurse (LPN) explained the following about Resident #12 and Resident #19: Per Staff D, she (Staff D) was the one that brought to the DON's attention, ok with family, because kept on doing stuff holding hands, hugging. Per Staff D, had gotten approval from family that ok for friendly relationship, peck on the lips, sit with each other, hold hands, and nothing behind closed doors. Staff D explained Resident #12 would seek Resident #19 out, and Resident #19 calmed Resident #12 down. Staff D explained an aide said he saw Resident #19 reach up Resident #12's shirt. Staff D further explained the aide did not want them (residents) to be together because the aide thought Resident #12 could not make decisions for herself. The aide was identified as Staff H. When queried if Resident #12 had ever had a negative reaction, Staff D responded no. Per Staff D, she had never seen Resident #19 pursue Resident #12, and when she saw, Resident#12 went to Resident #19.

On 11/13/24 at 12:22 PM, Staff H, Certified Nursing Assistant (CNA) explained the following about Resident #12 and Resident #19: Staff H explained they had seen interactions between

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Resident #12 and Resident #19 on two or three different times, and Resident #19 had inappropriately touched Resident #12 in some way. Per Staff H, Resident #12 stood there not doing anything, Resident #12 would bring herself to Resident #19, and needed to separate constantly and redirect to keep them away from each other. Staff H further explained they thought only one time Resident #19 grabbed Resident #12's breast, and they thought occurred the weekend of October 26/27. Per Staff H, another time Resident #19 grabbed Resident #12's butt. A third time, Staff H did not remember if Resident #19 grabbed or "groped", Resident #19 did touch Resident #12 and Staff H did not remember how. Staff H provided the following details about when Resident #12's incident with breast touching: Staff H explained the grabbing of Resident #12's breast was under the clothes with full arm up

When queried how Staff H knew what interactions were appropriate, Staff H explained they did not need a degree to see inappropriate anywhere. Staff H explained don't need to be grabbed/groped. Staff H explained they reported all of them (incidents) to staff at facility. When queried which staff Staff H talked to, Staff H responded the Director of Nursing (DON) one time, then talked to the floor nurses every time. Staff H further explained Resident #12 would just stand there and let Resident #19 do everything. When queried if Resident #12 said anything when it was happening, Staff H responded no.

On 11/13/24 at 1:07 PM, Staff G, RN queried about any interactions between Resident #12 and Resident #19, responded yes, explained the DON said was ok, and Staff G thought inappropriate. Staff G explained Resident #12 sat on Resident

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#19's lap right in the middle of the day hall with all the residents there. Staff G explained she (Staff G) thought probably not good idea related to behaviors, and if approved by family, ok she supposed. Staff G explained the DON said had it approved by families could see each other. Staff G explained Resident #12 was not really "with it". Per Staff G, it wasn't like sitting beside him (Resident #19) holding hands, was sitting on his (Resident #19's) lap. Staff G further explained she had told CNAs (Certified Nursing Assistants) why don't let divert these two, and got their attention somewhere else, which was easy to do.

On 11/14/24 at 1:56 PM, the Administrator responded Resident #19 and Resident #12 were friends, the Administrator explained had heard holding hands came to light. The Administrator acknowledged not aware of touching of the resident's breast and butt. Per the Administrator, if unaware of touching of the resident's breast, then could not report.

On 11/18/24 at 9:03 AM, Staff I, CNA queried about how Resident #12 and Resident #19 interacted. Staff I explained, part, Resident #12 was very sweet, and Staff I explained Resident #19 would take advantage of someone who's medicated. When queried what Staff I meant by take advantage, Staff I responded, like touch, explained I'm sitting beside you where would my hands go, and further explained I'm your friend can we take a walk. Staff I explained she got that feeling, and didn't think Resident #19 would do anything sexual but touching.

When queried about touching between Resident #12 and Resident #19, Staff I responded holding hands walking down the hall, further explained

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she had seen them walk to breakfast, and Resident #19 would walk Resident #12 into the breakfast room. When queried about Resident #12's cognition, Staff I responded 50/50, and explained the resident had insomnia and was sometimes up at night. Per Staff I, Resident #12 wondered where her parents were, and would say here for memory not so good, then would flash back, and thought in [Another State Redacted] at times.

On 11/18/24 at 10:39 AM, Staff J, CNA queried about Resident #12 and Resident #19. Per Staff J, Resident #19 a very independent guy and did not like getting too much in his space. Staff J described Resident #19's interactions with Resident #12 as normal, and Staff J further explained she felt like Resident #12 got confused when she (Resident #12) looked at Resident #19. Per Staff J, there were times when Resident #12 looked and asked to sit on Resident #19's lap, and Resident #19 said no. Staff J denied seeing any physical interactions between the residents, and said no, he's (Resident #19's) really with it. Per Staff J, Resident #19 had respect for Resident #12 and other residents.

When queried about Resident #12's cognition, Staff J explained Resident #12 was anxious, loved to pace up and down the halls, and loved to sleep. Per Staff J, around the afternoon Resident #12 would start pacing back and forth, would get really anxious, and did not stop walking. Staff J explained Resident #12 had a hard time breathing because resident walked back and forth, which was usually a 4 hour thing or all night thing, and during the day resident slept all day. Staff J explained this was normal for the resident.

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On 11/19/24 at 10:43 AM, the Activities Director/Social Worker (SW) queried regarding consent process, and queried regarding Resident #12 and Resident #19. The Activities Director/SW explained she came to work one day and was told about consent (for Resident #12), the Activities Director/SW did not actually get a verbal from Resident #12's Power of Attorney (POA), and the Activities Director/SW was told POA was called and consent obtained to hold hands, talk, to sit on his lap, nothing else. The Activities Director/SW explained this was communicated via the facility's Director of Nursing (DON). When queried about a documented assessment for Resident #12 regarding consent to sexual activity, the Activity Director/SW explained she did a recent BIMS, resident scored a 6, and other than that no.

When queried about consent regarding Resident #19, the Activities Director/SW explained it was all told to her (Activities Director/SW) on that same day. When queried about the facility's process for obtaining consent, the Activities Director/SW responded she was told as long as no touching of private areas it was ok, and it was residents rights. Per the Activities Director/SW, she felt had rights to hold hands, and nothing more than that. When queried if any staff had come to her with concerns, the Activities Director/SW denied, explained she even witnessed them talking to each other, and other than that nothing sexual going on.

Per the Activities Director/SW, there was an allegation that transpired that the DON mentioned when in morning meeting, which was when the DON told Activities Director/SW she had gotten consent from Resident #12's POA and had talked

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to Resident #19 about not doing anything inappropriate. When queried what the allegation entailed, the Activities Director/SW explained was about him putting his hand in her shirt. The Activities Director/SW explained there was an incident a couple weeks ago that Resident #19 did to the Activities Director/SW which she documented and talked to Resident#19 that inappropriate. The Activities Director/SW explained Resident #19 had grabbed the Activities Director/SW's butt.

On 11/19/24 at 2:43 PM when queried if there was a process of whether or not resident able to give consent on the resident level, the facility's Administrator shook her head. Per the Administrator, went by the BIMS score, and the POA and see what consent they give. The Administrator further explained a situation where maybe the POA would say resident in their own mind and could make their own decisions, and the POA may be able to make consent for the resident to make their own decisions.

Review of the Facility Policy titled Abuse Policy, undated, revealed the following: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart...Sexual abuse is defined as non-consensual sexual contact of any type with a resident, including sexual harassment, sexual coercion or sexual assault.

On 11/4/24 at 11:26 a.m., Resident #19 sat in a chair in the main dining room and ate lunch. The State Agency(SA) made multiple attempts throughout the survey to speak with him with no

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success.

3. The Minimum Data Set(MDS) assessment tool, dated 6/21/24, listed diagnoses for Resident #22 which included diabetes, arthritis, and hip fracture. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 1 out of 15, indicating severely impaired cognition. The MDS stated the resident had the following:
a. physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) which occurred 1-3 days out of the 7 day review period.
b. verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) which occurred 4-6 days out of the 7 day review period.
c. other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) which occurred 1-3 days out of the 7 day review period.

A 6/21/24 Care Plan entry directed staff to intervene as necessary to protect the rights and safety of the other residents, divert attention, remove from the situation/location if needed, and approach/speak in a calm manner.

An 8/22/24 Care Plan entry directed staff to redirect the resident when she became notably agitated and to monitor her when she was around others.

An 8/26/24 Care Plan intervention directed staff

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to monitor the resident when she was in the hallways to ensure safe interactions with other residents. The entry directed staff to remove her from other residents and intervene when she headed toward other residents.

An 8/28/24 Care Plan entry stated the physician made medication changes as an intervention to behaviors and resident to resident interactions.

A 9/30/24 Care Plan entry directed staff to place the resident in an area where not within an arm's length of other residents.

A Care Plan entry, revised 10/21/24, stated the resident had episodes of behaviors/potential for behaviors as evidenced by combativeness, negative verbalizations, name calling, screaming out, throwing things at staff, cursing at staff and other residents, stabbing the dining table with a fork, scratching staff, cussing at staff and other residents, flipping staff off with middle finger, yelling, as well as other aggressive behaviors.
The resident had the following incidents:
On 8/22/24, the resident hit another resident.
On 8/26/24, the resident grabbed and scratched another resident.
On 9/6/24, the resident slapped another resident.
On 9/30/24, the resident slapped and pinched another resident while she called them names.
On 10/20/24, the resident grabbed the arm of another resident.

a. Resident #22 and Resident #77

The MDS assessment tool, dated 7/10/24, listed diagnoses for Resident #77 which included diabetes, non-Alzheimer's dementia, and chronic pain. The MDS listed his BIMS score as 0 out of

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15, indicating severely impaired cognition.

An 8/22/24 Resident to Resident Altercation report stated the resident approached another resident who sat in the lobby area watching TV and hit him in the head.

An 8/22/24 Nursing Note stated Resident #77 sat in the TV room and Resident #22 walked over to him, began talking, and hit him on the head several times. The CNA intervened and took Resident #22 to her room to lie down.

b. Resident #22 and Resident #12

The MDS assessment tool, dated 6/13/24, listed diagnosis for Resident #12 which included arthritis, Alzheimer's, and non-Alzheimer's dementia. The MDS listed the resident's BIMS score as 5 out of 15, indicating severely impaired cognition.

An 8/26/24 Resident to Resident Altercation report stated the Resident #22 had a hold of another resident's bilateral(referring to both sides) arms and scratched the resident.

An 8/26/24 Progress Note stated another resident grabbed and scratched Resident #12's arms.

c. Resident #22 and Resident #11

The MDS assessment tool, dated 8/28/24, listed diagnoses for Resident #11 which included non-Alzheimer's dementia, anxiety, and psychotic disorder. The MDS listed a BIMS score of 0 out of 15, indicating severely impaired cognition.

A 9/6/24 Resident to Resident Altercation report

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stated a female resident told Resident #22 to "shut up" and Resident #22 slapped the female resident across the face to the left cheek.

A 9/6/24 Nursing Note stated Resident #11 told another resident to "shut up" and the other resident slapped Resident #11. Staff separated the residents.

d. Resident #22 and Resident #13

The MDS assessment tool, dated 8/21/24, listed diagnoses for Resident #13 which included non-Alzheimer's dementia, depression, and psychotic disorder. The MDS listed the resident's BIMS score as 4 out of 15, indicating severely impaired cognition.

A 9/30/24 Physical Aggression Initiated report hit and pinched another resident. The other resident also hit Resident #22.

A 9/30/24 Nursing Note stated the resident sat in the lobby next to another resident and started hitting and pinching her. The other resident also hit and pinched.

e. Resident #22 and Resident #21

The MDS assessment tool, dated 9/13/24, listed diagnoses for Resident #21 which included diabetes, Parkinson's(a disease which causes tremors), and depression. The MDS listed the resident's BIMS score of 0 out of 15, indicating severely impaired cognition.

A 10/20/24 Verbal Aggression Received report stated another resident yelled at Resident #22 and Resident #22 carried out a light grasp of the

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right upper arm(of the other resident).

A 10/20/24 Incident Note stated a resident grabbed Resident #21's arm when Resident #21 asked her not to tap the couch.

On 11/7/24 at 2:04 p.m., the Administrator stated she wanted residents treated with respect,compassion and kindness.

On 11/13/24 at 8:38 a.m., Staff D Licensed Practical Nurse(LPN) stated Resident #22 was banging on the couch and Resident #21 yelled at her to stop. She stated Resident #22 reached over and took Resident #21's arm. She stated Resident #22 could be pretty rough but Resident #21 did not scream out. She stated Resident #22 "will snap". She stated she assumed the facility reported the altercation.

On 11/18/24 at 8:44 a.m., via phone, Staff I Certified Nursing Assistant(CNA) stated Resident #22 did act out against other residents. She stated if she thought people were in her bubble, she would point her finger at them, cuss at them, and sometimes she slapped them. She stated they kept an eye on her but there were not enough staff to monitor her and they were busy. She stated when she worked there were only 2 people on staff and this was not enough.

On 11/19/24 at 11:59 a.m. via phone, the Director of Nursing(DON) of a sister facility stated with regard to a resident with a history of resident to resident physical altercations, she would not sit that person near residents where she could reach them. Staff should carry out checks and monitoring.

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F 600	Continued From page 29 On 11/19/24 at 1:57 p.m., the Administrator stated Resident #22 was spontaneous. She stated it could get congested(in the TV area) and they needed to come up with a better plan because the residents were too close together. She stated they needed to educate staff so they were more aware of what was best to keep everyone safe. The undated facility "Abuse Policy" stated the resident had the right to be free from abuse which would include physical and sexual abuse.	F 600		
F 609 SS=K	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported 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, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 609		

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accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and facility policy review, the facility failed to ensure all allegations of abuse including allegations of staff to resident rough treatment resulting in fear, resident to resident physical altercations, injuries of unknown origin, and inappropriate touching of a resident's breast and buttocks by another resident, were reported timely to the facility administration for ten of twelve residents reviewed for abuse (Resident #7, Resident #11, Resident #12, Resident #13, Resident #15, Resident #16, Resident #19, Resident #20, Resident #21, Resident #22). This failure resulted in Immediate Jeopardy to the health, safety, and security of the resident. The facility reported a census of 26 residents.

The State Agency informed the facility of the Immediate Jeopardy (IJ) on 11/14/24 at 1:57 PM. The IJ began on 9/26/24. Facility staff removed the Immediate Jeopardy on 11/18/24 at 12:28 PM by implementing the following actions:
1. All residents interviewed on 11/14/24, with no further allegations of abuse or neglect identified.
2. All staff interviewed on 11/14/24, with 4 allegations reported to State Agency and initiated investigations. Any associated staff suspended, pending investigation.
3. Facility provided all staff education on abuse, immediate separation, and reporting of any abuse immediately to the Facility Administrator. Education completed by end of the day 11/14/24

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or prior to working next shift.
4. An ad hoc Quality Assurance and Performance Improvement (QAPI) meeting conducted on 11/14/24, to review policy on abuse, immediate separation, reporting of abuse, and completing thorough investigation.

The scope lowered from "K" to "E" at the time of the survey after ensuring the facility implemented education and their policy and procedure.

Findings Include:

1. The Minimum Data Set (MDS), dated 10/09/24, revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicated moderate cognitive impairment. MDS revealed Resident #20 had delusions, verbal and physical behaviors, and rejection of cares. Resident #20 had impairment of bilateral lower extremities, utilized a wheelchair for mobility, and required substantial to maximal amount of staff assistance to transfer. Diagnoses included non-traumatic brain dysfunction, non-Alzheimer's dementia, heart failure, depression, and psychotic disorder.

The Care Plan, revised on 9/27/24 revealed Resident #20 had impaired cognitive function evidenced by short and long term memory deficits, impaired decision making, and impaired ability to understand others related to a diagnosis of dementia with mood disturbance. The Care Plan identified a risk for chronic pain and revealed Resident #20 had displaced comminuted fracture of the left humeral neck and greater tuberosity with soft tissue swelling on 9/26/24. Intervention instructed staff to apply left shoulder immobilizer as ordered and as tolerated

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by resident, for comfort.

A Nursing Progress Note, dated 9/25/24 at 5:53 AM, revealed Resident #20 was found to have swelling and slight bruising on left shoulder spread down arm to the elbow, resident unable to move arm. Note informed that nurse reported Resident #20's condition to an on call Provider and received orders to send resident to the hospital for an evaluation. On 9/25/24 at 8:18 AM, a Nursing Note revealed that Resident #20's Hospice Provider notified the Hospital of resident and family wishes for no treatment and resident sent back to the facility. On 9/25/24 at 8:50 AM, Note informed that Resident #20 had returned to facility with pain rated 8 on a scale of 1 to 10, and charted left arm appeared purple and black around the entire upper arm. At 10:00 AM, facility received an order from Provider for portable x-ray, 2 views, of left shoulder.

An x-ray report, dated 9/26/24, revealed findings of displaced comminuted fracture of the left humeral neck and greater tuberosity with soft tissue swelling.

Incident Report for injury of unknown cause, completed on 9/26/24 by Director of Nursing (DON). The Report description of incident revealed Resident #20 found by Certified Nursing Assistant (CNA) with pain to left shoulder, Nurse assessed resident, observed bruising and abnormal range of motion. Incident Report identified an injury located on the front of left shoulder, unable to identify injury type, and immediate action had been to send Resident #20 to Emergency Room (ER).

Review of the facility's submitted list of self

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reported incidents revealed a report had been submitted on 9/26/24 at 3:22 PM to the State Agency, which listed the incident date as 9/25/24 and incident type as accident with major injury.

Review of the facility's 5 day investigation summary for self-reported incident revealed an investigation was completed for an unwitnessed incident and informed that an incident occurred on 9/25/24 at approximately 2:15 PM.

On 11/19/24 at 12:30 PM, Director of Nursing for sister facility, provided assistance with State Survey, revealed the expectation for an injury of unknown origin to be automatically turned in to State Agency and investigated as potential abuse. Sister facility DON revealed that the investigation would include a root cause analysis, interviews with staff and residents, to try and figure out what happened.

On 11/19/24 at 2:06 PM, Facility Administrator revealed that Resident #20's injury of unknown origin had been reported to the State Agency after notification had been received from DON that resident had a left shoulder fracture.
2. Review of the MDS assessment for Resident #19 dated 10/9/24 revealed the resident scored 14 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition.

The Care Plan for Resident #19 revised 7/13/23 revealed, [Resident #19] has a behavioral management program due to his hx (history) of aggressive behavior towards other residents.

Review of Resident #19's Care Plan dated 7/4/24 and revised 7/5/24 revealed, [Resident #19] has a Mutual friendship with a resident of the opposite

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sex. Interventions per Resident #19's Care Plan included the following:

a. (Initiated 7/5/24, Revised 9/10/24): Do not shame or embarrass [Resident #19] regarding this relationship.
b. (Initiated 7/5/24, Revised 9/10/24): If [Resident #19's] friendship escalates beyond hugging/hand holding/sitting together, please redirect in a calm manner and we will reassess the plan with staff, family and medical advice.
c. (Initiated 7/5/24, Revised 9/10/24): Mild affection (hugging/hand holding/sitting together) is acceptable for both families.
d. (Initiated 10/28/24): POA (Power of Attorney) [Name Redacted] verbalizes that hand holding, sitting together, female resident sitting this resident's lap, and a gentle kiss on the lips is within his scope for approval of behavior. He states to please separate residents if behaviors become more sexual in nature such as touching of one another's private areas. [POA name redacted] also requests to be made aware if resident's behaviors with female friend appear to become inappropriate and not reciprocated.
e. (Initiated 7/5/24, Revised 9/10/24): Report interactions as needed to Charge Nurse.
f. (Initiated 7/5/24, Revised 9/10/24): This friendship is acceptable as long as [Resident #19] is safe and happy

On 11/18/24 at 2:10 PM, Resident #19 observed standing up by the nursing station.

a. Resident #12 and Resident #19:

Review of the Minimum Data Set (MDS) assessment for Resident #12 dated 9/13/24 revealed the resident scored 5 out of 15 on a

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Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Per this assessment, the resident inattention which fluctuated and delusions.

Review of Medical Diagnoses for Resident #12 included Wernicke's encephalopathy, dementia with psychotic disorder, dementia with mood disturbance, restlessness and agitation, and delusional disorders.

Review of Resident #12's Care Plan dated 7/7/24 revealed, [Resident #12] has a Mutual friendship with a resident of the opposite sex. Interventions per the Care Plan included the following:

a. (Created 7/7/24, revised 9/10/24): Do not shame or embarrass [Resident #12] for her friendship.
b. (Created 7/7/24, revised 9/10/24): If [Resident #12's] friendship escalates beyond hugging/hand holding/sitting together, please redirect in a calm manner and we will re-assess the plan with staff, family and medical advice.
c. (Created 7/7/24, revised 9/10/24): Mild affection (hugging/hand holding/sitting together) is acceptable for both families.
d. (Created 10/28/24): Per POA: hand holding, sitting together, resident sitting on other male resident's lap, and a gentle kiss on the lips is within her scope for approval of behavior. Please separate residents if behaviors become more sexual in nature such as touching of one another's private areas
e. (Created 7/7/24, revised 9/10/24): Report interactions as needed to Charge Nurse.
f. (Created 7/7/24, revised 9/10/24): This friendship is acceptable if [Resident #12] is safe and happy.

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The Nursing Note for Resident #12 dated 10/26/24 at 5:56 PM revealed, CNA (Certified Nursing Assistant) reports to this nurse that at around 1555 (3:55 PM) a male resd reached up this resd (resident) shirt et groped her lt (left) breast while she was standing next to him. These 2 resd are care planned to have a friendly relationship that involve holding hands et hugging. This nurse witnessed female resd approach male resd seated in lobby, they proceeded to hold hands before this nurse had left to attend another resd. CNA separated the 2 resd. CNA reports that resd was asking where male resd went? CNA redirected et kept them apart. When female resd asked by this nurse if the male resd had touched her breast she states "No." Administrator made aware. Called x2 numbers for POA (Power of Attorney) with no answer et (and) left message.

The Nursing Note for Resident #19 dated 10/26/24 at 5:43 PM revealed, CNA reports to this nurse that at around 1555 (3:55 pm) this resd reached up a female resd shirt et groped her lt breast while she was standing next to him. These 2 resd are care planned to have a friendly relationship that involve holding hands et hugging. This nurse witnessed female resd approach male resd seated in lobby, they proceeded to hold hands before this nurse had left to attend another resd. No other resd in lobby witnessed event when asked. [Resident #19] was confronted and asked if anything happened when female resd approached him? resd states "No." when asked if they were holding hands? He states "yeah we were holding hands." Resd was asked if he touched female resd anywhere else? states "her back side a little." Resd asked if he

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reached up female resd shirt?States "no." Administrator made aware. POA [POA Name Redacted] made aware.

On 11/13/24 at 12:06 PM, Resident #12 observed in her room in bed. On 11/18/24 at 2:10 PM, Resident #12 observed standing up by the nurses station near the lobby area of the facility.

Review of the self report list emailed by the Administrator on 11/4/24 lacked the alleged incident between Resident #12 and Resident #19 which occurred 10/26/24.

Review of an updated self report list emailed by the facility's Administrator on 11/13/24 lacked the alleged incident between Resident #12 and Resident #19 on 10/26/24.

On 11/14/24 at 1:56 PM, the Administrator responded Resident #19 and Resident #12 were friends, the Administrator explained had heard holding hands came to light. The Administrator acknowledged not aware of touching of the resident's breast and butt. Per the Administrator, if unaware of touching of the resident's breast, then could not report.

On 11/19/24 at 2:44 PM. the Administrator explained, in part, she had received a text message over the weekend; Staff D, Licensed Practical Nurse (LPN) did the investigation, and was told one thing versus what the CNA said. When queried more about the text message, the Administrator explained she had received a voicemail, and acknowledged she listened to the voicemail maybe a couple of days ago. When queried about the voicemail, the Administrator explained said there's an allegation of CNA

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saying Resident #19 put hand up Resident #12's shirt and touched breast. Per the Administrator, the voicemail was from Staff D, Licensed Practical Nurse.

b. Resident #15 and Resident #19:

Review of the Minimum Data Set (MDS) assessment for Resident #15 dated revealed the resident scored 00 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition.

Review of the Care Plan for Resident #15 dated 2/22/24, revised on 3/17/24, revealed, [Resident #15] has episodes of behaviors as evidenced by: being combative grabbing slapping pulling away hitting negative verbalizations name calling refusal of medications/ cares resists cares tries to leave facility crying episodes screaming out hallucinations/ delusions. Interventions per Resident #15's Care Plan included, in part, the following:
a. Observe for early warning signs of oncoming behaviors- Approach in a call manner, call by name, remove
b. Minimize the potential for the residents disruptive behaviors by offering tasks which divert attention.

The Incident Note for Resident #15 dated 8/18/24 at 11:46 AM revealed, in part, [Resident #15] has been pacing in w/c (wheelchair) this morning, at 1015 this nurse witnessed [Resident #15] run over male resd root in w/c, male resd seated in large recliner in lobby hit [Resident #15] across back with both arms et (and) fists. Male resd asked to go to room in order to separate the two residents. No redness or bruising noted to

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back, when asked if having pain states "yes." DON (Director of Nursing) et administrator notified at 1022.

The Incident Note for Resident #19 dated 8/18/24 at 11:15 AM revealed, At 1015 this nurse witnessed [Resident #19] seated in large recliner in lobby wack female resd across back with both arms et fists, female resd in w/c pacing et ran over [Resident #19's] foot. Resd wearing sneakers. Spoke with [Resident #19], informed that this female resd is not doing it intentionally, resd states "I know." Discussed with [Resident #19] that there are other ways to handle a situation. [Resident #19] asked to go to his room in order to separate the two residents. Resd in bed, reports that lt (left) foot was ran over, when assessed no bruising, swelling or redness. Resd reports he is still having pain to lt foot 5/10.

The Nursing Note for Resident #15 dated 8/19/24 at 5:52 AM revealed, CNA [Name Redacted, Staff I] reports 2
red marks on resident's low back from incident on 9/18/24.

Although the incident between Resident #15 and Resident #19 was documented in both resident records on 8/18/24, review of the facility's list of self reported incidents revealed an Allegation of Abuse was reported between Resident #15 and Resident #19 for an incident date 8/19/24.

Observation on 11/06/24 at 9:26 AM revealed Resident #15 up and ambulatory at the facility.

On 11/4/24 at 11:26 a.m., Resident #19 sat in a chair in the main dining room and ate lunch. The

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State Agency(SA) made multiple attempts throughout the survey to speak with him with no success.

On 11/14/24 at approximately 1:00 p.m., the Administrator stated the incident with Residents #15 and #19 occurred on 9/19/24 and she reported it on 9/20/24.

3. The Minimum Data Set(MDS) assessment tool, dated 6/21/24, listed diagnoses for Resident #22 which included diabetes, arthritis, and hip fracture. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 1 out of 15, indicating severely impaired cognition. The MDS stated the resident had the following:
a. physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) which occurred 1-3 days out of the 7 day review period.
b. verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) which occurred 4-6 days out of the 7 day review period.
c. other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) which occurred 1-3 days out of the 7 day review period.

A 6/21/24 Care Plan entry directed staff to intervene as necessary to protect the rights and safety of the other residents, divert attention, remove from the situation/location if needed, and approach/speak in a calm manner.

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An 8/22/24 Care Plan entry directed staff to redirect the resident when she became notably agitated and to monitor her when she was around others.

An 8/26/24 Care Plan intervention directed staff to monitor the resident when she was in the hallways to ensure safe interactions with other residents. The entry directed staff to remove her from other residents and intervene when she headed toward other residents.

An 8/28/24 Care Plan entry stated the physician made medication changes as an intervention to behaviors and resident to resident interactions.

A 9/30/24 Care Plan entry directed staff to place the resident in an area where not within an arm's length of other residents.

A Care Plan entry, revised 10/21/24, stated the resident had episodes of behaviors/potential for behaviors as evidenced by combativeness, negative verbalizations, name calling, screaming out, throwing things at staff, cursing at staff and other residents, stabbing the dining table with a fork, scratching staff, cussing at staff and other residents, flipping staff off with middle finger, yelling, as well as other aggressive behaviors.
The resident had the following incidents:
On 8/22/24, the resident hit another resident.
On 8/26/24, the resident grabbed and scratched another resident.
On 9/6/24, the resident slapped another resident.
On 9/30/24, the resident slapped and pinched another resident while she called them names.
On 10/20/24, the resident grabbed the arm of another resident.

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a Resident #22 and Resident #13

The MDS assessment tool, dated 8/21/24, listed diagnoses for Resident #13 which included non-Alzheimer's dementia, depression, and psychotic disorder. The MDS listed the resident's BIMS score as 4 out of 15, indicating severely impaired cognition.

A 9/30/24 Physical Aggression Initiated report hit and pinched another resident. The other resident also hit Resident #22.

A 9/30/24 Nursing Note stated the resident sat in the lobby next to another resident and started hitting and pinching her. The other resident also hit and pinched.

The facility lacked documentation they reported the 9/30/24 incident to the State Agency until 10/2/24.

On 11/14/24 at approximately 1:00 p.m., the Administrator stated the incident between Resident #22 and Resident #13 occurred on 9/30/24. She was informed of it on 10/1/24 and reported it on 10/2/24.

b. Resident #22 and Resident #21

The MDS assessment tool, dated 9/13/24, listed diagnoses for Resident #21 which included diabetes, Parkinson's(a disease which causes symptoms such as tremors), and depression. The MDS listed the resident's BIMS score of 0 out of 15, indicating severely impaired cognition.

A 10/20/24 Verbal Aggression Received report

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stated another resident yelled at Resident #22 and Resident #22 carried out a light grasp of the right upper arm(of the other resident).

A 10/20/24 Incident Note stated a resident grabbed Resident #21's arm when Resident #21 asked her not to tap the couch.

The facility lacked documentation they reported the 10/20/24 incident to the State Agency.

4a. The MDS assessment tool, dated 10/23/24, listed diagnoses for Resident #7 which included diabetes, non-Alzheimer's dementia, and anxiety disorder. The MDS stated the resident's BIMS score was 1 out of 15, indicating severely impaired cognition.

A 6/20/19 Care Plan entry stated the resident was independent with transfers.

b. The MDS assessment tool, dated 8/28/24, listed diagnoses for Resident #11 which included non-Alzheimer's dementia, anxiety, and psychotic disorder. The MDS stated the resident required partial to moderate assistance for walking and listed a BIMS score of 0 out of 15, indicating severely impaired cognition.

A 2/24/24 Care Plan entry stated the resident required the assistance of 1 staff for short and long distance walking as the resident allowed.

c. The MDS assessment tool, dated 9/11/24, listed diagnoses for Resident #15 which included Alzheimer's disease, non-Alzheimer's dementia, and anxiety disorder. The MDS stated the resident walked independently and listed the resident's BIMS score as 0 out of 15, indicating

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severely impaired cognition.

A 2/22/24 Care Plan entry stated the resident walked independently.

d. The MDS assessment tool, dated 9/20/24, listed diagnoses for Resident #16 which included Alzheimer's, non-Alzheimer's dementia, and depression. The MDS
stated the resident walked independently and listed her BIMS score as 0 out of 15, indicating severely impaired cognition.

A 7/7/21 Care Plan entry stated the resident walked independently.

On 11/7/24 at 1:28 p.m., via phone, Staff E Registered Nurse(RN) stated there were a couple staff members, Staff O Certified Nursing Assistant(CNA) and Staff P CNA who were a "little rough" with the residents when walking down the hall. She stated they pulled them instead of walking with them and said "come on". She stated they pulled them with both of their hands and do this with Residents #7, #11, #15, and #16. She stated it was unsafe and the residents were scared and "shaking". She stated she reported this to the Business Office Manager.

The facility lacked documentation they reported the above allegations of abuse and lacked documentation they separated residents from Staff O and Staff P during the investigation.

On 11/7/24 at 2:04 p.m., the Administrator stated she wanted residents treated with respect,compassion and kindness. She stated Staff O and Staff P were both kind and no staff reported any concerns to her about them.

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F 609	Continued From page 45 On 11/12/24 at 12:00 p.m., via phone Staff E stated she spoke to the Administrator about staff walking with staff in an unsafe manner and stated the Administrator told her she didn't like how they pulled people but she was "stuck between a rock and a hard place". On 11/12/24 at 1:06 p.m., Staff G RN stated staff pulled residents by the arms while they walked them. She stated they were not abusive but rushed and rude. On 11/19/24 at 11:59 a.m. via phone, the Director of Nursing(DON) of a sister facility stated staff should report allegations of abuse to the DON and then the Administrator and they would investigate and report. She stated the staff in question would be suspended. The facility policy "Abuse Reporting and Investigation" revised 11/28/16, stated the facility would thoroughly investigate all reports of suspected or alleged abuse and stated if an employee is involved in the suspected violation, they would be immediately removed from duty for he duration of the investigation. The undated facility "Abuse Policy" stated the facility would report incidents of suspected abuse to the SA immediately but not later than 2 hours. On 11/14/24 at approximately 1:00 p.m., the Administrator stated it was her understanding that allegations of abuse be reported within 24 hours.	F 609		
F 610 SS=K	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		

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§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.

§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to conduct thorough investigations into allegations of abuse including injury of unknown origin, following concerns with staff rough treatment towards residents resulting in fear, following resident to resident incidents, and failed to ensure separation of alleged perpetrators following staff after becoming aware of allegations of abuse for eight of twelve residents reviewed for abuse (Resident #7, Resident #11, Resident #12, Resident #15, Resident #16, Resident #19, Resident #20, Resident #21). This failure resulted in Immediate Jeopardy to the health, safety, and security of the resident. The facility reported a census of 26 residents.

The State Agency informed the facility of the

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Immediate Jeopardy (IJ) on 11/14/24 at 1:57 PM. The IJ began on 9/26/24. Facility staff removed the Immediate Jeopardy on 11/18/24 at 12:28 PM by implementing the following actions:
1. All residents interviewed on 11/14/24, with no further allegations of abuse or neglect identified.
2. All staff interviewed on 11/14/24, with 4 allegations reported to State Agency and initiated investigation. Any associated staff suspended pending investigation.
3. Facility provided all staff education on abuse, immediate separation, and reporting of any abuse immediately to the Facility Administrator. Education completed by end of the day 11/14/24, or prior to working next shift.
4. An ad hoc Quality Assurance and Performance Improvement (QAPI) meeting conducted on 11/14/24, to review policy on abuse, immediate separation, reporting of abuse, and completing thorough investigation.

The scope lowered from "K" to "E" at the time of the survey after ensuring the facility implemented education and their policy and procedure.

Findings Include:

1. The Minimum Data Set (MDS), dated 10/09/24, revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicated moderate cognitive impairment. MDS revealed Resident #20 had delusions, verbal and physical behaviors, and rejection of cares. Resident #20 had impairment of bilateral lower extremities, utilized a wheelchair for mobility, and required substantial to maximal amount of staff assistance to transfer. Diagnoses included non-traumatic brain dysfunction, non-Alzheimer's

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dementia, heart failure, depression, and psychotic disorder.

The Care Plan, revised on 9/27/24 revealed Resident #20 had impaired cognitive function evidenced by short and long term memory deficits, impaired decision making, and impaired ability to understand others related to a diagnosis of dementia with mood disturbance. The Care Plan identified a risk for chronic pain and revealed Resident #20 had displaced comminuted fracture of the left humeral neck and greater tuberosity with soft tissue swelling on 9/26/24. Intervention instructed staff to apply left shoulder immobilizer as ordered and as tolerated by resident, for comfort.

A Nursing Progress Note, dated 9/25/24 at 5:53 AM, revealed Resident #20 was found to have swelling and slight bruising on left shoulder spread down arm to the elbow, resident unable to move arm. Note informed that nurse reported Resident #20's condition to an on call Provider and received orders to send resident to the hospital for an evaluation. On 9/25/24 at 8:18 AM, a Nursing Note revealed that Resident #20's Hospice Provider notified the Hospital of resident and family wishes for no treatment and resident sent back to the facility. On 9/25/24 at 8:50 AM, Note informed that Resident #20 had returned to facility with pain rated 8 on a scale of 1 to 10., and left arm charted as purple and black around the entire upper arm. At 10:00 AM, facility received an order from Provider for portable x-ray, 2 views, of left shoulder.

An x-ray report, dated 9/26/24, revealed findings of displaced comminuted fracture of the left humeral neck and greater tuberosity with soft

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tissue swelling.

Incident Report for injury of unknown cause completed on 9/26/24 by Director of Nursing (DON). The Report description of incident revealed, Resident #20 found by Certified Nursing Assistant (CNA) with pain to left shoulder, Nurse assessed resident observed bruising and abnormal range of motion. Incident Report identified an injury located on the front of left shoulder, unable to identify injury type, and immediate action had been Resident #20 sent to Emergency Room (ER).

Review of Skin Assessments completed on Resident #20, revealed the following information documented on left shoulder bruising:
1. 9/26/24: Bruise to front of left shoulder measuring 16 centimeters (cm) by 26 cm.
2. 9/30/24: Large bruise to front of left shoulder with Resident #20's arm in sling. No measurements or wound description documented.
3. 10/03/24: Bruise to left shoulder, migrated down front of left chest and down left arm to the wrist and hand. No measurements or wound description documented.
4. 10/07/24: Large bruise starting at left shoulder and extending down the left chest/breast and left arm/hand. Bruising noted to be different colors of healing and Resident #20 continued to have sling in place.

Review of the facility's submitted list of self reported incidents revealed a report had been submitted on 9/26/24 at 3:22 PM to the State Agency, which listed the incident date as 9/25/24 and incident type as accident with major injury.

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Review of the facility's 5 day investigation summary for self-reported incident revealed an investigation was completed for an unwitnessed incident and informed that an incident occurred on 9/25/24 at approximately 2:15 PM. The investigation summarized incident as Resident #20 being fine and without pain or bruising noted to left shoulder on 9/25/24, between 8:00 AM and 5:38 PM. Bruising then observed to left shoulder on 9/26/24 at 6:00 AM and nurse sent Resident #20 to the hospital. Upon return from the hospital a portable x-ray had been completed and results of fracture shared with Provider, who stated this injury had to come from trauma or a fall, no staff had witnessed. The 5 day investigation revealed intervention for incident would be to redirect Resident #20 as she required staff assistance and often ambulated on her own. The root cause analysis of incident informed that Resident #20 is not able to recall event and had not stressed any long term effects from the incident. Facility's 5 day summary did not identify potential for abuse and lacked abuse related investigation for injury of unknown origin.

The facility provided a document to State Surveyor on 11/14/24 at 12:46 PM, titled Injury Timeline, and listed that the following events had taken place on 9/25/24 and 9/26/24:
1. On 9/25/24, no time documented, Resident #20 observed standing in doorway of another resident's room, leaning heavily on left arm/elbow against the doorframe and was assisted by 2 staff into wheelchair.
2. On 9/25/24, no time documented, Resident #20 found in bathroom by nurse, self-transferred to toilet, assisted by 2 staff to ambulate with walker back to bed.
3. On 9/26/24, no time documented, night shift

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Certified Nursing Assistant (CNA) found bruise to Resident #20's left shoulder and reported to nurse who sent Resident #20 to the hospital. Resident #20 returned to facility and had x-ray completed on left shoulder, results received and reported to Attending Physician, family, and Hospice Provider.
4. On 9/26/24, no time documented, facility began self report process, and obtained statements from all staff members who worked with Resident #20 on 9/25/24 and 9/26/24.

A Provider Note, dated 10/23/24, revealed that Resident #20 had a fall and sustained a fracture to left humerus and left upper extremity in an immobilizer. Addendum to 10/23/24 Visit Note, documented on 11/13/24, revealed that there is no facility documentation of a fall and how arm fracture occurred is unknown.

On 11/06/24 at 1:00 PM, Staff L, CNA, stated they had found bruise on Resident #20's left shoulder, on 9/26/24 around 5:00 AM, when the resident stated that her arm hurt and immediately reported this to nurse. Staff L recalled that Resident #20 had previously complained of a male CNA being rough with her, Staff L unable to provide specific dates or times for these occurrences and had not personally witnessed any rough handling of Resident #20 by any staff. Resident #20 unable to provide Staff L with a name, instead described male CNA as "that big guy".

On 11/12/24 at 11:15 AM, Staff E, Registered Nurse (RN) stated that around 5:00 AM on 9/26/24, Staff L had called nurse into room to report left shoulder bruise. Staff E recalled that Resident #20's left shoulder appeared huge with black and blue colored bruising. Staff E stated

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that this injury had not been passed along in shift report and no one had reported anything previously about bruising or falls that she was aware of. Staff E informed that if Resident #20 had fallen, there would be no way resident could get up off the floor independently. Staff E also recalled that Resident #20 had previously mentioned both a male CNA, and a female CNA being rough with her, Resident #20 unable to provide Staff E with staff names. Staff E unable to provide specific dates or times for these occurrences with Resident #20.

On 11/12/24 at 1:30 PM Staff G, RN, confirmed working as charge nurse on the evening of 9/25/24 and stated they did not receive any report or have any observation of Resident #20's left shoulder being bruised or swollen. Staff G reported finding Resident #20 alone in her bathroom, sitting on the toilet and called for CNA staff to assist resident with cares. Staff G stated that Staff C (CNA) and Staff J (CNA) entered Resident #20's room to assist with toileting and Staff G left the room. Staff G stated that after leaving Resident #20's room, she did hear resident call out for help and when Staff G re-entered Resident #20's room, the resident was laying in bed while Staff C and Staff J stood next to the bed. Staff G recalled that Resident #20 complained that she was hurting all over, but refused pain medication when nurse offered. Staff G stated she did not receive any report from Staff C or Staff J that any incidents or injuries occurred.

On 11/13/24 at 9:16 AM, Staff C, CNA, confirmed working with Resident #20 on the evening of 9/25/24 and informed that she had been called by Staff G (RN) into bathroom to assist after

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Resident #20 had self-transferred to toilet. Staff C reported that Staff J also assisted with Resident #20's toileting cares and recalled that Resident #20 had difficultly when walking with walker from the bathroom back to bed. Staff C informed that Resident #20 had complained of having pain all over and reported this to the nurse. Staff C denied any incident or injury observed or reported while assisting Resident #20 with cares.

On 11/18/24 at 10:30 AM, Staff J, CNA, confirmed working with Resident #20 on the evening of 9/25/24 and revealed that Resident #20 had self transferred to bathroom so charge nurse asked Staff J and Staff C to assist her. Staff J recalled Resident #20 had been sitting on toilet when approached with tabbed brief off on the floor of the bathroom, staff assisted resident with cares and when ambulating her back to bed, Resident #20 became weak and required transfer into wheelchair, then a stand-pivot transfer into bed. Staff J stated Resident #20 had complained of her whole body hurting when CNA staff repositioned her in bed.

On 11/19/24 at 12:30 PM, Director of Nursing for sister facility, provided assistance with State Survey, revealed the expectation for an injury of unknown origin to be automatically turned in to State Agency and investigated as potential abuse. Sister facility DON revealed that the investigation would include a root cause analysis, interviews with staff and residents, to try and figure out what happened.

On 11/19/24 at 2:06 PM, Facility Administrator revealed that Resident #20's injury of unknown origin had been reported to the State Agency after notification had been received from DON that

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resident had a left shoulder fracture.
2. Review of the Quarterly Minimum Data Set (MDS) assessment for Resident #12 dated 9/13/24 revealed the resident scored 5 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Per this assessment, the resident inattention which fluctuated and delusions.

Review of Resident #12's Care Plan dated 7/5/23 revealed the following: Trauma Informed Care: [Resident #12] is at risk for alterations in my psycho-social well being related to: Allegation of abuse. History of being recipient of unsolicited sexual touching.

Review of Resident #12's Care Plan dated 7/7/24 revealed, [Resident #12] has a Mutual friendship with a resident of the opposite sex. Interventions per the Care Plan included the following:

a. (Created 7/7/24, revised 9/10/24): Do not shame or embarrass [Resident #12] for her friendship.
b. (Created 7/7/24, revised 9/10/24): If [Resident #12's] friendship escalates beyond hugging/hand holding/sitting together, please redirect in a calm manner and we will re-assess the plan with staff, family and medical advice.
c. (Created 7/7/24, revised 9/10/24): Mild affection (hugging/hand holding/sitting together) is acceptable for both families.
d. (Created 10/28/24): Per POA: hand holding, sitting together, resident sitting on other male resident's lap, and a gentle kiss on the lips is within her scope for approval of behavior. Please separate residents if behaviors become more sexual in nature such as touching of one another's private areas

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e. (Created 7/7/24, revised 9/10/24): Report interactions as needed to Charge Nurse.
f. (Created 7/7/24, revised 9/10/24): This friendship is acceptable if [Resident #12] is safe and happy.

The Nursing Note for Resident #12 dated 10/26/24 at 5:56 PM revealed, CNA (Certified Nursing Assistant) reports to this nurse that at around 1555 (3:55 PM) a male resd reached up this resd (resident) shirt et groped her lt (left) breast while she was standing next to him. These 2 resd are care planned to have a friendly relationship that involve holding hands et hugging. This nurse witnessed female resd approach male resd seated in lobby, they proceeded to hold hands before this nurse had left to attend another resd. CNA separated the 2 resd. CNA reports that resd was asking where male resd went? CNA redirected et kept them apart. When female resd asked by this nurse if the male resd had touched her breast she states "No." Administrator made aware. Called x2 numbers for POA (Power of Attorney) with no answer et (and) left message.

3. Review of the Annual MDS assessment for Resident #19 dated 10/9/24 revealed Resident #19 scored 14 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition.

Review of Resident #19's Care Plan dated 7/4/24 and revised 7/5/24 revealed, [Resident #19] has a Mutual friendship with a resident of the opposite sex. Interventions per Resident #19's Care Plan included the following:

a. (Initiated 7/5/24, Revised 9/10/24): Do not

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shame or embarrass [Resident #19] regarding this relationship.
b. (Initiated 7/5/24, Revised 9/10/24): If [Resident #19's] friendship escalates beyond hugging/hand holding/sitting together, please redirect in a calm manner and we will reassess the plan with staff, family and medical advice.
c. (Initiated 7/5/24, Revised 9/10/24): Mild affection (hugging/hand holding/sitting together) is acceptable for both families.
d. (Initiated 10/28/24): POA (Power of Attorney) [Name Redacted] verbalizes that hand holding, sitting together, female resident sitting this resident's lap, and a gentle kiss on the lips is within his scope for approval of behavior. He states to please separate residents if behaviors become more sexual in nature such as touching of one another's private areas. [POA name redacted] also requests to be made aware if resident's behaviors with female friend appear to become inappropriate and not reciprocated.
e. (Initiated 7/5/24, Revised 9/10/24): Report interactions as needed to Charge Nurse.
f. (Initiated 7/5/24, Revised 9/10/24): This friendship is acceptable as long as [Resident #19] is safe and happy

The Nursing Note for Resident #19 dated 10/26/24 at 5:43 PM revealed, CNA reports to this nurse that at around 1555 (3:55 pm) this resd reached up a female resd shirt et groped her lt (left) breast while she was standing next to him. These 2 resd are care planned to have a friendly relationship that involve holding hands et hugging. This nurse witnessed female resd approach male resd seated in lobby, they proceeded to hold hands before this nurse had left to attend another resd. No other resd in lobby witnessed event when asked. [Resident #19] was

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confronted and asked if anything happened when female resd approached him? resd states "No." when asked if they were holding hands? He states "yeah we were holding hands." Resd was asked if he touched female resd anywhere else? states "her back side a little." Resd asked if he reached up female resd shirt?States "no." Administrator made aware. POA [POA Name Redacted] made aware.

On 11/12/24 at 2:27 PM, Staff D, Licensed Practical Nurse (LPN) explained the following about Resident #12 and Resident #19: Per Staff D, she (Staff D) was the one that brought to the DON's attention, ok with family, because kept on doing stuff holding hands, hugging. Per Staff D, had gotten approval from family that ok for friendly relationship, peck on the lips, sit with each other, hold hands, and nothing behind closed doors. Staff D explained Resident #12 would seek Resident #19 out, and Resident #19 calmed Resident #12 down. Staff D explained an aide said he saw Resident #19 reach up Resident #12's shirt. Staff D further explained the aide did not want them (residents) to be together because the aide thought Resident #12 could not make decisions for herself. The aide was identified as Staff H. When queried if Resident #12 had ever had a negative reaction, Staff D responded no. Per Staff D, she had never seen Resident #19 pursue Resident #12, and when she saw, Resident#12 went to Resident #19.

Review of the self report list emailed by the Administrator on 11/4/24 lacked the alleged incident between Resident #12 and Resident #19 which occurred 10/26/24.

On 11/6/24 at 9:23 AM, Incident Reports for

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Resident #12 and #19 for the last six months requested via email to the facility's Administrator and Director of Nursing (DON). The Incident Report received did not address any interactions between Resident #12 and Resident #19.

Review of an updated self report list emailed by the facility's Administrator on 11/13/24 lacked the alleged incident between Resident #12 and Resident #19 on 10/26/24.

On 11/19/24 at 2:44 PM. the Administrator explained, in part, she had received a text message over the weekend; Staff D did the investigation, and was told one thing versus what the CNA said. Per the Administrator, she trusted the Charge Nurse to do investigation. When queried more about the text message, the Administrator explained she had received a voicemail, and acknowledged she listened to the voicemail maybe a couple of days ago. When queried about the voicemail, the Administrator explained said there's an allegation of CNA saying Resident #19 put hand up Resident #12's shirt, and doing investigation. Per the Administrator the voicemail was from Staff D.

The Administrator explained Staff D asked Resident #12 and Resident #19 what really happened, and both denied. From there, separated and made sure no more contact. The Administrator further explained the DON investigated when she got back to work, there was care plan for holding hands, hugging, not to do other stuff.

The Administrator acknowledged there was no statement from Staff H, CNA until 11/19/24 or 11/18/24.

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It was noted Staff H reported to State Agency having witnessed multiple interactions between Resident #12 and Resident #19, and it was also documented in both Resident #12 and Resident #19's clinical record on 10/26/24 that a CNA reported Resident #19 touched Resident #12's breast.

On 11/4/24 at 11:26 a.m., Resident #19 sat in a chair in the main dining room and ate lunch. The State Agency(SA) made multiple attempts throughout the survey to speak with him with no success.

4. The Admission Minimum Data Set (MDS) assessment tool, dated 6/21/24, listed diagnoses for Resident #22 which included diabetes, arthritis, and hip fracture. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 1 out of 15, indicating severely impaired cognition. The MDS stated the resident had the following:
a. physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) which occurred 1-3 days out of the 7 day review period.
b. verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) which occurred 4-6 days out of the 7 day review period.
c. other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal

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symptoms like screaming, disruptive sounds) which occurred 1-3 days out of the 7 day review period.

A 6/21/24 Care Plan entry directed staff to intervene as necessary to protect the rights and safety of the other residents, divert attention, remove from the situation/location if needed, and approach/speak in a calm manner.

An 8/22/24 Care Plan entry directed staff to redirect the resident when she became notably agitated and to monitor her when she was around others.

An 8/26/24 Care Plan intervention directed staff to monitor the resident when she was in the hallways to ensure safe interactions with other residents. The entry directed staff to remove her from other residents and intervene when she headed toward other residents.

An 8/28/24 Care Plan entry stated the physician made medication changes as an intervention to behaviors and resident to resident interactions.

A 9/30/24 Care Plan entry directed staff to place the resident in an area where not within an arm's length of other residents.

A Care Plan entry, revised 10/21/24, stated the resident had episodes of behaviors/potential for behaviors as evidenced by combativeness, negative verbalizations, name calling, screaming out, throwing things at staff, cursing at staff and other residents, stabbing the dining table with a fork, scratching staff, cussing at staff and other residents, flipping staff off with middle finger, yelling, as well as other aggressive behaviors.

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The resident had the following incidents:
On 8/22/24, the resident hit another resident.
On 8/26/24, the resident grabbed and scratched another resident.
On 9/6/24, the resident slapped another resident.
On 9/30/24, the resident slapped and pinched another resident while she called them names.
On 10/20/24, the resident grabbed the arm of another resident.

5. The Quarterly MDS assessment tool, dated 9/13/24, listed diagnoses for Resident #21 which included diabetes, Parkinson's (a disease which caused symptoms such as tremors), and depression. The MDS listed the resident's BIMS score of 0 out of 15, indicating severely impaired cognition.

A 10/20/24 Verbal Aggression Received report stated another resident yelled at Resident #22 and Resident #22 carried out a light grasp of the right upper arm(of the other resident).

A 10/20/24 Incident Note stated a resident grabbed Resident #21's arm when Resident #21 asked her not to tap the couch.

The facility Self Reports log lacked documentation they reported the 10/20/24 incident. The facility also lacked documentation they conducted an investigation regarding the above incident or took steps to separate Resident #22 from other residents.

On 11/13/24 at 8:38 a.m., Staff D Licensed Practical Nurse(LPN) stated Resident #22 was banging on the couch and Resident #21 yelled at her to stop. She stated Resident #22 reached over and took Resident #21's arm. She stated

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Resident #22 can be pretty rough but Resident #21 did not scream out. She stated Resident #22 "will snap". She stated she assumed the facility reported the altercation.

On 11/18/24 at 8:44 a.m., via phone, Staff I Certified Nursing Assistant(CNA) stated Resident #22 did act out against other residents. She stated if she thought people were in her bubble, she would point her finer at them, cuss at them, and sometimes she slapped them. She stated they kept an eye on her but there were not enough staff to monitor her and they were busy. She stated when she worked there were only 2 people on staff and this was not enough.

On 11/19/24 at 1:59 p.m. via phone, the Director of Nursing (DON) of a sister facility stated with regard to a resident with a history of resident to resident physical altercations, she would not sit that person near residents where she could reach them. Staff should carry out checks and monitoring.

On 11/19/24 at 1:57 p.m., the Administrator stated Resident #22 was spontaneous. She stated it could get congested(in the TV area) and they needed to come up with a better plan because the resident were too close together. She stated they needed to educate staff so they were more aware of what was best to keep everyone safe

6a. The MDS assessment tool, dated 10/23/24, listed diagnoses for Resident #7 which included diabetes, non-Alzheimer's dementia, and anxiety disorder. The MDS stated the resident's BIMS score was 1 out of 15, indicating severely impaired cognition.

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A 6/20/19 Care Plan entry stated the resident was independent with transfers.

b. The MDS assessment tool, dated 8/28/24, listed diagnoses for Resident #11 which included non-Alzheimer's dementia, anxiety, and psychotic disorder. The MDS stated the resident required partial to moderate assistance for walking and listed a BIMS score of 0 out of 15, indicating severely impaired cognition.

A 2/24/24 Care Plan entry stated the resident required the assistance of 1 staff for short and long distance walking as the resident allowed.

c. The MDS assessment tool, dated 9/11/24, listed diagnoses for Resident #15 which included Alzheimer's disease, non-Alzheimer's dementia, and anxiety disorder. The MDS stated the resident walked independently and listed the resident's BIMS score as 0 out of 15, indicating severely impaired cognition.

A 2/22/24 Care Plan entry stated the resident walked independently.

d. The MDS assessment tool, dated 9/20/24, listed diagnoses for Resident #16 which included Alzheimer's, non-Alzheimer's dementia, and depression. The MDS
stated the resident walked independently and listed her BIMS score as 0 out of 15, indicating severely impaired cognition.

A 7/7/21 Care Plan entry stated the resident walked independently.

On 11/7/24 at 1:28 p.m., via phone, Staff E Registered Nurse(RN) stated there were a couple

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staff members, Staff O Certified Nursing Assistant(CNA) and Staff P CNA who were a "little rough" with the residents when walking down the hall. She stated they pull them instead of walking with them and say "come on". She stated they pull them with both of their hands and do this with Residents #7, #11, #15, and #16. She stated it was unsafe and the residents were scared and "shaking". She stated she reported this to the Business Office Manager.

The facility lacked documentation they investigated the above allegations of abuse and lacked documentation they separated residents from Staff O and Staff P during the investigation.

On 1/7/24 at 2:04 p.m., the Administrator stated she wanted residents treated with respect,compassion and kindness. She stated Staff O and Staff P were both kind and no staff reported any concerns to her about them.

On 11/12/24 at 12:00 p.m., via phone Staff E stated she spoke to the Administrator about staff walking with staff in an unsafe manner and stated the Administrator told her she didn't like how they pulled people but she was "stuck between a rock and a hard place".

On 11/12/24 at 1:06 p.m., Staff G RN stated staff pulled residents by the arms while they walked them. She stated they were not abusive but rushed and rude.

On 11/19/24 at 11:59 a.m. via phone, the Director of Nursing(DON) of a sister facility stated staff should report allegations of abuse to the DON and then the Administrator and they would investigate and report. She stated the staff in

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F 610	Continued From page 65 question would be suspended. The facility policy "Abuse Reporting and Investigation" revised 11/28/16, stated the facility would thoroughly investigate all reports of suspected or alleged abuse and stated if an employee was involved in the suspected violation, they would be immediately removed from duty for the duration of the investigation.	F 610		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would	F 623		

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be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance

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and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, policy review, and staff interview, the facility failed to notify the Office of the State Long-Term Care Ombudsman of a hospital transfer for 1 of 4 residents reviewed for hospitalizations(Resident #3). The facility reported a census of 26 residents.

Findings include:

The Quarterly Minimum Data Set (MDS)

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F 623	Continued From page 68 assessment tool, dated 9/18/24, listed diagnoses for Resident #3 which included diabetes, non-Alzheimer's dementia, and psychotic disorder. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 0 out of 15, indicating severely impaired cognition. The facility policy "Transfer or Discharge, Facility-Initiated", dated October 2022, stated the facility would provide notice of therapeutic discharges to the long-term care ombudsman. A 10/19/24 Physician's Order Note stated the facility received an order to send the resident to the ER for evaluation and treatment. A 10/21/24 Health Status Note stated the resident returned to the facility. The facility lacked documentation of notification of the transfer to the Office of the State Long-Term Care Ombudsman. On 11/19/24 at 1:57 p.m., the Administrator stated she fixed a filter on her discharge report so that all transfers would be on the report sent to the ombudsman.	F 623		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by	F 637		

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implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to complete a significant change assessment following a resident starting hospice services for one of three residents reviewed for hospice (Resident #22). The facility reported a census of 26 residents.

Findings include:

Review of the quarterly Minimum Data Set (MDS) assessment for Resident #22 dated 9/18/24 revealed the resident scored 00 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Per this assessment, the resident did not receive hospice services while a resident. The next MDS for the resident was a quarterly assessment dated 12/11/24, which remained in progress.

Review of Resident #22's Hospice IDG (Interdisciplinary Group) Comprehensive Assessment and Plan of Care Update Report dated 10/1/24 revealed start of care date for hospice services on 9/19/24.

On 11/19/24 at 12:34 PM during an interview with a Director of Nursing (DON) from a sister facility, the DON queried about significant change MDS. Per the DON, should be done right away, depended on if MDS person, but should be notified have MDS needs to be changed.

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F 637	Continued From page 70 Review of the Facility Policy titled Change in a Resident's Condition or Status dated 2001, most recently revised 11/16/21, revealed the following: 8. If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted as required by OBRA regulations governing resident assessments and as outlined in the MDS RAI (Resident Assessment Instrument) Instruction Manual.	F 637		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		

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comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and facility policy review the facility failed to ensure Care Plan revision following discontinuation of antidepressant medication, failed to revise to include receipt of hospice services, failed to revise to include new skin concerns, and failed to revise to accurately reflect resident transfer status for four of sixteen residents reviewed for Care Plans (Resident #3, Resident #5, Resident#10 Resident #22).The facility reported a census of 26 residents.

Findings include:

1. Review of the Annual Minimum Data Set (MDS) assessment for Resident #5 dated 9/18/24 revealed the resident scored 00 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Per this assessment, the resident took antidepressant medication.

On 11/19/24 at 9:21 AM, review of Resident #5's Care Plan revised 2/15/24 included the following: [Resident #5] receives antidepressant medication related to diagnosis of Dementia (Antidepressant).

Review of the Pharmacist's Recommendation to Prescriber dated 8/19/24, agreed upon by the Prescriber on 9/25/24, revealed the following recommendation: Discontinue Trazodone Tab 50 mg (milligram) via taper as follows: Trazodone Tab 50 mg: Take 1/4 tab (12.5 mg) by mouth at bedtime for fourteen days then stop.

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On 11/19/24, review of Resident #5's Physician Orders lacked receipt of antidepressant medication. Preview of prior Physician Orders for Resident #5 revealed Trazodone, an antidepressant medication, was discontinued on 10/10/24.

Review of the resident's Medication Administration Record (MAR) dated November 2024 lacked receipt of antidepressant medication for Resident #5.

2. Review of the Quarterly Minimum Data Set (MDS) assessment for Resident #22 dated 9/18/24 revealed the resident scored 00 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Per this assessment, the resident did not receive hospice services while a resident. The next MDS for the resident was a quarterly assessment dated 12/11/24, which remained in progress.

Review of the Care Plan for Resident #22 dated 6/19/24 revised on 10/21/24 revealed, in part, the following:

[Resident #22] has episodes of behaviors/potential for behaviors as evidenced by being combative, negative verbalizations, name calling, refusal of medications and cares, resists cares, screaming out, throwing things at staff, cursing at staff and other residents, Stabbing dining table with fork, scratching staff, cussing at staff and other residents, flipping staff off with middle finger, yelling, restless, exit seeking, asking other residents for cigarettes, accusing female CNA (Certified Nursing Assistant) of being

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a male, as well as other aggressive behaviors.

The Intervention dated 9/6/24, revised 9/10/24, revealed: Pending hospice referral to help with pain and anxiety/behavior management awaiting POA (Power of Attorney) to choose hospice company at this time.

Review of Resident #22's Hospice IDG (Interdisciplinary Group) Comprehensive Assessment and Plan of Care Update Report dated 10/1/24 revealed start of care date for hospice services on 9/19/24.

On 11/19/24 at 12:36 PM, interview conducted with a sister facility's Director of Nursing (DON). The DON acknowledged if joins hospice, should be on the care plan. When queried about care plan revision if was on antidepressant then taken off of them, the DON responded would have so many days of follow up, so still looking for signs and symptoms. When queried about medication which ended 10/10, the DON responded it should be off by now.

The Facility Policy titled Care Plans, Comprehensive Person-Centered dated 2001, most recently revised 11/19, revealed the following: 13. Assessment of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

3. The MDS assessment tool, dated 10/23/24, listed diagnoses for Resident #3 which included non-Alzheimer's dementia, depression, and psychotic disorder. The MDS stated the resident

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was dependent on staff for toilet and chair transfers and listed his BIMS score as 0 out of 15, indicating severely impaired cognition.

A 9/10/24 Care Plan entry stated the resident transferred independently.

On 11/6/24 at 12:15 p.m., Staff C Certified Nursing Assistant(CNA) and Staff M CNA assisted the resident with a gait belt to stand up in order to pull down his pants and remove his brief.

On 11/19/24 at 1:59 via phone, the Director of Nursing of a sister facility stated Care Plans should be up to date with regard to transfer status.

4. A Weekly Skin Review dated 10/07/24 documented Resident#10 had the following skin concerns; a stage three open pressure area to the coccyx measuring 0.8 centimeters (cm) by 0.8 cm with depth of 0.2cm, four plus pitting edema to the right leg with 4/5 open areas, right great toe purplish in color.

The Hospice Admission Note dated 10/14/24 documented skin interventions as follows; assess wound for location, size, stage, drainage, wound bed and peri wound to left inner buttock- use barrier cream with incontinence cares, Assessed area also included right anterior shin- cover with bordered foam every 3 days and as needed . Measure wounds weekly.

The Care Plan for Resident#10 identified focus area with revision date 8/7/24 as follows; the resident has potential for impaired skin integrity

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F 657	Continued From page 75 and is at risk for edema, skin/tissue color changes, swelling, pain and pressure ulcers related to diagnosis of dementia. The Care Plan interventions included; 1. Administer treatments as ordered and monitor for effectiveness. Treatments as per orders/facility protocol. (7/18/24) 2. Encourage resident to shift weight, if able, every 2 hours to assist with skin integrity (7/18/24) 3. Monitor/document location, size and treatment of skin injury. Report any abnormalities, failure to heal. s/sx of infection, maceration, ets to physician as indicated (7/18/24) 4. Encourage good nutrition/hydration in order to promote healthier skin. (7/18/24). The Care Plan lacked update for the skin areas identified on the Weekly Skin Review dated 10/07/24.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, policy review, and staff interview, the facility failed to ensure timely assistance with incontinence cares and positioning for 3 of 3 residents reviewed for incontinence cares (Residents #3, #20, and #22) and failed to provide eating assistance for 1 of 3 residents reviewed for nutrition(Resident #20). The facility reported a census of 26 residents.	F 677		

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Findings include:

1. The Significant Change Minimum Data Set(MDS) assessment tool, dated 10/23/24, listed diagnoses for Resident #3 which included diabetes, non-Alzheimer's dementia, and psychotic disorder. The MDS stated the resident was dependent on staff for toilet transfers and toileting hygiene and was always incontinent of bowel and bladder. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 0 out of 15, indicating severely impaired cognition.

Care Plan entries, dated 3/20/24, directed staff to ensure the resident toileted frequently before meals, after meals, at bedtime, and as needed.

Observations on 11/6/24 revealed the resident sat in his Broda (a reclining chair on wheels) chair in the TV area at 9:04 a.m. Continuous observation revealed the resident remained in the chair until 11:00 a.m. when Staff C Certified Nursing Assistant(CNA) took him into the dining room. Staff C did not offer to take the resident to the bathroom or change his incontinent brief. The resident remained in the dining room until 11:33 a.m. when Staff C brought him back out to the TV area. Staff C did not offer the toilet at this time. At 12:03 p.m. and 12:05 p.m., the resident appeared restless and leaned forward in his chair. The resident remained in the TV room until 12:15 p.m. when Staff C and Staff M CNA took him into the shower room. Staff C and Staff M stood the resident up and removed his incontinent brief which was soiled with feces. Continuous observation revealed staff did not offer or provide positioning assistance or

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incontinence care assistance from 9:04 a.m. until 12:15 a.m.

On 11/19/24 at 11:59 a.m. via phone, the Director of Nursing(DON) of a sister facility stated how often residents needed changed depended on the resident. She stated if a resident looked uncomfortable, staff should change them. She stated the time should not exceed 3 hours.

The facility policy "Urinary Incontinence-Clinical Protocol", revised April 2018, stated staff would provide scheduled toileting. The policy lacked guidance on the frequency with which staff should offer toileting assistance.

2. Review of the Minimum Data Set (MDS) assessment for Resident #22 dated 9/18/24 revealed the resident scored 00 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Per this assessment, Resident #22 was occasionally incontinent of urine.

Review of the Care Plan dated 6/19/24 revealed, [Resident #22] has a self-care deficit as evidenced by requiring assistance with ADLs (activities of daily living), impaired balance during transitions requiring assistance and /or walking, incontinence, fx (fracture) to L) (left) hip. The Intervention dated 6/19/24 revealed, TOILETING: 2 person assist.

Observation on 11/13/24 at 10:02 AM revealed Resident #22 tilted back in broda chair in the television area, present in the front of the facility.

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F 677	Continued From page 78 On 11/13/24 at 12:55 PM during an interview with Staff G, Registered Nurse (RN), Staff G explained the following about Resident #22: Per Staff G, Resident #22 naked in a "pee bed", Resident #22 cold, and when asked certain CNAs (Certified Nursing Assistants) and when told needed to put clothes on her (Resident #22) and change her bed, response given was we just did. Staff G explained still needed to do it. Staff G explained they (Staff G) went in and changed the bed and changed resident's clothes. Per Staff G, reported to the DON who said just changed her, and resident has the right to be naked so pull her curtain. Staff G further explained she knew the resident was hospice and knew she (Resident #22) was a "handful", and to Staff G it looked horrid. Staff G explained when she (Staff G)bent down to give medicine Staff G's knee was in pee in the resident's bed. Staff G said we can't have this, and explained the response given to her was, we are too busy. When queried how often she found the resident soaked in urine, Staff G responded was when the resident quit walking had seen her that way, and was aware of at least twice. 3. The Quarterly Minimum Data Set (MDS), dated 10/09/24, revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicated moderate cognitive impairment. Resident #20 had impairment of bilateral lower extremities, utilized a wheelchair for mobility, frequently incontinent of urine, and required substantial to maximal amount of staff assistance for transfers. Diagnoses included non-traumatic brain dysfunction, non-Alzheimer's dementia, heart failure, depression, and psychotic	F 677		

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disorder.

The Care Plan, revised on 9/27/24, revealed Resident #20 had impaired cognitive function evidenced by short and long term memory deficits, impaired decision making, and impaired ability to understand others related to a diagnosis of dementia with mood disturbance. Resident #20 identified to have self-care performance deficit for Activities of Daily Living (ADLs) and required set up assistance when eating. Resident #20 identified as at risk for altered nutritional status and dehydration.

On 11/04/24 at 11:57 AM, Resident #20 observed laying supine in bed with head of bed slightly elevated. Noted lunch tray had been placed on overbed table, however lid continued to cover plate and drinks remained full.

On 11/04/24 at 12:39 PM, Resident #20 transported to lobby area via wheelchair, staff brought lunch tray from resident's room to lobby area, removed lid, and attempted to give Resident #20 bites of food. Resident #20 refused to eat bites of food staff offered.

On 11/13/24 at 9:16 AM, Staff C, Certified Nursing Assistant (CNA) stated Resident #20 required staff assistance or cueing to eat during meals since she sustained left shoulder fracture.

On 11/19/24 at 12:30 PM, Director of Nursing for sister facility, provided assistance during State Survey, revealed the expectation of residents with cognitive impairment and upper extremity mobility impairments be supervised during meals so cueing or assistance may be implemented and choking or swallowing hazards may be

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F 677	Continued From page 80 monitored. The facility policy, titled Assistance with Meals, dated 7/2017, instructed staff to help residents who require assistance with eating and prepare residents confined to bed for eating.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, policy review, and staff interview, the facility failed to provide ongoing, resident centered activities for 2 of 2 residents reviewed for activities(Residents #3, and #11). The facility reported a census of 26 residents. Findings: 1. The annual Minimum Data Set(MDS) assessment tool, dated 12/10/23, listed diagnoses for Resident #3 which included non-Alzheimer's dementia, diabetes, and arthritis. The MDS stated the resident felt the following activities were "somewhat important": group activities, news, fresh air. The MDS listed the	F 679		

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resident's Brief Interview for Mental Status(BIMS) score as 7 out of 15, indicating severely impaired cognition.

Care Plan entries, dated 1/1/24, stated the resident had the potential for alteration in recreational activities and socialization related to cognition, diabetes, depression, psychotic disorder and arthritis. The entries stated the resident enjoyed playing cards, attending group activities, bantering with other residents, singing, dog visits, music, outdoor events, exercises, table games, good parties, and outings. The entries stated the resident would attend activities of choice and interact with others appropriately during peer group activities and directed staff to invite and encourage to attend activities.

Observations on 11/6/24 revealed the resident sat in his Broda(a reclining chair on wheels) chair in the TV area at 9:04 a.m. Continuous observation revealed the resident remained in the chair until 11:00 a.m. when Staff C Certified Nursing Assistant(CNA) took him into the dining room and told him it was time for lunch. The resident remained in the dining room until 11:33 a.m. when Staff C brought him back out to the TV area. The resident remained in the TV room until 12:15 p.m. when Staff C and Staff M CNA took him into the shower room. Continuous observation revealed staff did not offer or provide any activities or engage in a conversation with the resident from 9:04 a.m. until 12:15 p.m.

The Documentation Survey Report for the period of 11/1/24-11/19/24 documented the resident watched a movie or television every day, attended music on 1 day, and attended a party on 1 day. The report lacked documentation the resident

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participated in any additional individual or group activities during the time period.

2. The Annual MDS assessment tool, dated 5/30/24, listed diagnoses for Resident #11 which included non-Alzheimer's dementia, anxiety disorder, and unsteadiness on the feet. The MDS documented the resident felt the following activities were "somewhat important": music, animals, fresh air. The MDS listed the resident's BIMS score as 3 out of 15, indicating severely impaired cognition.

An 8/6/24 Care Plan entry stated the resident had impaired activity and recreational pursuits related to social, physical, and cognitive impairments that may affect the ability to get to activities. The entry directed staff to engage the resident in simple, structured activities that avoid overly demanding tasks.

On 11/6/24 at 9:05 a.m., the resident sat in a chair in the TV room. The resident remained there until 10:58 a.m. when she stood up and told Staff M CMA that she had to go to the bathroom. Continuous observation revealed staff did not offer or provide any activities or engage in a conversation with the resident from 9:05 a.m. until 10:58 a.m.

The Documentation Survey Report for the period of 11/1/24-11/19/24 documented the resident watched TV or a movie on 16 of the days, attended church on 4 of the days, attended current events 2 days, and attended music 3 days and attended a party 1 day. The report lacked documentation the resident participated in any additional individual or group activities during the time period.

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F 679	Continued From page 83 On 11/13/24 at 9:08 a.m., Staff C CNA stated she worked at the facility since 2023. She stated she heard Resident #3 say he was bored and that it would be fair to say there were no activities provided. She stated the residents were bored and it was "sad". On 11/19/24 at 10:31 a.m., the Activity Director stated she documented activity documentation in the electronic health record(EHR) activity report section. She stated she tried to provide 4-5 activities per day. She stated Resident #3 spent a lot of time in the common area. She stated she provided 1:1 ' s with him and did this 4-5 times per month. She stated Resident #11 liked dominoes, bingo, and cards and she tried to talk to her every day. She stated it was a struggle for time she she began completing social worker duties as well. On 11/19/24 at 1:57 p.m., the Administrator stated there were usually 5-6 activities on the calendar per day and other staff could also participate. If staff had down time, they could conduct a 1:1 visit. The facility policy "Activities/Recreation Administration", revised 3/2023, stated the Activities/Recreation department shall communicate effectively to promote optimal resident care and develop individualized activity plans after assessing the resident to include the resident's choice of activities to reflect their interests and needs.	F 679		
F 684 SS=J	Quality of Care CFR(s): 483.25	F 684		

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F 684	Continued From page 84 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review, and facility policy review, the facility failed to provide adequate assessment and intervention for 3 of 4 residents reviewed for a change in condition. On 9/07/24 at approximately 12:30 PM, Resident #25 had difficulty transferring, which was a significant change in status, then at 2:35 PM the resident later had an unwitnessed fall, and was found face down in another resident's room, with laceration to the left forehead, Physician was sent a fax on 9/07/24, however, there was no response from physician until 9/09/2024 which noted they should could continue to monitor per facility protocol. There was no follow-up from the facility between 9/07/2024 and 9/09/2024. Staff acknowledged continued decline in Resident #25's condition when Resident #25 required assistance and cueing with all meals when independent prior. The Resident declined to a non-weightbearing of the left leg. The physician was notified on 9/17/24 of decline in transferring, at which time x-ray of a hip performed, no diagnostic tests were completed at this time for the head injury, there was no fracture of the hip. On 9/22/24 Resident #25 transferred to the Hospital, due to experiencing stroke-like symptoms and was diagnosed with Subdural Hematoma. Resident	F 684		

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#25 died on 9/29/24. Resident #25's death certificate revealed the immediate cause of death as complications due to accidental elderly fall, Due to or as a consequence of: subdural hematoma, and due to or as a consequence of an unsteady gait. The facility additionally failed to complete neurological assessments and post fall follow up documentation for Resident #20 following an unwitnessed fall and further failed to provide continued assessment for Resident #226 after an episode of excessive coughing caused by consuming the incorrect consistency of food during lunch meal for a resident with dysphagia. This failure resulted in Immediate Jeopardy to the health, safety, and security of the resident. The facility reported a census of 26 residents.

Findings include:

The State Agency informed the facility of the Immediate Jeopardy (IJ) on 11/07/24 at 5:12 PM. The IJ began on 9/07/24 . Facility staff removed immediacy of the Immediate Jeopardy on 11/12/24 at 3:02 PM by implementing the following actions:

1. A comprehensive head to toe assessment conducted and completed on 11/07/24, for all residents to identify any changes that deviated from their baseline status.

2. All staff members received training on how to identify changes in residents' conditions and the importance of reporting these changes to charge nurse. Staff training completed 11/07/24.

3. All Charge Nurse staff trained on how to recognize a change in condition and the expectation to notify the attending provider via

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phone immediately when a change is identified. Charge Nurse training completed on 11/07/24.

4. Facility conducted an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting on 11/07/24, to review the change of condition process, assess staff education, and develop auditing mechanisms to monitor and prevent recurrence.

The scope lowered from "J" to "G" after ensuring the facility implemented education and their policy and procedure.

1. The Admission Minimum Data Set (MDS), dated 6/19/24, revealed Resident #25 had severely impaired cognitive skills for daily decision making and occasional behaviors that included wandering and rejection of cares. Resident #25 had no impairment of the upper or lower extremities and did not require use of mobility devices. The Admission MDS revealed that Resident #25 was able to ambulate at least 150 feet independently, transfer independently, and eat independently after set up assistance. Resident #25 had history of a fall in the last 2-6 months prior to facility admission and utilized a wander/elopement alarm on a daily basis. Diagnoses included Alzheimer's Disease and osteoporosis.

A Significant Change MDS, dated 9/19/24, revealed Resident #25 received Hospice Care services, while a resident at facility, and had one fall with non-major injury since admission (major injury defined in MDS as fall resulting in bone fracture, joint dislocation, closed head injury with altered level of consciousness, or subdural hematoma). The Significant Change MDS

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revealed that Resident #25 required use of walker and wheelchair for mobility with substantial to maximal staff assistance to ambulate at least 10 feet and dependent on staff to transfer. Resident #25 required supervision or touching assistance with eating and substantial to maximal staff assistance with hygiene and dressing tasks. Diagnoses included: Non-traumatic brain dysfunction, Alzheimer's Disease, and osteoporosis.

The Care Plan, initiated 6/14/24, identified Resident #25 at risk for falls and injury due to wandering and decreased safety awareness. The Care Plan revealed Resident #25 had an unwitnessed fall on 9/07/24 with a bruise to hip, interventions included a urine dip and an evaluation to be completed by Physical/Occupational Therapy. Fall risk interventions listed in the Care Plan instructed staff to: anticipate the resident's needs, ensure resident wore appropriate footwear when ambulating, provide safe environment with floor free of spills or clutter, adequate light, call light in reach, bed in low position at night, side rails as ordered, handrails on walls, and personal items within reach.

On 9/07/24 at 3:26 PM, Nursing Progress Note revealed a yell had been heard down East Hall at 2:35 PM, Resident #25 observed face down on the floor in another resident's room. The Progress Note informed that Resident #25 had been known to wander, was last seen in lobby area, last toileted around 1:15 PM, and wore grippy socks. Progress Note revealed that active range of motion was intact and that Resident #25 was assisted by one staff to a standing position, then walked down the hall until a staff arrived with

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wheelchair when Resident #25 still appeared to be unsteady. Resident #25 noted to have sustained a skin tear to left forehead, measuring 2 centimeters (cm) long by 0.5 cm wide, and required skin to be approximated (closed) using 3 steri strips (adhesive skin closures). Nursing documented Resident #25's Power of Attorney (POA) was notified of fall and that the Provider had been faxed with results of a urine dip performed and Resident #25's injuries.

A facility facsimile (fax), dated 9/07/24, revealed an FYI notification sent to Provider which informed that Resident #25 observed prone on the floor in another resident's room and had skin tear to left forehead with steri strips in place. Fax revealed that nursing would monitor every shift for 3 days, then weekly for 3 weeks and included results of a urine dip performed related to POA's indication of past falls with Urinary Tract Infection (UTI). Provider response to fax, dated 9/09/24, instructed nursing to monitor per facility protocol and to obtain a Urinalysis with culture and sensitivity if indicated.

On 9/08/24 at 10:08 AM, Nursing Progress Note revealed Resident #25 continued on post fall monitoring and had utilized a wheelchair due to an unsteady, weak gait. Progress Note informed that facility was awaiting response from Provider regarding Resident #25's urine dip.

Review of Resident #25 Electronic Health Records (EHR), revealed a neurological assessment had been completed on the following dates and times: 9/07/24 at 2:35 PM, 9/07/24 at 6:35 PM, 9/07/24 at 10:35 PM, 9/08/24 at 2:54 AM, 9/08/24 at 6:35 AM, 9/08/24 at 2:25 PM, 9/08/24 at 10:35 PM, and 9/09/24 at 7:59 AM.

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Neurological assessments included normal findings of vital signs, orientation to person/place/time, level of consciousness, pupil size, ability to response appropriately, pain, and movement of extremities.

The facility provided two additional hand written neurological assessments, both dated 9/09/24, and both lacked documentation of the time completed. One hand written neurological assessment informed that Certified Nursing Assistant (CNA) reported difficulty with lower extremity movement when ambulating Resident #25 to the toilet. The second hand written neurological assessment informed that Resident #25 had 3 steri strip closures to left forehead, a large purple bruise to left hip, and bruising to 2 digits on the left hand.

The facility provided two pages of hand written Nursing Progress Note. Review of note dated 9/09/24 at 1:00 PM, revealed a fax had been received related to fall with an order to obtain Urinalysis (UA) with culture and sensitivity. Progress Note also revealed that Resident #25 was unable to stand on her own, leaning to the left when walking, utilizing a wheelchair, and had large bruises noted on left outer hip. Review of a hand written Nursing Progress Note, dated 9/09/24 at 6:30 PM, revealed Resident #25 ambulated with staff assist of one, was noted to favor left side, and stumble during ambulation.

A Provider Visit Note, dated 9/11/24, revealed Resident #25 had fall on 9/07/24 with skin tear to head and stable neuros. Provider documented that review of systems taken with assistance from nursing staff and chart review due to Resident #25 poor cognition, with no concerns or acute

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issues per nursing staff. Provider listed the following under orders and requisitions: monitor unsteadiness and weakness, complete neuro checks per protocol, complete skin checks per protocol, and continue current medications and treatment.

On 9/17/24 at 1:07 PM, a Nursing Progress Note revealed that Resident #25 had not been bearing weight on left leg after fall and a fax was sent to physician about possible x-ray. On 9/17/24 at 8:40 PM Provider ordered x-ray to include 2 view of pelvis and left hip for acute pain post fall and to monitor bruise until healed. On 9/18/24 at 1:23 PM, a portable x-ray performed on Resident #25 left hip, results were negative for fracture.

Review of Resident #25's Electronic Health Records and paper clinical records, revealed no Provider notification related to change in transfer ability or notification of left hip bruising was documented between the dates of 9/07/24 and 9/17/24.

A Change in Condition Assessment completed on 9/18/24, revealed Resident #25 had recent fall with a decline in mobility, utilized a wheelchair, and required total staff assistance with transfers, mobility, and hygiene. Change in Condition Assessment informed that Resident #25 was unable to bear at least 50% weight on at least 1 leg and unable to sit upright without physical assistance.

A Care Conference Note, dated 9/19/24, revealed that prior to fall, Resident #25 was often found walking around and sitting in staff offices to visit with staff and other residents. At time of Care Conference, Resident #25 required increased

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assistance in activities of daily living and feeding assistance post fall.

Review of a facility fax, dated 9/19/24, revealed notification to Provider the following information: Physical Therapy (PT) to evaluate, Resident #25 not walked since fall 2 weeks ago. Fax included results of x-ray completed 9/18/24 of left pelvis/hip. Provider response received 9/19/24 with order for PT to evaluate and treat.

On 9/21/24 at 6:04 PM, Nursing Progress Note revealed that Resident #25 continued to have a decline, sat at resident assisted feeding table but did not eat, and was noted to be lethargic. Note informed that POA was notified, no documentation of Provider notification for decline in condition.

On 9/22/24 at 10:37 AM, Nursing Progress Note revealed that nurse spoke to on-call Provider at 8:45 AM and received order to send Resident #25 to Emergency Room for evaluation to rule out stroke. Resident #25 noted to continue with lethargy and decrease in level of consciousness. Resident #25 transferred from facility to hospital via ambulance at 9:40 AM.

Hospital Discharge Report, dated 9/22/24, revealed that Resident #25 had a large subdural hematoma and likely the cause for decline in mental status and functional abilities. Diagnoses listed as Altered Mental Status and Subdural Hematoma.

On 9/22/24 at 1:19 PM, Nursing Progress Note revealed Resident #25 returned to facility via ambulance with diagnosis of subdural hematoma. Note indicated POA requested Resident #25 be

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admitted to Hospice. On 9/22/24 at 1:26 PM, verbal orders received from Provider for referral to Hospice services and to discontinue Physical/Occupational Therapy orders.

Review of Provider Visit Note, dated 9/25/24, informed that Resident #25 had unwitnessed fall, was admitted to the hospital, and found to have a subdural hematoma. Provider documented that Resident #25 had significant decline in her status, was weak, lethargic, and slow to respond. Visit Note revealed that Resident #25 had been admitted to Hospice.

On 9/29/24 at 9:45 AM, Resident #25 deceased. Hospice and family present at facility. Note informed that Hospice had contacted Medical Examiner.

Resident #25 Certificate of Death, revealed immediate cause of death from complications due to accidental elderly fall, due to or as a consequence of subdural hematoma, due to or as a consequence of unsteady gait and dementia. Manner of Resident #25's death listed as accident with the date and time of injury occurring on 9/07/24 at 2:35 PM at the facility. A description of injury informed that on 9/07/24 at 2:35 PM, facility heard a yell and nurse found Resident #25 laying prone, face down on the floor of another residents room, sustained a skin tear on left side of the forehead and that resident did not bear weight on her left leg.

On 11/06/24 at 11:00 AM, Staff B, Licensed Practical Nurse (LPN) revealed that Resident #25 wandered independently throughout the facility prior to fall and that around the same the time of fall, she never walked again. Staff B recalled

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coming back to work after a weekend and finding that Resident #25 had steri strips on her head and a dark bruise on left hip after a fall. Staff B did not recall speaking with the Provider about Resident #25's decline in transfer ability. Staff B informed that facility protocol for completing neurological assessments was to assess resident every 4 hours, then every 8 hours for 3 days.

On 11/06/24 at 2:40 PM, Staff D, Licensed Practical Nurse (LPN), revealed that Resident #25 had difficulty transferring and ambulating, and required use of a wheelchair, on the morning of her fall. Staff D stated that she had been called to Resident #25's bathroom, sometime shortly after lunch, by Staff N, Certified Nursing Assistant (CNA) due to resident struggling to get up from the toilet. Staff D stated that she helped CNA get Resident #25 up from toilet and recalled that Resident #25 had struggled to get up from the toilet but was able to ambulate once up. Staff D informed that she did not put Resident #25 back in wheelchair because she normally ambulated independently. Staff D stated that about 3 hours after helping to assist Resident #25 up from toilet, fall occurred. Staff D reported that another resident came out of their room and told nurse that Resident #25 fell. When Staff D approached the other resident's room, she recalled that Resident #25 had been laying face down on the floor. Staff D stated that Resident #25 had skin tear to forehead with flap of skin hanging down. Staff D recalled, Resident #25 had been able to move all extremities, was assisted to sit up on the floor, then assisted to a standing position and ambulated out of room and into the hallway. When ambulating in the hallway, Staff D said Resident #25 had been a bit wobbly so another staff got the wheelchair. Staff D stated Resident

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#25 sat in wheelchair the rest of the day. Staff D stated Provider had been notified of fall with skin tear to head on 9/07/24 via fax and explained that on weekends the Provider would be faxed unless a resident needed to be sent out.

On 11/07/24 at 2:50 PM Staff N, CNA, stated Resident #25 was in wheelchair prior to fall due to weakness, attempted to get up from wheelchair but couldn't. Staff N recalled reporting to nurse that Resident #25 was unstable in the bathroom from toilet. Staff N stated it was unlike Resident #25 to need help getting up from the toilet, normally transferred and ambulated independently.

On 11/07/24 at 11:58 AM, Director of Nursing (DON) confirmed that Resident #25 ambulated independently without use of assistive device and wandered with steady gait prior to fall. DON recalled Resident #25 had been declining and was sent to the hospital for stroke like symptoms. DON confirmed that a fax was sent to Provider to notify of fall with head injury and revealed an expectation that nurses call Provider for a fall with head injury. DON stated Resident #25 should have been sent to the Emergency Room (ER) the first day because of head injury. DON unable to provide documentation of additional communication with the Provider related to Resident #25 decline in mobility or condition change.

On 11/19/24 at 12:30 PM, DON for sister facility, assisted facility during State Survey, revealed the expectation for post fall monitoring to include documentation at least every shift for 3 days and, in addition, nursing staff would need to complete neurological checks every 15 minutes x4, then

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every hour x4, then every 2 hours x4, then every 4 hours x4, then every shift for a total of 3 days. The sister facility DON revealed the expectation of nurses to call, not fax, a Provider immediately when a resident has any condition change and expected if a head injury is known for staff to call Provider and send resident to ER to evaluate.

The facility policy titled, Change in a Resident's Condition or Status, dated 12/16/21, revealed that the nurse will notify resident's Attending Physician or physician on call when there has been a significant change in the resident's physical, emotional, or mental condition and informed that notifications will be made within 24 hours of change, except in medical emergencies. The policy defined significant change of condition as a major decline or improvement in a resident's status that:
a. Will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions.
b. Impacts more than one area of the resident's health status.
c. Requires interdisciplinary review and/or revision to the Care Plan.
d. Ultimately is based on the judgement of the clinical staff.

2. The Quarterly Minimum Data Set (MDS), dated 10/09/24, revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicated moderate cognitive impairment. Resident #20 utilized a wheelchair for mobility and required substantial to maximal amount of staff assistance to transfer. The MDS revealed that Resident #20 had one fall without

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injury since the previous assessment. Diagnoses included non-traumatic brain dysfunction, non-Alzheimer's dementia, heart failure, and psychotic disorder.

The Care Plan, revised 8/27/24, revealed Resident #20 at risk for injury from falls related to impaired mobility, bilateral macular degeneration, lumbar stenosis, Congestive Heart Failure, Peripheral Vascular Disease, dementia with mood disturbance, delusional disorder, and osteoarthritis of right knee. The Care Plan informed that Resident #20 had an unwitnessed fall without injury on 8/27/24. Fall intervention instructed staff to keep bed at appropriate height in order for resident to stand safely.

A Nursing Progress Note, dated 8/27/24 at 9:12 AM, revealed Resident #20 was found on the floor in room and indicated that resident had slid out of bed onto the floor. Note informed that neurological assessments would be completed per facility protocol and that notification of fall was provided to physician, family, Director of Nursing (DON), and Facility Administrator.

On 8/27/24 at 6:47 PM, a Nursing Note informed that no injuries had been observed post fall, Resident #20 able to ambulate and transfer per baseline.

On 8/28/24 at 10:14 AM, Nursing Note informed that neurological checks were within normal limits and Resident #20 had no complaints of pain. No additional documentation provided in Nursing Progress Notes related to fall on 8/27/24.

Review of Resident #20's Electronic Health Records (EHR) revealed 2 neurological

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assessments had been completed on 8/27/24, at 3:46 PM and 9:57 PM, related to unwitnessed fall on 8/27/24.

On 11/19/24 at 12:30 PM, Director of Nursing (DON) from sister facility, assisted with State Survey, revealed an expectation for post fall monitoring to include documentation at least every shift for 3 days and in addition nursing staff would need to complete neurological checks every 15 minutes x4, then every hour x4, then every 2 hours x4, then every 4 hours x4, then every shift for a total of 3 days

The facility policy titled, Fall Management System, dated 9/2022, revealed expectation for resident evaluation to include the following:
1. Any fall that involves an actual head injury and all un-witnessed falls will include follow-up neurological checks. Neurological checks will be documented.
2. When a resident sustains a fall, an evaluation may include investigation to determine probable causal factors considering environmental factors, resident medical condition, resident behavioral manifestations, and medical or assistive devices that may be implicated in the fall. The investigation and appropriate interventions will be evaluated at the time of the fall and reviewed by Nursing Management or the IDT. Interventions secondary to the investigation will be documented in the Care Plan, as indicated.

The facility policy titled, Neurological Evaluation, dated 7/20/19, revealed a Neurological evaluation may be indicated following an unwitnessed fall and instructed staff to complete evaluation every 15 minutes for an hour, then every 30 minutes for 4 hours, then every 1 hour for 2 hours, then every

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shift for 72 hours unless otherwise specified by physician order. Policy revealed expectation for documentation of neurological evaluations to include date and time procedure was performed, all assessment data obtain during procedure, if resident refused the procedure, and the signature and title of person recording the data.
3. The Medical Diagnosis form in Resident #226's Electronic Health Record had the following diagnoses listed: dysphagia (difficulty swallowing), gastro-esophageal reflux disease (acid irritates the throat), and mild cognitive impairment (difficulty processing thoughts). Resident ' s #226 ' s diet texture was ordered pureed texture with thin liquids.

The Dysphagia Facility Policy, dated September 2017, directed staff to identify the cause of the dysphagia and obtain symptom details for proper treatment.

The Care Plan, initiated on 10/31/24, instructed staff to serve diet as ordered.

On 11/04/24 at 11:20 a.m., Staff A, Cook served Resident #226 a plate of regular consistency food. One minute later, Staff A, Cook came back and stated that he knew he was going to screw that up and proceeded to take the food away from Resident #226 after he had consumed several bites of food. At that time the resident had began excessively coughing with a large amount of phlegm coming from mouth and nose.

On 11/04/24 at 11:22 a.m., Resident #226 stopped coughing and drooling.

On 11/04/24 at 11:24 a.m., Resident #226 was served the correct consistency and proceeded to

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cough with eating intermittently, but was able to eat some more food of the pureed consistency.

On 11/04/24 at 11:30 a.m., the DON was interviewed on what Resident#226's diet is ordered as and she stated that it is puree texture with thin liquids and handle cups. She stated that she provided it to the kitchen herself prior to the resident's arrival. She was then queried on what would happen if Resident #226 would be provided with regular consistency food and she stated that he would most likely choke because he eats his food very fast. At this point in time, the State Agency (SA) notified the DON of the findings to allow for appropriate assessment and interventions for this resident.

On 11/04/24 at 11:38 a.m., interview from Staff A, Cook, revealed that the dietary staff get the dietary information from the nurses. Staff A, Cook, acknowledged that he provided the resident with regular consistency food and then noticed that his count was off for plates so he and went back to fix it. Staff A, Cook, acknowledged that Resident #226 would probably choke if he ate regular consistency food. When queried about the location of the modified diet postings in the kitchen, Staff A, stated that it is posted in the kitchen and that it is also in a book. Staff A, stated that he does not utilize the books because he has struggled with them.

On 11/04/24 at 11:48 a.m., Resident #226 was found lying in his room alone. The Resident stated that he was fine and he did not feel short of breath. At that time, the resident was noted to still have an intermittent cough. The resident denied feeling like there was anything stuck in his throat.

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F 684	Continued From page 100 On 11/04/24 at 12:14 p.m., a second interview with the DON revealed that the resident had not yet had vitals or had an assessment and the physician had not been aware of the resident receiving the wrong consistency of food. The DON stated that she had a text out to the physician but had not talked with him yet. The DON reported that she had not yet done an assessment or vitals due to behavioral issues with this resident. Observation on 11/04/24 at 12:47 p.m., revealed Resident #226 was observed lying in bed with a blanket covering him, and a nurse walked out of the room at that time. On 11/04/24 at 12:50 p.m., interview with Staff B, LPN revealed that she had assessed Resident #226 at approximately 12:30 p.m. and that vitals and lung sounds did not reveal anything out of the ordinary to her. When asked for the vitals, she stated that she had provided them to the DON for her to document.	F 684		
F 689 SS=H	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 689		

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review the facility failed to ensure evaluation of a mobility device prior to resident use, failed to ensure gait belt utilized for transfer, failed to remain with a resident when a non-verbal resident suspected to have a seizure resulting in a fall, failed to ensure adequate supervision for resident with known history of falls when the resident was found multiple times post unwitnessed fall in the lobby of the facility, failed to ensure residents' feet were placed on wheelchair foot pedals when residents assisted via wheelchair, and failed to ensure residents remained free from environmental hazards when one resident ingested a robin egg and another resident obtained access to a locked restroom without the knowledge of facility staff for six of ten residents reviewed for accidents (Resident #2, Resident #3, Resident #5, Resident #10, Resident #21, and Resident #22). This deficient practice resulted in the following injuries: Resident #2 sustained bruises and a head laceration on 6/22/24. Resident #22 sustained a laceration to the right orbit with surrounding bruising, pain, and multiple skin tears sustained from falls on 7/5/24, 8/22/24, and 9/3/24. Resident #5 sustained bruising to the right forehead, pain, and a shattered humerus related to a fall on 11/1/24 and was hospitalized.

Findings include:

1. Review of the Annual Minimum Data Set (MDS) assessment for Resident #5 dated 9/18/24 revealed the resident scored 00 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition.

a. Review of Resident #5's Care Plan dated 4/2/21, revised 11/1/24, revealed the following:

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[Resident #5] is at risk for injury from falls r/t (related to) hx (history) of right (R) femur fx (fracture), dementia, diabetes, anemia, neurogenic bladder, muscle atrophy, hx of TIA/CVA (Transient ischemic attack/Cerebrovascular accident). Falls: 11/1/24 witnessed fall with injury.

Interventions per the Care Plan included the following:
a.(Initiated 2/15/24, revised 9/10/24): Gripper strips to bed.
b. (Initiated 2/15/24, revised 9/10/24): Gripper strip toilet.
c. (Imitated 11/1/24): Send to ER (emergency room) for evaluation
d. (Initiated 2/15/24, revised 9/10/24): Toilet rails

Review of the Therapy Communication Form dated 1/26/24 revealed, in part, pt. (patient) is functional independent with 4 ww (wheeled walker) gait in hallway & common spaces after assist with stance WBAT (weight bearing as tolerated).

Review of the Late Entry Nursing Note dated 10/30/24 at 11:00 AM revealed, Maintenance gave three wheel walker to resident after being notified by Maintenance manager that this is the only walker that he has available at this time. Walker was given to resident by Maintenance manager. Maintenance Manager had been notified of wheels loose on resident's normal four wheel walker and needing it to be fixed or replaced.

Review of the Fall Incident Report dated 11/1/24 at 7:38 AM for Resident #5 revealed, Nurse made aware of witnessed fall at 0738 from house

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keeping down West hall way. Resd (resident) utilizing new 3ww (wheeled walker) et was turning around when she lost her footing. Resd Observed lying on rt side, head against wall, sensation et movement to extremities, able to move rt hand when asked, unable to assess AROM (active range of motion) to rt (right) arm at this time as she was lying on it. Resd x1 (times one) assisted to chair in activity room, utilized walker with rt (right) hand, gripping activity director shirt with lt (left). 3x3cm (centimeter) bruise noted to rt (right) forehead...When skin protectant sleeve on rt arm rolled back up from obtaining BP (blood pressure) resd called out in pain. Swelling noted to rt arm et resd does not move extremity when asked.
Verbal order to send to ER obtained at 0755 from [Name Redacted] fax out for signature...Ambulance arrived at 0835 (8:35 AM), paramedic notes crepitus to rt arm, when requested to transport to [Location Redacted] medics refuse as hey state "We're not sure if its broken so we will start with x-ray in [Location Redacted]." [Resident #5] left facility via ambulance at 0841,
MAR (Medication Administration Record)/TAR (Treatment Administration Record), IPOST (Iowa Physician Orders for Scope of Treatment), face sheet et hospital transfer form sent with.

Per the Incident Report dated 11/1/24, Resident #5 had a bruise to the top of the scalp and pain score of 6.

The Incident Note dated 11/1/2024 at 1:58 PM revealed, [Name Redacted] ER (Emergency Room) nurse from
[Location Redacted] called facility, informed this nurse that [Resident #5's] "humorous <sic> is shattered." [Resident #5] is to be transported to

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[Location Redacted], et ER has already notified POA (Power of Attorney).

Review of a Radiology Report of the resident's right elbow completed on 11/1/24 at 9:45 AM, with reason for process documented as bruising around elbow and fall, revealed the following: Findings/Impression: Comminuted fracture of the distal humerus with separation of medial and lateral epicondyles. Note of 49 mm (millimeter) butterfly fragment. There is foreshortening and posterior displacement of the distal fracture fragments with respect of the proximal humerus. There is dislocation of the humeral ulnar joint.

Review of Hospital Records dated with admission date 11/1/24, and date of discharge 11/4/24, revealed the following admitting diagnoses: fall, hematoma over R (right) frontal area, just above R eye, distal R humerus fracture, and slightly angulated/overlapping, and UTI (urinary tract infection).

On 11/07/24 at 10:55 AM Staff F, Housekeeper queried regarding Resident #5. When queried if she was familiar with the resident, Staff F responded she was. When queried if she worked when the resident had fallen, Staff F explained here recently she was getting ready to mop the West hall, happened to turn, and [Resident] was losing balance when tried to turn her walker around. Staff F explained the resident's walker had gotten stuck when [Resident] was turning around and happened to lose balance. Staff F explained went to try to catch [Resident], and didn't get to her in time. Staff F queried where occurred, and responded between the activity door and West hall. Per Staff F, the resident had walker with her, and walker was 3 wheel walker

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the resident had recently gotten. When queried if Staff F saw resident fall, said yes. When queried what happened next, Staff F explained the resident had fell and hit head on the wall, and landed on her right side. When queried about visible injuries, Staff F responded she did not notice any visible injuries. Staff F acknowledged there were no staff around that (Staff F) saw when resident fell. Per Staff F, after the fall was a bruise on the resident's forehead. Staff F explained resident did not say anything when she fell, and did not call out or anything like that.

On 11/7/24 at 11:50 AM, the Director of Nursing (DON) explained there was not a PT/OT evaluation done for Resident #5's 3 wheeled walker. The DON explained for a new piece of equipment, usually got from maintenance. The DON explained called maintenance because of resident's walker wheel. Per the DON, the resident was ordered to use 4 wheeled walker, and DON explained called to have it fixed and replaced with other 4 wheeled walker. The DON further explained facility was getting a new admission at the time, maintenance came out with a walker, was told it was the wrong walker, maintenance said it was brand new, and DON said it was wrong walker. The DON explained she went to the admission, staff had the resident sitting in a chair, maintenance gave 3 wheeled walker, and definitely should not have. The DON explained did not know if was another 4 wheeled walker or not, and didn't have access to storage.

The DON explained if a witnessed fall, they would do statements and had a fall report checklist. Per the DON, statements were turned into the DON if witnessed, otherwise everything was typed into notes in [electronic health record system]. The

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DON statements for witnessed falls were very rare, and most if not all were unwitnessed. When queried about root cause analysis, the DON explained do follow up when go though the fall incident report. When queried where would find root cause, the DON explained it was also in the incident report, and did not know if it was printed into the incident report or not.

On 11/12/24 at 11:38 AM, Staff E, Registered Nurse (RN) queried about resident's arm/injury. Staff E responded the resident had four breaks, and was just told she fell. Staff E further explained was not present when it happened, and got it in report. Per Staff E, the resident normally had a 4 wheel walker with seat, the bearings were out she guessed, and someone got the resident a 3 wheeled walker. Staff E explained a staff member (Staff I, Certified Nursing Assistant) said they were not getting resident up with the 3 wheeled walker, and another staff member said the resident had used it yesterday fine, and would get her up. Per Staff E, Staff I had already said wanted no part in that. Staff E queried what she thought about the 3 wheeled walker, and provided the following description: little kid's walker, very tiny width, handles, no seat, really narrow and didn't look maneuverable. Staff E further explained in a conversation with staff member (staff member who had previously said not getting resident up with 3 wheeled walker), Staff E told Staff I they called it, [Resident #5] broke arm.

On 11/12/24 at 2:19 PM an interview completed with Staff D, Licensed Practical Nurse (LPN) who had completed the resident's incident report on 11/1/24. Staff D explained she didn't see it happen, and Staff F, Housekeeping witnessed and brought to attention. Per Staff D, resident in

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hall, walked independently with walker, and had new walker that Staff D not aware of at all. Resident #5 using new walker, was normally pretty steady, could have lost balance, and fell right side. Per Staff D, the resident was not in pain, was able to move, and was holding onto walker with broken arm. Staff D explained Resident #5 pretty much non-verbal, and when ask if in pain the resident doesn't say anything. Staff D further explained with upward motion and bringing geri sleeve up, the resident cried out in pain. Staff D explained she contacted medics and family, and when the medics got there didn't think the arm was broken, Staff D tugged geri sleeve again, and the resident screamed in pain. Per Staff D, medics said didn't think was broken and to start x-ray in [Location Redacted], while the other medic felt crepitus. Per Staff D, the resident did have a bump on the head.

On 11/18/24 at 8:54 AM, Staff I, Certified Nursing Assistant (CNA) explained, in part, Resident #5 walked with a front wheeled 4 wheel walker, because she could not do a 3 wheeler had never been trained on it. When queried if Resident #5 ever had a 3 wheeled walker, Staff I responded two weeks ago before fall had the bearing going out of her (Resident #5's) walker and maintenance gave her a 3 wheel walker. Per Staff I, she thought the resident got the walker on a Thursday, Staff I had worked that night 10 to 6, and Friday morning the resident had it sitting there. Staff I explained she did not get Resident #5 out of bed because Staff I did not feel comfortable. Per Staff I, that morning (Resident #5) fell. Staff I explained Resident #5 was like a "cylinder" and Staff I did not feel comfortable to use the 3 wheel walker. Per Staff I, the resident stayed in bed until the day shift got her up, and

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Staff I asked the nurse if was ok to leave Resident #5 in bed until the day shift as there were no notes for her to use it (3 wheel walker). Staff I explained just played it safe. When queried about communication would occur, Staff I explained usually in nurses notes, and during report when walked in room checked resident if something different, then would ask the nurse. Per Staff I, she passed it to day shift, and they said would check into it.

Observation on 11/05/24 at 12:36 PM revealed Resident #5 in the common area with bruising present to the right side of the resident's head. Resident had green bruise to right forehead. No staff observed in line of sight of the nursing desk/common area at time of observation. There was a housekeeping staff observed in the North hall. Other staff not observed to be present.

Observation on 11/13/24 at 9:59 AM revealed Resident #5 in wheelchair in the common area.

On 11/13/24 at 12:13 PM, the Maintenance Supervisor interviewed about Resident #5's walker. Per the Maintenance Director, somebody said the resident's walker wheels were acting weird, the Maintenance Supervisor looked at it, and the bearings were popped out. The Maintenance Supervisor explained found other one (walker) that had brought in. The Maintenance Supervisor described the walker with the bearings popped out as a walker with 4 wheels with handles and breaks on it. The replacement walker was described as follows by the Maintenance Supervisor: Had same stance, 3 wheels, and had break cables like the resident was used to.

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When queried if facility had any 4 wheel walkers available, the Maintenance Supervisor responded just the ones without wheels that put tennis balls on. The Maintenance Supervisor queried not like the walker the resident had, and confirmed. Per the Maintenance Supervisor, he was not sure where the 3 wheeled walker came from, it was in facility's storage. When queried if any staff expressed concerns with using the 3 wheeled walker for the resident, the Maintenance Supervisor denied, and explained he adjusted the handles down to meet the height of the resident's old one (walker) so it was the same height.

On 11/19/24 at 2:56 PM the facility's Administrator explained was not the fault of the walker, was the fault of her (Resident #5's) feet. Per the Administrator, had done education about with any change in equipment, maintenance, therapy, and the DON review. The Administrator then explained she was not sure the cause was related to the resident's footing. When queried regarding an evaluation for a resident's new piece of equipment, the Administrator explained should be evaluated by therapy. When queried if there should be an evaluation when going from 4 wheel to 3 wheel walker, the Administrator responded yes.

b. Review of Resident #5's Care Plan dated 4/2/21 and revised 2/15/24 revealed, [Resident #5] requires assist with ADL's (activities of daily living) due to impaired mobility, recent hip fx (9/2023), Alzheimer with dementia, diabetes mellitus, anemia, edema, neurogenic bladder, atrophy of muscles, depression/anxiety, TIA & CVA. The Intervention revised on 9/10/24 revealed, ASSISTIVE DEVICES: w/w (wheeled walker); w/c (wheelchair) PRN (as needed) for

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appointment.

Observation conducted 11/5/24 at 12:41 PM revealed Staff C, Certified Nursing Assistant (CNA) assisted Resident #5 down the hallway in the wheelchair, and the resident's right foot observed off of the foot pedal and skimmed across the floor while the resident was assisted.

2. Review of the Minimum Data Set (MDS) assessment for Resident #22 dated 6/21/24 revealed the resident scored 1 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated the resident severely cognitively impaired. Per the assessment, the resident had not had any falls since admission, entry, reentry, or prior assessment, had physical behavioral symptoms 1-3 days, had verbal behavioral symptoms 4-6 days, and other behavioral symptoms 1-3 days, and wandered 1-3 days.

The resident's MDS dated 9/18/24 revealed the resident scored 00 out of 15 on BIMS exam, which indicated severely impaired cognition. Per this assessment, Resident #22 had falls since admission, entry, reentry, or prior assessment, two with no injury and two with injury (except major).

The Care Plan dated 6/17/24 revised 10/14/24 revealed, [Resident #22] is at risk for falls and has had a fall related to impaired balance, poor safety awareness, functional impairment and the use of medications that may increase falls risks.

a. 6/17/24 Fall with injury
b. 6/24/24 Fall without injury
c. 7/2/24 Fall without injury
d. 7/5/24 Fall without injury

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e. 9/3/24 Fall with skin tear
f. 9/30/24 unwitnessed fall without injury
g. 10/9/24 unwitnessed fall without injury
h. 10/14/24 witnessed fall with skin tear

Interventions per Resident #22's Care Plan included the following:

a. (Initiated 7/2/24, revised 9/10/24): Dycem placed below and on top of cushion in wheelchair.
b. (Initiated 9/30/24): Educate and encourage family visits for orientation purposes.
c. (Initiated 9/30/24): Educate family about fall risks and increased weakness due to resident weight loss and refusal to eat much at meal or snack times.
d. (Initiated 6/17/24, revised 6/19/24): Ensure [Resident #22] is wearing appropriate footwear when ambulating or utilizing their wheelchair. Resident prefers to wear open toe shoes.
e. (Initiated 6/19/24, revised 9/10/24): Fall mat at bedside.
f. (Initiated 6/17/24): Follow all facility protocol related to falls ie: initiation of neuros (if applicable), fall report/investigation, immediate interventions and long term interventions, informing of physician/family.
g. (Initiated 6/17/24, revised 9/10/24): Gripper socks in place when out of bed.
h. (Initiated 7/5/24, revised 9/10/24): [Resident #22] was given a different wheelchair that Dycem holds to better than previous wheelchair.
i. (Initiated 10/14/24): Offer and encourage resident to rest between meals or when she appears drowsy in wheelchair.
j. (Initiated 6/17/24, revised 9/10/24): PT/OT (physical therapy/occupational therapy) to eval and treat if appropriate due to fall.
k. (Initiated 10/9/24): Reorient resident to her own

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room and belongings any time that she is found in the hallways.
I. (Initiated 9/3/24, revised 9/10/24): Staff to check on resident frequently when in the area that resident is in.

Review of Incident Reports and the clinical record for Resident #22 revealed the following:

The Incident Report dated 6/17/24 at 9:00 AM revealed, This nurse was in another resident's room when I heard a yell, walked out the door, resident sitting on floor near North hall back door, with back against wall...R (right) leg moved without pain, L (left) leg-hip pain. Dr. notified, verbal orders to send resident to ER (Emergency Room) for evaluation and treat for pain to L hip. A predisposing situation factor was improper footwear. The Immediate Action Taken section revealed, ask family about replacing shoes.

Discharge instructions from the Emergency Department dated 6/18/24 at 9:47 AM revealed, L (left) hip fx (fracture)-nonsurgical, walk with walker. Review of the Physician Note dated 6/20/24 revealed, in part, the following for Resident #22: Alert and oriented to person. Dementia. Episodes of confusion and disorientation. She has been having delusions about her medications and staff...She has a history of osteoporosis and hip fractures...She was sent to the ED (Emergency Department) after a fall on 6/17/24 and was found to have a left hip fracture. Uncertain if it was new or a previous fracture. It was non-surgical.

The Nursing Note dated 6/19/24 at 1:02 PM revealed, Fall Interventions: fall mat next to bed, gripper socks on at all times when out of bed,

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PT/OT eval and treat if appropriate.

The Incident Report dated 6/24/24 at 5:05 PM revealed, Was called to room [number redacted] to find resident sitting on her hands and knees in front of the bathroom facing the bathroom in front of her w/c (wheelchair). The Immediate Action Taken section revealed, in part, was helped by 2 CNAs and gait belt to her w/c then she was transferred to the bathroom, resident was then brought to the nurses station where this writer was able to have one on one with resident, to help with redirecting of resident.

The Incident Report dated 7/2/24 at 10:45 AM revealed, Resident was wheeling herself down west hallway, the 2nd door on the left she tried to open, shaking the door handle, when it didn't open resident slid herself, cushion and all to the floor. Witnessed by activity aide, resident, didn't hit head. The Immediate Action Taken section revealed, Place dycem below cushion in wheelchair and on top of cushion in wheelchair.

The Incident Report dated 7/5/24 at 1:28 PM revealed, Activity director notified this nurse of resd seated on the floor at 1328 (1:28 PM). Resd previously exit seeking. Resd observed by front lobby entrance seated in front of w/c on w/c cushion dycem in place below et (and) on-top of w/c cushion. AROM (active range of motion) intact, x3 skin tears to outer rt (right) forearm from elbow down 1.7x1cm, 2x1cm, 0.8x0.5cm, areas cleansed with steri strips put in place. The Immediate Action Taken section revealed, New w/c provided that is more suitable for dycem to prevent sliding out. Review of a Fax dated 7/25/24 revealed, in part, post fall injuries x3 skin tears from elbow down to rt (right) outer forearm

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1.7x1cm, 2x1 cm, 0.8x0.5cm areas cleansed et approximated c (with) steri strips. The Immediate Action Taken section revealed, New w/c provided that is more suitable for dycem to prevent sliding out.

The Incident Report dated 8/22/24 at 1:43 PM revealed, This nurse was called to the reception/lobby area. Resident suffered an unwitnessed fall. [Resident #22] was lying flat on the floor with legs out. Blood noted on right side of forehead with bruising. Bleeding stopped by providing pressure to the area. Resident voices complaints of pain from hitting head on floor. The Immediate Action Taken section revealed, Resident wearing sandals at time of incident, sandals removed and resident allowed grip socks to be placed.

Review of the Nursing Note for Resident #22 dated 8/22/24 at 1:43 PM revealed, in part, This nurse was called out to reception/front lobby. [Resident #22] was noted to be lying on the floor with legs outstretched near chairs/table. Blood noted to left forehead. Staff and other residents reporting she fell. Staff did not witness event.

The N-Weekly Non Pressure Wound Assessment V2 Form completed 8/22/24 at 3:52 PM revealed the following: FYI (for your information) post fall skin assessment was written on the form. A wound was documented to the resident's face described as follows: rt (right) orbital 1.3x0.3cm (centimeter) laceration with surrounding bruise of 7x7cm.

Review of Resident #22's Care Plan to address falls lacked documentation of the resident's fall with injury in the list of resident's falls in the focus

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area of Resident #22's Care Plan, and lacked any interventions added in August 2024.

The Incident Report dated 9/3/24 at 3:44 PM revealed, Called 15:30 (3:30 PM) to North hallway, unwitnessed fall, when resident was with Administrator and another resident standing nearby. Resident was standing and talking when I started initial assessment. Resident denies pain of discomfort at this time Skin tear to right upper arm 5" x1.5". The Immediate Action Taken section documented an assessment of the resident.

Review of a Fax dated 9/3/24 at 3:50 PM revealed, in part, unwitnessed fall skin tear to right arm.

The Fall-Initial Note dated 9/3/24 at 3:30 PM revealed the following cause: Unwitnessed fall due to confusion.

The Incident Report dated 9/30/24 at 2:35 PM revealed, This nurse heard a loud thud, entered lobby to find resident laying on her right side with her wheelchair tipped over top of her. The Immediate Action Taken section revealed, ROM (range of motion) assessed without any abnormal range of motion observed or reported. Resident assisted with x2 assist to wheelchair. Resident denies pain.

Review of a Fax dated 9/30/24 at 2:35 PM revealed, unwitnessed fall from wheelchair. no injuries observed at this time. Will monitor per policy.

Review of the Fall Risk Evaluation dated 9/30/24 revealed Resident #22 scored 17 on the

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assessment, which indicated high risk.

The Incident Report dated 10/9/24 at 12:45 PM revealed, This nurse alerted by housekeeping that this R (resident) was on the floor and the drawers on other R dresser were open and (et) R arm was in one sleeve of jacket...R was helped up into her wheelchair et back to her room et laid down. R is unable to respond correctly as is her usual. The Immediate Action Taken section revealed, R (resident) helped off floor and taken to bed. Per the Incident Report, a predisposing situation factor was bare feet or inappropriate footwear.

The Fall Risk Evaluation dated 10/9/24 revealed Resident #22 scored 21 on the assessment, which indicated high risk for falls.

The Incident Report dated 10/13/24 at 6:02 PM revealed, Resident sitting in w/c by nurses desk, slipped to floor hitting left elbow on wall on the way down. The Immediate Action Taken section revealed, Vitals, assisted back into w/c cleansed and applied dressing to elbow.

The Fall Risk Evaluation dated 10/13/24 revealed Resident #22 scored 25 on the assessment, which indicated high risk.

Observation on 11/13/24 at 10:02 AM revealed Resident #22 tilted back in broda chair in the television area/nursing station in the front of the facility.

On 11/13/24 at 9:09 AM, Staff C, Certified Nursing Assistant (CNA) queried if at facility when Resident #22 had fallen, and responded she was sure she was. Staff C explained now the resident

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did not ambulate at all, and explained the resident went downhill really fast. Staff C explained she thought a lot of the resident's falls happened on the weekends. When queried how fall risk was communicated, Staff C explained usually through the nurses on report. When queried if the resident's current wheelchair was from hospice, Staff C acknowledged it was. Staff C explained the resident was in a regular wheelchair before, and wasn't working out too well. Staff C explained the resident was leaning over and leaning too forward, and was so much comfier in chair and looked so much better in it too.

On 11/13/24 at 12:55 PM, Staff G, Registered Nurse (RN) explained when she first went to the facility, resident was walking. Staff G explained not having enough staff at the facility because they were all out on break instead of watching residents.. Per Staff G, she had CNAs on break all the time not telling that they went on break. Per Staff G, the resident started failing and was put on hospice. When queried if she had ever worked when the resident had fallen, Staff G denied. When queried about increased monitoring for the resident, Staff G responded just the behaviors, explained the resident had tried to bite a staff member when intervened, and further explained made sure to keep an eye on her and know where was at, at least where located.

On 11/18/24 at 10:36 AM, interview conducted with Staff J, CNA regarding Resident #22 and falls. When queried if she had been at facility when Resident #22 had fallen, Staff J replied always. Per Staff J, when resident first at facility would walk, would put self on the floor, and was care planned now for laying on the floor. When

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queried if Resident #22 was someone who could be left in the common area without staff watching her, Staff J responded no, and further explained the resident still had energy and strength to sit self up, and personally she wouldn't do so. Staff J explained now resident in a wheelchair, and have caught her trying to stand up to side of wheelchair, trying to dangle legs. Staff J explained when the resident used to have an actual wheelchair she would get up and start walking down the hallways, and now the resident had a reclining wheelchair.

On 11/18/24 at 8:59 AM, Staff I, CNA acknowledged Resident #22 had fallen a couple of times, and not for Staff I. Staff I explained when resident at the front desk liked to climb out of geri chair, and eased self down or sat down. When queried what the resident tried to do, Staff I explained the resident was busy, felt needed to go shopping, traveling, and was in her own world. Staff I further explained the resident had their current chair for a month/month and a half, and could get out of it. Per Staff I, even though it tilted rolled off to the side, and explained the resident was very agile. When queried about watching persons in the lobby, Staff I explained it depended upon who it was, and explained the following pertaining to Resident #22: If people like [another resident redacted] or [Resident #22], tried to keep someone up there behind the desk, a couple times would get laundry to have them help fold towels, and keep them busy, get them out of their bubble so not so agitated.

On 11/19/24 at 2:59 PM, the Administrator queried if she had been at facility when Resident #22 had fallen, and denied. The Administrator explained for the last six to eight weeks the

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resident had been pretty much wheelchair bound.

3. On 11/6/24 at 6:06 a.m., Staff B Licensed Practical Nurse(LPN) placed Resident #6's Lisinopril(a blood pressure medication) 5 milligrams(mg) and Olanzapine(an antipsychotic) 10 mg into a medication cup and placed it on top of the medication cart. Staff B left the medication cart and entered the medication room and closed the door. The Director of Nursing(DON) was present on the other side of the nursing station but left the vicinity for approximately 1 minute. When the DON returned, Staff B was still in the medication room. The DON picked up the medications and when Staff B returned to the cart, she handed the medications back to her.

Untitled facility lists documenting cognitive status and mobility, listed 13 cognitively impaired, independently mobile residents.

The facility policy "Storage of Medications", revised 4/2007, stated the facility would store all drugs in a safe, secure, and, orderly manner.

On 11/19/24 at 1:57 p.m., the Administrator stated medications should not be left unattended.

4. The Minimum Data Set(MDS) assessment tool, dated 3/14/24, listed diagnoses for Resident #2 which included seizure disorder, anxiety disorder, and depression. The MDS stated the resident required partial to moderate assistance to transfer from chair to bed and listed his cognitive skills for daily decision making as

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moderately impaired.

Care Plan entries, dated 5/17/13, stated the resident had the potential for uncontrolled seizures resulting in a safety hazard and falls and stated he would have no major injury related to his seizure disorder.

An 8/1/19 Care Plan entry directed staff to keep a gait belt on the resident when he stood while dressing and to keep ahold of him by the gait belt so he could be assisted if he lost his balance.

A 9/16/20 Care Plan entry directed staff to quickly assist the resident to lie down if he felt a seizure coming on.

A 10/25/21 Care Plan entry stated the resident required the assistance of one staff member for transfers.

Care Plan entries, dated 4/11/22, directed staff to not leave the resident alone during a seizure and protect from injury. The Care Plan directed staff to help the resident to the floor to prevent injury if the resident was not in bed.

Care Plan entries, dated 6/24/24, stated the resident was at risk for falls related to impaired balance, poor safety awareness, neuromuscular/functional impairment, and the use of medications that may increase fall risks related to a diagnosis of seizure disorder. The entries directed staff to encourage him to ask for assistance when transferring, check on him frequently, and offer assistance with any activities of daily living(ADLs).

a. Resident #2 Falls

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A 5/12/24 BHCP-Falls9 Report stated a Certified Nursing Assistant(CNA) assisted the resident to transfer from the wheelchair to the bed and he lost his balance and fell to the side . The CNA was unable to stop his fall and was not using a gait belt during the transfer. The resident sustained a bruise to the left iliac crest(the upper portion of the frontal pelvic bone).

A 6/22/24 6:22 p.m. Incident Note stated the resident placed his call light on during meal time and the nurse left to get assistance as when the resident requested to be laid down he was not always stable and also possibly requested to lie down when feeling the onset of seizures. The nurse and CNA walked to the resident's room when they heard a loud bang. The resident laid between the bed and the TV and a large amount of blood pooled on the floor. Staff called 911 and theresident transferred to the ER.

A 6/22/24 9:40 p.m. Incident Note stated the resident returned to the facility and the hospital treated him for a scalp laceration and possible seizure. The resident returned to the facility with staples.

The Care Plan lacked documentation of an intervention related to the above falls in order to prevent future falls.

On 11/7/24 at 11:49 a.m., Staff N CNA stated Resident #2 required a gait belt with transfer assistance.

On 11/13/24 at 8:38 a.m., Staff D Licensed Practical Nurse(LPN) stated (on 6/22/24)Resident #2 waved his hands when he wanted to lie down.

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She stated she left to get help because she did not want to help him by herself. She stated it was a busy time so she returned 10-15 minutes later. She stated she and other staff were outside the door when he fell. She stated there was enough staff but the CNAs were feeding residents at the time.

On 11/13/24 at 3:06 p.m., the Director of Nursing(DON) stated Resident #2 should transfer with a gait belt. She stated when a resident fell, staff looked at why they fell and developed an intervention.

On 11/19/24 at 1:59 via phone, the DON of a sister facility stated if staff thought a resident was having a seizure, they would prioritize this even if they were busy. She would want staff to put them in bed and tell the nurse.

b. Resident #2 Wheelchair Safety

On 11/5/24 at 8:56 a.m., Staff M CNA pushed Resident #2 in the wheelchair from his room to the shower room. The resident's wheelchair did not have attached foot pedals and the resident's feet hung down towards the floor.

The facility policy "Transporting a Resident via Wheelchair" , adopted 5/2024, stated for safety purposes, staff would not transport residents in wheelchairs without the use of leg rests.

On 11/19/24 at 1:59 via phone, the DON of a sister facility stated when staff pushed residents in a wheelchair, they should make sure feet rested on foot pedals.

5. The MDS assessment tool, dated 12/10/23,

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listed diagnoses for Resident #3 which included non-Alzheimer's dementia, psychotic disorder, and depression. The MDS listed his BIMS score as 7 out of 15, indicating severely impaired cognition.

Care Plan entries, dated 1/1/24, stated the resident had impaired cognitive function or impaired thought processes related to frontal lobe dementia, had difficulty with the ability to understand others, and had impaired decision making. The entries stated the resident required verbal cueing and direction during activities and directed staff to supervise the resident.

A 5/3/24 Order Note stated the resident swallowed a raw, whole robin's egg and received direction from the provider to monitor for salmonella(a bacteria which could be present on bird eggs) and stomach upset.

On 11/13/24 at 8:38 a.m., Staff D LPN stated the facility found a robin's egg outside and brought it in to show the residents. They passed it around and Resident #2 put it in his mouth and swallowed it whole. She called the doctor and monitored him after the incident.

On 11/19/24 at 1:59 via phone, the DON of a sister facility stated she would not pass around a robin's egg unless it were cleaned so it was free of bacteria. She stated with residents who had dementia, she was not sure because she didn ' t want them sticking it in their mouths.

6. The MDS assessment tool, dated 10/30/24, listed diagnoses for Resident #21 which included Parkinson's(a disease which caused symptoms such as tremors), arthritis, and diabetes. The

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MDS stated the resident was independent with walking and toileting and listed the resident's BIMS score as 0 out of 15, indicating severely impaired cognition.

A 10/31/23 Care Plan entry stated the resident was at risk for falls related to Parkinson's.

A 4/17/2024 6:00 a.m. Nursing Note stated the resident laid on the bathroom floor and there were briefs and a towel on the bathroom floor.

A 4/17/24 6:31 a.m. Nursing Note stated the resident complained of right rib pain and the facility obtained an order for an x-ray.

A 4/18/24 1:48 p.m. eMar-Medication Administration Note stated the x-ray revealed no fractures.

A 4/19/24 9:58 p.m. Order Note stated the resident cried and complained of rib pain.

A 6/21/2024 9:01 a.m. Nursing Note stated the resident was on the floor near the doorway to her room with blood coming from her forehead. The resident had a laceration deep enough to require stitches or staples.

A 6/21/24 10:06 p.m. Nursing Note stated the resident's husband also fell and Resident #21 transferred to the ER due to her head laceration.

A 6/21/24 Care Plan entry stated the resident moved to a separate room from her husband to prevent them from leaning on each other.

A 6/22/24 1:55 a.m. Nursing Note stated the resident returned to the facility and was treated at

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F 689	Continued From page 125 the ER for a forehead laceration. An 11/17/24 Incident Note stated staff heard a "thud" and the resident laid on the floor near the doorway to the bathroom. The resident had a hematoma(bruise) to the left side of the forehead and the facility received an order to transport to the ER. An 11/17/24 Nursing Note stated the resident sustained left humerus(upper arm bone) and left hip fractures and admitted to the hospital. The Care Plan lacked further documentation of root cause analysis of the previous falls and additional, specific interventions related to the prevention of future falls. On 11/19/24 at 11:59 a.m. via phone, the DON of a sister facility stated if a resident had a fall, they would conduct a root cause analysis to find out what caused the fall. They would complete teaching and education. They would decide a root cause and go from there to formulate interventions. The facility policy "Falls Management System", revised 9/2022, stated the facility would provide an environment that remained as free of accident hazards as possible. The facility would provide each resident with appropriate evaluations and interventions to prevent falls. After each fall, the facility updated the care plan to include the fall and measurable objectives. Care Plan interventions would address those elements determined by the investigation as probable causal factors that contributed to the fall.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI	F 690		

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F 690	Continued From page 126 CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 690		

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review the facility failed to treat a urinary tract infection in a timely manner for one of two residents reviewed for urinary tract infection (Resident #12). The facility reported a census of 26 residents.

Findings include:

Review of the Minimum Data Set (MDS) assessment for Resident #12 dated 9/13/24 revealed the resident scored 5 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Per this assessment, the resident was frequently incontinent of urine.

The Care Plan dated 2/18/24 revealed, [Resident #12] has episodes of bladder incontinence and is at risk for impaired skin, UTI's, irritation in the peri-area. The Intervention dated 2/18/24 revealed, Monitor/document for s/sx (signs/symptoms) UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns.

The Health Status Note dated 10/25/24 at 4:50 PM revealed, Increased urinary incont et (and) foul smelling urine noted today, fluids encouraged will monitor for continued s/s (signs/symptoms) throughout weekend.

The Health Status Note dated 10/26/24 at 2:59 PM revealed, Continues to have urinary incont today, on third pair of pants. CNAs (Certified Nursing Assistants) do not report foul smell when asked. Fluids encouraged.

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The Health Status Note dated 10/27/24 at 9:42 AM revealed, Remains incont of urine, fax out with request for UA (urinalysis).

The Health Status Note dated 10/28/24 at 8:19 AM revealed, R (Resident) has had increased incontinence and foul smelling urine. Fax sent to [Redacted] for possible UA with C&S (culture and sensitivity). Will await response.

The Health Status Note dated 10/28/24 at 9:53 AM revealed, Order received to obtain UA with C&S. Will obtain via hat in toilet. Send to lab.

The Laboratory/Diagnostics note dated 10/29/24 at 3:03 PM revealed, UA sent to lab awaiting results.

The Health Status Note dated 10/30/24 at 1:10 PM revealed, Fax received from [Redacted] to await culture and sensitivity for UA. No new orders at this time

The Health Status Note dated 11/1/24 at 11:53 AM revealed, Received culture results, faxed to Dr.

Review of the Urine Culture Result, dated 10/29/24, with final and received date 11/1/24, revealed 50,000 to 100,000 cfu (colony forming unit)/ml (milliliter) Klebsiella Pneumoniae.

The Health Status Note dated 11/2/24 at 8:46 AM revealed, [Name Redacted] faxed back, await final C&S. Lab faxed final C&S, labs faxed to [Redacted].

The Physician's Order Note dated 11/5/24 at 3:14

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	165355	A. BUILDING _____ B. WING _____	11/19/2024

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AM revealed, NO (New Order) Macrobid 100mg PO (per oral) BID (twice a day) x 10 days from [Name Redacted] ARNP (Advanced Registered Nurse Practitioner) per C&S recommendation.

The Physician Order dated 11/5/24 revealed, Nitrofuran (Macrobid) 100 MG (milligram) CP with directions to take one capsule by mouth twice daily for 10 days * Do not chew/crush* (Indications for Use: UTI).

Review of the resident's Medication Administration Record (MAR) dated November 2024 revealed the resident received the first dose of Nitrofuran 100 MG the morning of 11/5/24.

On 11/12/24 at 11:51 AM when queried if any issues getting lab results, Staff E, Licensed Practical Nurse (LPN) denied. When queried about UA C&S, Staff E explained the UA should be next day, was usually not an issue, and the C and S could take while. Staff E explained a week or two was extensive, acknowledged had occurred recently, and further explained may have been for Resident #12.

On 11/13/24 at 12:06 PM, Resident #12 observed in their room in bed. Resident engaged in conversation when greeted.

On 11/19/24 at 12:34 PM, interview with a Director of Nursing (DON) from a sister facility queried about when culture came back and the timeframe, would send to clinic to Doctor so he could see, and if they did not send back within hour or two would fax, and have nurses call and fix right then and there, and would fax back the order.

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F 690	Continued From page 130 Review of the Facility Policy titled Antibiotic Stewardship, dated 2001 and revised 12/16, revealed the following: 11. When a culture and sensitivity (C&S) is ordered lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued.	F 690		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, policy review, and staff interviews, the facility failed to ensure the dimensions from the mattress	F 700		

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to the bed rail or the bed rail gaps were less than 4 3/4 inches to ensure the bed rails did not pose a risk of entrapment or injury for 1 of 26 residents reviewed for bed rail safety(Resident #2). The facility reported a census of 26 residents.

Findings include:

The Minimum Data Set(MDS) assessment tool, dated 9/13/24, listed diagnoses for Resident #2 which included seizure disorder, anxiety disorder, and depression. The MDS stated the resident was independent with rolling right to left and moving from lying to sitting. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 0 out of 15, indicating severely impaired cognition.

A 9/10/24 Bed Rails Informed Consent for Use stated the resident utilized bed rails for mobility and security(fear of falling out of bed).

Care Plan entries, dated 9/10/24 , stated the resident was at risk for injury related to the use of bed rails/grab bars and stated the resident had a right side transfer loop(a type of bar placed on a bed which allowed residents to grab onto to assist in rising).

On 11/5/24 at 10:34 a.m., the Maintenance Director measured the width of the resident's transfer loop as 9 5/8 inches from the top bar of the loop to the middle bar of the loop and measured the width between the middle bar to the top of the mattress as 8 3/4 inches. The Maintenance Director stated he did not complete any audits and did not know what the maximum gap size should be. He stated the resident had

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F 700	Continued From page 132 that bed since he started working at the facility which was about one year. The Guidance for Industry and Food and Drug Administration Staff Hospital Bed System Dimensional And Assessment Guidance to Reduce Entrapment, issued 3/10/6, stated the space between the rails should be small enough to prevent head entrapment (4 3/4 inches). On 11/5/24 at 11:45 a.m., the Administrator stated Resident #2's bed was old because he had been there a while. She stated it should be the nursing and therapy staff 's responsibility to check side rail safety and she did not think that maintenance was aware of the regulations. She stated gap size should be in line with the federal guidelines. On 11/5/24 at 4:01 p.m., the Administrator stated the facility checked the remainder of the beds in the facility. The facility policy "Bed Safety" revised December 2007, stated the facility would ensure gaps in the bed system were within the dimensions established by the FDA.	F 700		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and	F 725		

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diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.

§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
(i) Except when waived under paragraph (e) of this section, licensed nurses; and
(ii) Other nursing personnel, including but not limited to nurse aides.

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, policy review, and staff interviews, the facility failed to ensure sufficient nursing staff to provide care to residents in accordance with the care plan by failing to supervise 1 of 1 resident with a history of physical resident to resident altercations from other residents(Resident #22) and by failing to provide timely assistance for 1 of 1 resident reviewed with a history of falls and seizures(Resident #2). The facility reported a census of 26 residents.

Findings include:

1. The Minimum Data Set(MDS) assessment tool, dated 6/21/24, listed diagnoses for Resident #22 which included diabetes, arthritis, and hip fracture. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 1 out

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of 15, indicating severely impaired cognition. The MDS stated the resident had the following:
a. physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) which occurred 1-3 days out of the 7 day review period.
b. verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) which occurred 4-6 days out of the 7 day review period.
c. other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) which occurred 1-3 days out of the 7 day review period.

A 6/21/24 Care Plan entry directed staff to intervene as necessary to protect the rights and safety of the other residents, divert attention, remove from the situation/location if needed, and approach/speak in a calm manner.

An 8/22/24 Care Plan entry directed staff to redirect the resident when she became notably agitated and to monitor her when she was around others.

An 8/26/24 Care Plan intervention directed staff to monitor the resident when she was in the hallways to ensure safe interactions with other residents. The entry directed staff to remove her from other residents and intervene when she headed toward other residents.

An 8/28/24 Care Plan entry stated the physician

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made medication changes as an intervention to behaviors and resident to resident interactions.

A 9/30/24 Care Plan entry directed staff to place the resident in an area where not within an arm's length of other residents.

A Care Plan entry, revised 10/21/24, stated the resident had episodes of behaviors/potential for behaviors as evidenced by combativeness, negative verbalizations, name calling, screaming out, throwing things at staff, cursing at staff and other residents, stabbing the dining table with a fork, scratching staff, cussing at staff and other residents, flipping staff off with middle finger, yelling, as well as other aggressive behaviors.
The resident had the following incidents:
On 8/22/24, the resident hit another resident.
On 8/26/24, the resident grabbed and scratched another resident.
On 9/6/24, the resident slapped another resident.
On 9/30/24, the resident slapped and pinched another resident while she called them names.
On 10/20/24, the resident grabbed the arm of another resident.

a. Resident #22 and Resident #77

The Minimum Data Set(MDS) assessment tool, dated 7/10/24, listed diagnoses for Resident #77 which included diabetes, non-Alzheimer's dementia, and chronic pain. The MDS listed his Brief Interview for Mental Status(BIMS) score as 0 out of 15, indicating severely impaired cognition.

An 8/22/24 Resident to Resident Altercation report stated the resident approached another resident who sat in the lobby area watching TV

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and hit him in the head.

An 8/22/24 Nursing Note stated Resident #77 sat in the TV room and Resident #22 walked over to him, began talking and hit him on the head several times. The CNA intervened and took Resident #22 to her room to lie down.

b. Resident #22 and Resident #12

The MDS assessment tool, dated 6/13/24, listed diagnosis for Resident #12 which included arthritis, Alzheimer's, and non-Alzheimer's dementia. The MDS listed the resident's BIMS score as 5 out of 15, indicating severely impaired cognition.

An 8/26/24 Resident to Resident Altercation report stated the Resident #22 had a hold of another resident's bilateral arms and scratched the resident.

An 8/26/24 Progress Note stated another resident grabbed and scratched Resident #12's arms.

c. Resident #22 and Resident #11

The MDS assessment tool, dated 8/28/24, listed diagnoses for Resident #11 which included non-Alzheimer's dementia, anxiety, and psychotic disorder. The MDS listed a BIMS score of 0 out of 15, indicating severely impaired cognition.

A 9/6/24 Resident to Resident Altercation report stated a female resident told Resident #22 to "shut up" and Resident #22 slapped the female resident across the face to the left cheek.

A 9/6/24 Nursing Note stated Resident #11 told

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another resident to "shut up" and the other resident slapped Resident #11. Staff separated the residents.

d. Resident #22 and Resident #13

The MDS assessment tool, dated 8/21/24, listed diagnoses for Resident #13 which included non-Alzheimer's dementia, depression, and psychotic disorder. The MDS listed the resident's BIMS score as 4 out of 15, indicating severely impaired cognition.

A 9/30/24 Physical Aggression Initiated report hit and pinched another resident. The other resident also hit Resident #22.

A 9/30/24 Nursing Note stated the resident Resident #13 sat in the lobby next to another resident and started hitting and pinching her. The other resident also hit and pinched.

e. Resident #22 and Resident #21

The MDS assessment tool, dated 9/13/24, listed diagnoses for Resident #21 which included diabetes, Parkinson's, and depression. The MDS listed the resident's BIMS score of 0 out of 15, indicating severely impaired cognition.

A 10/20/24 Verbal Aggression Received report stated another resident yelled at Resident #22 and Resident #22 carried out a light grasp of the right upper arm(of the other resident).

A 10/20/24 Incident Note stated a resident grabbed Resident #21's arm when Resident #21 asked her not to tap the couch.

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2. The MDS assessment tool, dated 3/14/24, listed diagnoses for Resident #2 which included seizure disorder, anxiety disorder, and depression. The MDS stated the resident required partial to moderate assistance to transfer from chair to bed and listed his cognitive skills for daily decision making as moderately impaired.

Care Plan entries, dated 5/17/13, stated the resident had the potential for uncontrolled seizures resulting in a safety hazards and falls and stated he would have no major injury related to his seizure disorder.

An 8/1/19 Care Plan entry directed staff to keep a gait belt on the resident when he stood while dressing and to keep a hold of him by the gait belt so he could be assisted if he lost his balance.

A 9/16/20 Care Plan entry directed staff to quickly assist the resident to lie down if he felt a seizure coming on.

A 10/25/21 Care Plan entry stated the resident required the assistance of one staff member for transfers.

Care Plan entries, dated 4/11/22, directed staff to not leave the resident alone during a seizure and protect from injury. The Care Plan directed staff to help the resident to the floor to prevent injury if the resident was not in bed.

Care Plan entries, dated 6/24/24, stated the resident was at risk for falls related to impaired balance, poor safety awareness, neuromuscular/functional impairment, and the use of medications that may increase fall risks

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related to a diagnosis of seizure disorder. The entries directed staff to encourage him to ask for assistance when transferring, check on him frequently, and offer assistance with any activities of daily living(ADLs).

A 6/22/24 6:22 p.m. Incident Note stated the resident placed his call light on during meal time and the nurse left to get assistance as when the resident requested to be laid down he was not always stable and also possibly requested to lie down when feeling the onset of seizures. The nurse and CNA walked to the resident's room when they heard a loud band. The resident laid between the bed and the TV and a large amount of blood pooled on the floor. Staff called 911 and the resident transferred to the ER.

A 6/22/24 9:40 p.m. Incident Note stated the resident returned to the facility and the hospital treated him for a scalp laceration and possible seizure. The resident returned to the facility with staples.

On 11/13/24 at 8:38 a.m., Staff D Licensed Practical Nurse(LPN) stated (on 6/22/24) Resident #2 waved his hands when he wanted to lie down. She stated she left to get help because she did not want to help him by herself. She stated it was a busy time so she returned 10-15 minutes later. She stated she and other staff were outside the door when he fell. She stated there was enough staff but the CNAs were feeding residents at the time.

Facility Daily Assignment sheets for the period of 10/1/24-11/15/24 documented one nurse and one CNA scheduled for the 6:00 p.m. to 6:00 a.m. shift:

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10/5/24, 10/6/24, 10/11/24, 10/12/24, 10/13/24, 10/19/24, 10/20/24, 10/24/24, 10/25/24, 10/26/24, 10/27/24, 11/1/24, 11/2/24, 11/3/24, 11/8/24, 11/9/24, 11/10/24, 11/15/24.

The Facility Assessment, dated 8/15/24, listed staff needs for the evening shift as 1-2 LPNs and 1-3 Certified Nursing Assistants(CNAs) and listed the needs for the night shift as 1 LPN and 1-2 CNAs. The assessment directed to adjust as needed.

On 11/18/24 at 8:44 a.m., via phone, Staff I Certified Nursing Assistant(CNA) stated Resident #22 did act out against other residents. She stated if she thought people were in her bubble, she would point her finer at them, cuss at them, and sometimes she slapped them. She stated the keep an eye on her but there were not enough staff to monitor her and they were busy. She stated when she worked there were only 2 people on staff and this was not enough. She stated she had to prioritize and instead of changing residents every 2 hours, she completed this every 3 hours.

On 11/19/24 at 1:59 via phone, the Director of Nursing(DON) of a sister facility stated if staff thought a resident was having a seizure, they would prioritize this even if they were busy. She would want staff to put them in bed and tell the nurse.

On 11/18/24 at 11:31 a.m. via phone, Staff K CNA stated there were not enough staff "to go around". She stated if there were 2 CNAs, it was enough, but sometimes there was just 1. She stated it was hard for her to change everyone every two hours and it was probably every 2.5 hours

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F 725	Continued From page 141 instead. On 11/19/24 at 1:48 p.m., the Business Office Manager(BOM) stated she tried to place 2 CNAs on days and evenings and 1-2 on nights. She stated having the extra person helped. On 11/19/24 at 1:57 p.m., the Administrator stated ideal staffing was 2 CNAs and a nurse. She stated after 6:00 p.m., residents were sleeping. She stated staffing was modeled by guidance from corporate. The facility policy "Staffing", revised October 2017, stated the facility would provide sufficient numbers of staff to provide care and services for all residents in accordance with resident care plans and the facility assessment. On 11/13/24 at 12:55 PM, interview conducted with Staff G, Registered Nurse (RN). Staff G explained not having enough staff at the facility because they were all out on break instead of watching residents. Per Staff G, she had CNAs on break all the time not telling that they went on break.	F 725		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental	F 740		

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F 740	Continued From page 142	F 740		

and substance use disorders.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, policy review, and staff interview, the facility failed to provide necessary behavioral health care such as psychiatric services and the development and implementation of person-centered care plans that included and supported the behavioral health care needs for 1 of 2 residents reviewed for behaviors(Resident #17). The facility reported a census of 26 residents.

Findings include:

The Minimum Data Set(MDS) assessment tool, dated 9/4/24, listed diagnoses for Resident #17 which included traumatic brain injury, depression, and alcohol abuse with alcohol-induced mood disorder. The MDS stated the resident had physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) which occurred 1-3 days out of the 7 day review period, verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) which occurred 4-6 days out of the 7 day review period, other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) which occurred 4-6 days out of the 7 day review period, and rejection of care which occurred daily. The MDS listed his Brief Interview for Mental Status(BIMS) score as 0 out of 15, indicating severely impaired cognition.

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	165355	A. BUILDING _____ B. WING _____	11/19/2024

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Care Plan entries, dated 2/1/23, stated the resident had a mood disorder and was at risk for mood changes and inappropriate behaviors. The Care Plan directed staff to:
a. speak to the resident in a calm manner, divert attention, and remove the resident from the situation as needed.
b. provide opportunities for positive interaction and attention. Stop and talk with him as passing by.
c. discuss his behavior and explain/reinforce why behavior is inappropriate and/or unacceptable to the resident.
d. praise any indication of the resident's progress/improvement in behavior.

A 3/6/24 Care Plan entry stated the resident would at times scream/yell during cares and showers; when redirected he might stop for a moment, but often started back up until task is over. When asked why he screamed with cares; he often made a joke of the issue.

A 4/26/24 Psychiatric Subsequent Assessment stated the resident had diagnoses of depression, withdrawal, and anxiety and had an evaluation for adverse reactions/side effect to current psychotropic's and had a planned revisit in 4 weeks.

A 5/24/24 Nursing Note stated the resident had a psychiatric Telehealth visit and the facility awaited the progress notes.

On 11/13/24, the State Agency(SA) requested all psychiatric services visit notes for Resident #17. The most recent visit documentation the facility provided documented the 4/26/24 visit.

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F 740	Continued From page 144 Behavior Notes on the following dates revealed the resident screamed and yelled at staff during assistance with cares: 9/29/24, 10/4/24, 10/18/24, 10/19/24, 10/20/24, 10/21/24, 11/3/24. The resident's Care Plan lacked additional/more recent interventions to direct staff on how to care for the resident when he displayed behaviors during cares. On 11/13/24 at 3:06 p.m., the Director of Nursing(DON) stated the facility did not have Telehealth psychiatric services "for a little while"" and stated she would look to see how long it was. On 11/19/24 at 1:57 p.m., the Administrator stated they talked about the psychiatric services and providing them more consistently. She stated there was a nurse who was in charge of this who switched her hours to an as needed basis. She stated the services were not terminated but they needed to get them reestablished. The facility policy "Behavioral Assessment, Intervention, and Monitoring", dated 11/2019, stated residents would have minimal complications associated with the management of altered or impaired behavior. The interdisciplinary team would evaluate behavioral symptoms and the Care Plan would incorporate findings from the assessment. Care Plan interventions would be individualized to support psychosocial needs to prevent the resident's distress. The policy did not address the provision of psychiatric services.	F 740		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)	F 759		

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F 759	Continued From page 145 §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, policy review, and staff interviews, the facility failed to ensure its medication error rates were not 5 percent or greater. The facility's medication error rate calculated as 12% after staff administered an incorrect dose of Vitamin D3, failed to prime an insulin pen, and failed to administer insulin in a timely manner with regard to the meal time. The facility reported a census of 26 residents. Findings include: a. On 11/6/24 at 6:20 a.m., Staff B Licensed Practical Nurse(LPN) administered Vitamin D3 125 micrograms(mcg) to Resident #4. The November 2024 MAR(Medication Administration Record) listed an order for Vitamin D3 50 mcg 1 tablet orally one time a day. b. On 11/6/24 at 6:26 a.m., Staff B LPN checked Resident #2's blood sugar and it was 136 milligrams/deciliter(mg/dl). Staff B set the dosage of Resident #4's Humalog(a type of insulin) pen to 5 units and set the dosage of her Humulin(a type of insulin) pen to 5 units. Staff B did not prime the needle prior to setting the dose to 5 units. After the State Agency(SA) queried her as to if there was anything additional she usually carried out prior to setting the dosage, Staff B said she	F 759		

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F 759	Continued From page 146	F 759		

usually primed it but did not this time. Staff B then set the dosage to 2 units to prime the pen, and then set the dosage to 5 units again. Staff B did this with both insulin pens. Staff B then injected the insulins into the resident's right arm. Staff B then continued to administer medications to other residents.

The resident did not consume any food between the period of 6:26 a.m. and 6:41 a.m.

On 11/6/24 at 6:41 a.m., the Director of Nursing(DON) stated breakfast started at 7:00 a.m. and residents did not receive breakfast earlier than this. She stated residents should receive fast acting insulin with their meals. The SA informed her Resident #4 received her Humalog insulin at 6:26 a.m. The DON stated she would take care of this and told the resident she should eat some breakfast. The DON walked with the resident into the dining room and at 6:46 a.m., the resident received breakfast.

The November 2024 MAR listed an order for Humalog 5 units two times per day at 7:00 a.m. and 3:00 p.m.

The facility's had 3 errors out of 25 medication opportunities, calculated at a 12% error rate.

On 11/6/24 at 10:28 a.m., Staff B stated she had a Vitamin D3 25 mcg tablet available so she could have administered 2 of those.

On 11/13/24 at 3:06 p.m., the DON stated staff should prime the needle prior to administering insulin from a pen.

On 11/19/24 at 1:59 via phone, the DON of a

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F 759	Continued From page 147 sister facility stated staff should follow medication orders. The facility policy "Administering Medications", revised December 2012, directed staff to administer medications in accordance with the orders, including any required time frame. The Humalog insulin Patient Information, retrieved from https://uspl.lilly.com/humalog/humalog.html#ppi0 on 11/21/24, stated Humalog acted fast and directed patients to inject humalog within 15 minutes before or right after eating a meal. The Humalog Instructions for Use, retrieved from https://uspl.lilly.com/humalog/humalog.html#ug1 on 11/21/24, directed to prime the pen with 2 units prior to use. The Humulin Instructions for Use, retrieved from https://uspl.lilly.com/humulinru500/humulinru500.html#ug1 on 11/21/24, directed to prime the needle with 5 units prior to use.	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, policy review, and staff interview, the facility failed to ensure residents were free of significant medication errors by failing to ensure a resident consumed food in a timely manner after the administration of rapid acting insulin(Resident #4)	F 760		

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F 760	Continued From page 148	F 760		

and by failing to prime insulin pens prior to administration.. The facility reported a census of 26 residents.

Findings include:

The Minimum Data Set(MDS) assessment tool, dated 10/16/24 listed diagnoses for Resident #4 which included diabetes, non-Alzheimer's dementia, and unspecified dementia. The MDS listed the resident's Brief Interview for Mental Status score as 6 out of 15, indicating severely impaired cognition.

On 11/6/24 at 6:26 a.m., Staff B Licensed Practical Nurse(LPN) checked Resident #2's blood sugar and it was 136 mg/dl. Staff B set the dosage of Resident #4's Humalog pen to 5 units and set the dosage of her Humulin pen to 5 units. Staff B did not prime the needle prior to setting the dose to 5 units. After the State Agency(SA) queried her as to if there was anything additional she usually did prior to setting the dosage, Staff B said she usually primed it but did not this time. Staff B then set the dosage to 2 units to prime the pen, and then set the dosage to 5 units again. Staff B did this with both insulin pens. Staff B then injected the insulins into the resident ' s right arm. Staff B then continued to administer medications to other residents.

The resident did not consume any food between the period of 6:26 a.m. and 6:41 a.m.

On 11/6/24 at 6:41 a.m., the Director of Nursing(DON) stated breakfast started at 7:00 a.m. and residents did not receive breakfast earlier than this. She stated residents should

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F 760	Continued From page 149 receive fast acting insulin with their meals. The SA informed her Resident #4 received her Humalog insulin at 6:26 a.m. The DON stated she would take care of this and told the resident she should eat some breakfast. The DON walked with the resident into the dining room and at 6:46 a.m., the resident received breakfast. The November 2024 Medication Administration Record(MAR) listed an order for Humalog 5 units two times per day at 7:00 a.m. and 3:00 p.m. On 11/13/24 at 3:06 p.m., the DON stated staff should prime the needle prior to administering insulin from a pen. The facility policy "Administering Medications", revised December 2012, directed staff to administer medications in accordance with the orders, including any required time frame. The Humalog insulin Patient Information, retrieved from https://uspl.lilly.com/humalog/humalog.html#ppi0 on 11/21/24, stated Humalog acted fast and directed patients to inject humalog within 15 minutes before or right after eating a meal. The Humalog Instructions for Use, retrieved from https://uspl.lilly.com/humalog/humalog.html#ug1 on 11/21/24, directed to prime the pen with 2 units prior to use. The Humulin Instructions for Use, retrieved from https://uspl.lilly.com/humulinru500/humulinru500.html#ug1 on 11/21/24, directed to prime the needle with 5 units prior to use.	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals	F 761		

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F 761	Continued From page 150 CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, policy review, and staff interview, the facility failed to provide care and services according to accepted standards of clinical practice by preparing medications in advance for 4 of 9 residents(Residents #2, #9, #11, #12) observed during observations of the medication administration pass and the medication cart. The facility reported a census of 26 residents.	F 761		

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F 761	Continued From page 151	F 761		

Findings include:

On 11/6/24 at 5:59 a.m., Staff B Licensed Practical Nurse(LPN) walked up to the medication cart and unlocked it. In the top drawer of the cart, there was an unlabeled medication cup which contained 3 pills. Staff B stated she just set them up and stated they were Resident # 3's Amlodipine(a blood pressure medication), Carbidopa(a medication used to treat Parkinson's, a disease which causes symptoms such as tremors), and Citalopram(an antidepressant). Staff B stated she "just" set them up.

On 11/13/24 at 8:24 a.m., the top drawer of the medication cart located in the medication room contained 3 unlabeled medication cups each containing multiple medications. Staff B stated the medications were for Residents #2, #11, and #12 and stated they wanted to sleep in so she did not give them yet.

On 11/13/24 at 3:06 p.m., the Director of Nursing(DON) stated staff should not set up medications ahead of time and stated Staff B confessed today that she "messed up".

On 11/13/24 at 8:38 a.m., Staff D Licensed Practical Nurse(LPN) stated she did not set up medications ahead of time but if she had to, she would label them.

The facility policy "Storage of Medications", revised 4/2007, stated the facility would store all drugs in a safe, secure, and, orderly manner. The policy directed staff to store drugs in the packaging which they were received.

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F 803	Continued From page 152	F 803		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review, and facility documents review, the facility failed to ensure all menu items were served to residents with an alternate diet for 2 of 2 residents (R#1 and R#226) on a pureed diet. The facility reported a census of 26 residents. Findings include:	F 803		

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F 803	Continued From page 153	F 803		

1. The Care Plan, revised 2/20/24, revealed that Resident #1 is at risk for nutritional problems related to diagnosis of Cerebral Palsy and required pureed diet with honey thickened liquids.

Resident #1 diet order, dated 10/27/2017, revealed order for regular, puree texture diet and honey consistency drinks.

Review of Nutritional Assessment, dated 11/04/24, informed that Resident #1 remains at increased risk for altered nutrition.

2. The Care Plan, dated 10/31/24, revealed that Resident #226 has nutritional problem or potential for nutritional problem and required regular diet with pureed texture.

Resident #226 diet order, dated 10/31/24, revealed order for regular, puree texture diet and thin liquids.

Review of Nutritional Assessment, dated 11/04/24, informed that Resident #226 is at increased risk for altered nutrition due to co-morbidities, chewing and swallowing difficulty, and modified texture.

On 11/05/24 at 10:15 AM, Dietary Manager completed the puree process for food to be served to residents who required a pureed diet at the lunch meal. Food items that were pureed included a hot dog with bun and a side of sauerkraut. Dietary Manager stated there were two residents who required pureed diet, Resident #1 and Resident #226. Dietary Manager notified that kitchen would serve hot dog and bun as an

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F 803	Continued From page 154 alternative to smoked sausage and roll with margarine, listed on the menu. On 11/05/24 at 11:00AM, Dietary Manager served residents with general, regular diet, meal that included a hot dog with bun, sauerkraut, mashed potatoes, and brownie. On 11/05/24 at 11:15 AM Dietary Manager prepared two plates of the pureed hot dog with bun, the pureed sauerkraut, and a dish of chocolate pudding and served to Resident #1 and Resident #226. On 11/07/24 at 11:47 AM, Dietary Manager stated that everything on the menu should be pureed and served to the residents on a pureed diet. The facility provided menus for week of 11/04/24. On 11/05/24, the lunch menu informed that the following items would be served: smoked sausage, mashed potatoes, sauerkraut, roll with margarine, and brownie. The facility provided document, no title, no date, listed residents currently on pureed diet included Resident #1 and Resident #226.	F 803		
F 805 SS=G	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review,	F 805		

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F 805	Continued From page 155	F 805		

policy review, and staff interview, the facility failed to provide the correct diet for 2 of 5 residents reviewed for nutrition(Residents #11 and #226). The facility reported a census of 26 residents.

Findings include:

1. The Care Plan, dated 10/31/24, revealed that Resident #226 has nutritional problem or potential for nutritional problem and required regular diet with pureed texture, and instructed staff to serve diet as ordered.

Resident #226 diet order, dated 10/31/24, revealed order for regular, puree texture diet and thin liquids.

Review of Nutritional Assessment, dated 11/04/24, informed that Resident #226 is at increased risk for altered nutrition due to co-morbidities, chewing and swallowing difficulty, and modified texture.

The Discharge Summary from previous nursing home, dated 10/31/24, stated that resident needed supervision with eating and that resident should be served one food at a time with a small spoon .

On 11/04/24 at 11:20 a.m., Staff A, Cook served Resident #226 a plate of regular consistency food. One minute later, staff A, cook came back and stated that he knew he was going to screw that up and proceeded to take the food away from Resident #226 after he had consumed several bites of food. At that time the resident had began excessively coughing with large amount of phlegm coming from mouth and nose.

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On 11/04/24 at 11:22 a.m., Resident #226 stopped coughing and drooling.

On 11/04/24 at 11:24 a.m., Resident #226 was served the correct consistency and proceeded to cough with eating intermittently, but was able to eat some more food of the pureed consistency.

On 11/04/24 at 11:30 a.m., the Director of Nursing (DON) was interviewed on what Resident#226 ' s diet is ordered as and she stated that it is puree texture with thin liquids and handle cups. She stated that she provided it to the kitchen herself prior to the resident ' s arrival. She was then queried on what would happen if Resident #226 would be provided with regular consistency food and she stated that he would most likely choke because he eats his food very fast. At this point in time, the State Agency (SA) notified the DON of the findings to allow for appropriate assessment and interventions for this resident.

On 11/04/24 at 11:38 a.m., interview from Staff A, Cook, revealed that the dietary staff get the dietary information from the nurses. Staff A, cook, acknowledged that he provided the resident with regular consistency food and then noticed that his count was off for plates so he and went back to fix it. Staff A, cook, acknowledged that Resident #226 would probably choke if he ate regular consistency food. When queried about the location of the modified diet postings in the kitchen, staff A, cook stated that it is posted in the kitchen and that it is also in a book. Staff A, Cook, stated that he does not utilize the books because he has struggled with them.

On 11/04/24 at 11:48 a.m., Resident #226 was found lying in his room alone. The Resident

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stated that he was fine and he did not feel short of breath. At that time, the resident was noted to still have an intermittent cough. The resident denied feeling like there was anything stuck in his throat

2. The Minimum Data Set(MDS) assessment tool, dated 8/28/24, listed diagnoses for Resident #11 which included non-Alzheimer's dementia, anxiety, and psychotic disorder. The MDS listed a Brief Interview for Mental Status(BIMS) score of 0 out of 15, indicating severely impaired cognition.

On 11/6/24 at 11:23 a.m., Resident #11 ate cole slaw which contained shredded cabbage approximately a half inch long.

An Order Details report listed a 5/30/24 order for a mechanical soft ground meat diet texture.

The Week 1 Wednesday Menu directed staff to serve residents on a regular diet creamy coleslaw and residents on a mechanical soft diet steamed cabbage.

On 11/6/24 at 12:42 p.m., the Certified Dietary Manager(CDM) stated she served Resident #11 cole slaw because she did not have extra cabbage(to boil). She stated she cut it down to a smaller size for her to eat.

On 11/19/24 at 11:59 a.m. via phone, the Director of Nursing(DON) of a sister facility stated the facility should follow diet orders.

The facility policy "Therapeutic Diets", revised October 2017, stated diets would be determined

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F 805	Continued From page 158 in accordance with the resident's treatment goals and would include modifications in texture.	F 805		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings,	F 842		

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law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(h)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, policy review, and staff interview, the facility failed to ensure the accuracy of records for 1 of 2 residents receiving Hospice services(Resident #9) and for 1 of 5 residents reviewed for a change in condition(Resident #20). The facility reported a census of 26 residents.

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Findings include:

1. The Minimum Data Set(MDS) assessment tool, dated 8/14/24, listed diagnoses for Resident #9 which included Parkinson's disease(a disease which causes symptoms such as tremors), anxiety, and depression and listed his Brief Interview for Mental Status(BIMS) score as 9 out of 15, indicating moderately impaired cognition.

An 8/27/24 Hospice Discharge Summary stated the resident was no longer terminally ill and discharged from Hospice on 8/23/24.

A 10/1/24 Nursing Note stated the provider visited on 9/25/24 with no new orders and to continue on Hospice.

A provider Encounter Note, dated 10/23/24, stated the resident received Hospice services.

An 11/4/24 Dietary Note stated the resident remained on Hospice level of care.

On 11/19/24 at 1:57 p.m., the Administrator stated records should be accurate.

The facility policy "Charting and Documentation", revised July 2017, stated documentation in the medical record would be complete and accurate.

2. The Minimum Data Set (MDS), dated 10/09/24, revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicated moderate cognitive impairment. The MDS revealed that Resident #20 had one fall

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without injury since the previous assessment. Diagnoses included non-traumatic brain dysfunction, non-Alzheimer's dementia, heart failure, and psychotic disorder.

The Care Plan, revised 8/27/24, revealed Resident #20 at risk for injury from falls, and informed that Resident #20 had an unwitnessed fall without injury on 8/27/24. The Care Plan identified a risk for chronic pain and revealed Resident #20 had displaced comminuted fracture of the left humeral neck and greater tuberosity with soft tissue swelling on 9/26/24. Intervention instructed staff to apply left shoulder immobilizer as ordered and as tolerated by resident, for comfort.

A Nursing Progress Note, dated 9/25/24 at 5:53 AM, revealed Resident #20 was found to have swelling and slight bruising on left shoulder spread down arm to the elbow, resident unable to move arm.

Incident Report for injury of unknown cause completed on 9/26/24 by Director of Nursing (DON). The Report described incident as Resident #20 found by Certified Nursing Assistant (CNA) with pain to left shoulder, Nurse assessed resident observed bruise and abnormal range of motion. Incident Report identified an injury located on the front of left shoulder, unable to identify injury type, and immediate action had been Resident #20 sent to Emergency Room (ER).

A Provider Visit Note, dated 10/23/24, revealed that Resident #20 had a fall and sustained a fracture to left humerus and left upper extremity in an immobilizer. Addendum to 10/23/24 Visit

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Note, documented on 11/13/24, revealed that there is no facility documentation of a fall and how arm fracture occurred is unknown.

A Hospice Provider Note, dated 10/08/24, revealed that Resident #20 recently had a fell and experienced a fractured hip and bruising to left shoulder. Addendum to 10/08/24 Hospice Note, documented on 11/14/24, revealed that staff member did not receive evidence or report of patient fracturing left hip and did not receive evidence or report confirming patient had a fall.

Review of the facility's 5 day investigation summary for self-reported incident revealed an investigation was completed for an unwitnessed incident and informed that an incident occurred on 9/25/24 at approximately 2:15 PM.

Review of the facility's submitted list of self reported incidents revealed a report had been submitted on 9/26/24 at 3:22 PM to the State Agency, which listed the incident date as 9/25/24 and incident type as accident with major injury.

The facility provided a timeline of events, not dated, signed by Director of Nursing (DON), related to Resident #20's left shoulder fracture. The document revealed in bullet point number 6, under events that occurred on 9/26/24, that DON called Hospice to notify of fall and order for x-ray.

On 11/13/24 at 2:53 PM, Director of Nursing (DON), stated Resident #20 did not have any falls around the time of left shoulder fracture and informed that Resident #20 would not be able to get self up from floor if she had fallen. DON revealed they were unaware that Provide Visit Note and Hospice Note both noted a fall with

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F 842	Continued From page 163 fracture. On 11/19/24 at 2:06 PM, Facility Administrator revealed expectation that resident clinical records are accurate. The facility policy, titled Charting and Documentation, dated 7/2017, revealed the medical record should facilitate communication between interdisciplinary team regarding the resident's condition and response to care. The policy listed an expectation that documentation in the medical record be objective, complete, and accurate.	F 842		
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State	F 865		

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Survey Agency no later than 1 year after the promulgation of this regulation;

§483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and

§483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

§483.75(b) Program design and scope.
A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:

§483.75(b)(1) Address all systems of care and management practices;

§483.75(b)(2) Include clinical care, quality of life, and resident choice;

§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.

§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.

§483.75(f) Governance and leadership.

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The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:

§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.

§483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing;
§483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;

§483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.

§483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and

§483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect.

§483.75(h) Disclosure of information.
A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.

§483.75(i) Sanctions.
Good faith attempts by the committee to identify

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and correct quality deficiencies will not be used as a basis for sanctions.
This REQUIREMENT is not met as evidenced by:
Based on previous 2567 review, staff interview, and facility policy review the facility failed to ensure an effective QAPI (Quality Assurance Performance Improvement) process to address previously identified quality deficiencies, resulting in multiple repeat deficiencies identified on the facility's current recertification and complaint survey that were previously identified during surveys completed in the last twelve months. The facility reported a census of 26 residents.

Findings include:

Review of the facility's CMS-2567 form from a recertification and complaint survey dated 1/16/24 to 1/23/24 revealed, in part, deficient practices identified with advanced directives, care plan revision, activities of daily living related to incontinence care, lack of a qualified Infection Preventionist to attend Quality Assurance meetings, and lack of a qualified Infection Preventionist.

During the facility's current recertification and complaint survey initiated 11/4/24 to 11/19/24, deficient practices were again identified with all of the above areas from the facility's previous recertification survey.

On 11/19/24 at 3:35 PM, the facility's Administrator explained QA occurred the last Wednesday of the month, was done on a monthly basis, and ad hoc QAPI was done as well, whatever needed to do to fix processes.

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F 865	Continued From page 167 Review of the Facility Policy titled Quality Assurance Performance Improvement Plan [QAPI] for [Facility Name Redacted] revealed, in part, the following: IV. Feedback, Data Systems and Monitoring a. The facility will use a broad range of sources when monitoring and gathering data. b. Sources of this data may include but will not be limited to... iv. Survey findings (Annual and Complaint)	F 865		
F 868 SS=E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance	F 868		

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F 868	Continued From page 168 activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to employ a required Quality Assurance(QA) committee member, a qualified Infection Preventionist, to perform infection control surveillance and report to the governing body. The facility reported a census of 26 residents. Findings include: The QAPI Plan, dated 9/01/2021, revealed that staff members with the most knowledge and commitment to QAPI efforts will participate. Review of QAPI sign in sheets between 3/21/24 and 9/25/24 revealed no Infection Preventionist had been identified as present at meetings. The Facility Assessment, reviewed by Quality Assurance Committee on 8/15/24, revealed services and care offered based on resident needs included infection prevention and control, identification and containment of infection, and prevention of infections. On 11/19/24 at 2:06 PM, Facility Administrator	F 868	Past noncompliance: no plan of correction required.	

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F 868	Continued From page 169 reported that Director of Nursing (DON) had acted as Infection Preventionist for the facility, but was unsure if DON had been certified. Administrator informed that facility was unable to produce an Infection Preventionist certification. On 11/19/24, the facility was unable to produce any data that indicated a certified Infection Preventionist was employed at the facility. The facility policy titled, Infection Prevention and Control Program, revised 10/2018, revealed that the facility's infection prevention and control program is coordinated and overseen by the facility Infection Preventionist.	F 868		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165355	A. BUILDING _____ B. WING _____	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEOTA HEALTH CARE CENTER	204 NORTH KEOKUK WASHINGTON ROAD KEOTA, IA 52248

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 170	F 880		

conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165355	A. BUILDING _____ B. WING _____	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEOTA HEALTH CARE CENTER	204 NORTH KEOKUK WASHINGTON ROAD KEOTA, IA 52248

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F 880	Continued From page 171 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, the facility failed to carry out infection control practices for 1 of 6 residents observed during medication pass observations(Resident #6). The facility reported a census of 26 residents. Findings include: On 11/6/24 at 6:08 a.m., Staff B Licensed Practical Nurse(LPN) administered the following medications(pills) to Resident #6: Lisinopril(a medication for blood pressure), Olanzapine(an antipsychotic), calcium and vitamin D, iron, and Omeprazole(a medication for heartburn). The resident dropped one of the pills in his lap and Staff B picked up the medication with her bare hand and placed it back in the resident's mouth. On 11/19/24 at 1:59 via phone, the Director of Nursing(DON) of a sister facility stated staff should pick up medications with gloved hands. The facility policy "Administering Medications", revised December 2012, directed staff to follow infection control procedures during the administration of medications.	F 880		
F 882 SS=E	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)	F 882		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165355	A. BUILDING _____ B. WING _____	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 882	Continued From page 172 §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on policy review and staff interviews the facility failed to provide an Infection Preventionist with specialized training or certification to monitor and provide oversight for the facility's Infection Prevention and Control Program. The facility reported a census of 26 residents. Findings include: The facility policy titled, Infection Prevention and Control Program, revised 10/2018, revealed that the facility's infection prevention and control program is coordinated and overseen by the facility Infection Preventionist. On 11/19/24 at 2:06 PM, Facility Administrator reported that Director of Nursing (DON) had acted as Infection Preventionist for the facility, but was unsure if DON had been certified.	F 882	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165355	A. BUILDING _____ B. WING _____	11/19/2024

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F 882	Continued From page 173 Administrator informed that facility was unable to produce an Infection Preventionist certification. Director of Nursing (DON) unavailable during periods of state survey to provide additional information on Infection Preventionist certification. On 11/19/24, the facility was unable to produce any data that indicated a certified Infection Preventionist was employed at the facility.	F 882		

F 550 Resident Rights/Exercise of Rights

The facility does treat residents with respect and dignity and provides care that aligns with resident's rights.

All residents, including resident 20, have been assessed by the Administrator, Human Resources and DON for any ill effects from the result of this deficiency and no ill effects were found.

Resident rights will be reviewed each month at monthly council meetings held by the Activity Coordinator.

Resident #20's care plan has been updated and reviewed on December 10, 2024.

All staff have been re-educated regarding resident rights and dignity. All staff have been educated on appropriate comments towards residents and in their proximity, engaging with residents, and proper ADL cares. Residents Rights/Dignity policy will be in the facilities monthly education binder and will be reviewed annually during our monthly in-service meetings.

The facility Activity/Social Director or designee will audit resident rights and dignity by speaking with residents daily x 90 days and then weekly and as needed thereafter. Findings will be reviewed at the facility monthly QAPI meeting.

Responsible Party: Administrator/Activity Director/Social Worker/DON/HR Manager

Date of Compliance: December 19, 2024

F578 Request/Refuse/Discontinue/Advance Director

The facility does implement advanced directives per resident and family directives upon admission.

Resident #22's code status was clarified on November 24, 2024 and now is a DNR.

All residents advance directives/code status have been audited for accuracy as of December 10, 2024.

Nurses have been re-educated regarding advanced directives/code status matching in the medical records and being accurate on December 10, 2024.

Admin/DON/Designee will perform audits regarding advanced directives/code status to ensure accuracy weekly x4 and then monthly x2 with results discussed in monthly QAPI meetings for further review of continued compliance.

All new admissions will be discussed or compliance in monthly QAPI meetings.

Responsible Party: Admin/DON/Designee

Compliance Date: December 19, 2024

F583 Personal Privacy/Confidentiality

The facility will safeguard the personal privacy and confidentiality of all resident personal and medical information.

All staff have been educated on HIPPA policy December 2024 during our monthly in-service meeting.

Confidentiality of Information and Personal Privacy Policy will be maintained in the facilities education binders and reviewed upon hire and again annually.

All clinical staff have been educated on how to lock and also to lock their computer screens when they are not viewing residents' charts.

DON will continue to re-educate current staff and new hires about the policy.

This will be reviewed during our facility monthly QAPI x3.

Compliance Date: December 19, 2024

Responsible Party: Admin/DON/Designee

F600 Free from Abuse and Neglect

The facility does protect residents from abuse and neglect. Residents 7, 11, 12,15,16,19,20, and 21 have been assessed by nursing staff and have been found to have not suffered any ill effects from this deficient practice.

Care plans have been reviewed and updated for accuracy on November 14, 2024.

All staff have been educated on Abuse and Neglect and timely reporting and thorough investigations on November 14, 2024.

The Abuse and Neglect Policy will be maintained in the facilities education binders, reviewed in monthly in-services and during the new hire process.

Administrator and DON have been educated by the regional team on abuse, timely reporting, and thorough investigations on November 14, 2024.

DON/ADMIN/Designee will perform audits by frequently speaking with residents and staff regarding abuse 1:1 staffing weekly x4, monthly x2 with results discussed at monthly QAPI meeting for further review of continued compliance.

Compliance Date: November 14, 2024

Responsible Party: Admin/DON/Designee

F609 Reporting of Alleged Violations

The facility does report allegations of abuse. Residents 7, 11, 12,15,16,19,20, and 21 have been assessed by nursing staff and have been found to have not suffered any ill effects from this deficient practice.

All staff have been educated on abuse and reporting timely on November 14, 2024.

Nursing staff have been educated properly to be provided upon hire, monthly during in-service meetings and as needed to ensure compliance with abuse policies and procedures. The Abuse Reporting Policy will be maintained in the facility monthly education binders.

Administrator and DON have been educated by the regional team on abuse reporting, timely reporting, and thorough investigation on November 14, 2024.

The Administrator will audit abuse compliance weekly x4, monthly x6 and as needed with results reviewed in monthly facility QAPI meetings.

Responsible Party: ADMIN/DON

Compliance Date: November 14, 2024

F610 Investigate/Prevent/Correct Alleged Violation

The facility does complete thorough investigations and ensures immediate protection for residents.

Residents 7, 11, 12,15,16,19,20, and 21 have been assessed by nursing staff and have been found to have not suffered any ill effects from this deficient practice.

All staff have been educated on abuse and timely reporting on November 14, 2024.

Investigation, prevention and reporting will continue to be provided upon new hire, during monthly in-services and annually. The policy will be maintained in the facility educational binders.

The administrator will audit the abuse compliance weekly x4, monthly x6 and as needed with results reviewed in monthly facility QAPI meetings.

Responsible Party: ADMIN/DON/ALL staff

Compliance Date: November 14, 2024

F623 Transfer/Discharge

The facility does give notice of transfer and discharges to the LTC Ombudsman monthly.

The reasons for discharge are recorded in the monthly report.

Resident #3 was added to the updated Ombudsman report and resubmitted to the Ombudsman on November 13, 2024.

Administrator and designee have been reeducated on November 13, 2024, regarding accurate reporting to the Ombudsman.

The administrator will audit the Transfer/Discharge Notifications monthly and results will be reviewed in facility monthly QAPI meetings.

Reports will be maintained in the Administrators' office.

Responsible Party: Administrator/Designee

Compliance Date: December 19, 2024

637 – Comprehensive assessment after significant change

Keota Health Care Center will continue to provide care to residents who have experienced significant change in physical and mental conditions. In response to the allegation of violations regarding comprehensive care plan assessments, education has been provided to all Nursing Staff on proper, accurate, and timely comprehensive assessments. Any issues will be addressed in daily QA meeting.

The Director of Nursing or designee will complete 5 audits weekly for 4 weeks, then twice monthly for 4 weeks, then monthly ongoing until compliance is achieved per DIA standards. These audits will include 5 random residents to ensure comprehensive assessments are completed. All deficiencies are resolved with resident 22. Alleged compliance day is December 19, 2024.

F657 – Care plan timing and revision

Keota Health Care Center will continue to provide care to residents providing comprehensive and quarterly review assessments. In response to the allegation of violations regarding deficient comprehensive and quarterly review assessment

education has been provided to all nursing staff on regulatory standards for timely and comprehensive assessments. Any issues will be addressed in the daily QA meeting.

The Administrator/Designee will complete 5 audits weekly for 4 weeks, then twice monthly for 4 weeks, then monthly ongoing until compliance is achieved per DIA standards. Auditor will review 5 random residents to ensure all care plans are completed and revised per DIA standards. All deficiencies are resolved with resident 3, 5, 7, 10, and 22. Alleged compliance day is December 19, 2024.

F677 ADL's

Keota Health Care Center will continue to provide care to residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

Residents #3, 20, and 22 have been assessed by nursing staff and have been found to have not suffered any ill effects from this deficient practice.

Current residents residing in the facility have the potential to be affected.

Director of Nursing/Designee will complete audits weekly for four weeks, then twice monthly for four weeks, then monthly and ongoing until compliance is achieved per DIA standards. Auditor will review the bathing list and POC charting for bathing during daily QA meeting. Concerns identified will be reported and addressed in the facility quarterly QAPI committee meetings for additional intervention as indicated. Educated staff on refusal documentation.

Nursing staff have been educated on the policy regarding supporting Activities of Daily Living as of November 10, 2024

All sample resident deficiencies are resolved. Alleged date of compliance is December 19,2024.

F679 Activities Meet Interest of Residents

The facility does provide ongoing activity programs to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities.

The activities are designed to meet the interests of and the support of each resident, encouraging both independence and interaction in the community.

Resident #3 and 11 experienced no harm or ill effects from our deficient practice ad their care plans have been updated ensure compliance.

All residents will be encouraged to attend activities.

1 on 1 activities have been developed with additional activity projects have been purchased.

The Activity Director and designee will audit the activities program daily x5, weekly x 4, monthly x6 and as needed with results forwarded to the monthly QAPI meetings for further review and recommendations.

Responsible Party: Admin/Activity Director

Compliance Date: December 19, 2024

F684 – Quality of Care and Change of Condition

Keota Health Care Center will continue to provide care to residents through proper treatment and care to all facility residents. In response to the allegations for violations regarding change of condition and quality of care education has been provided to all nursing staff on providing appropriate cares, reporting significant changes, and following all orders. Any issues will be addressed in the daily QA meeting.

A comprehensive head to toe assessment was conducted for all residents to identify any changes of condition that deviated from their baseline status on November 7, 2024.

All staff members received training on how to identify changes in condition and the importance of reporting these changes to the charge nurse on November 7, 2024.

Charge nurses were trained on how to recognize a change of condition and the expectation to notify the attending provider immediately when a change is identified on November 7, 2024.

The Director of Nursing or designee will complete 5 audits weekly for 4 weeks, then twice monthly for 4 weeks, then monthly ongoing until compliance is achieved per DIA standards. Auditor will review 5 random residents to ensure all Medical, Dietary, Physician, and any other orders are followed per regulation, and all significant changes are reported to the Director of Nursing. All deficiencies are resolved with residents 20, 25, and 226. Alleged compliance day is November 7, 2024.

F689 Free of Accidents Hazards-Walker/Gait Belt

The facility does ensure that the residents environment remains free of accident as is possible.

The facility does provide adequate supervision and assistance devices to prevent accidents.

Residents #2, 3, 5, 10, 21 and 22 experienced no harm or ill effects and all fall preventions are in place and addressed in the resident care plan.

All nursing staff have been re-educated on the facility falls and fall risk management, as well as wheelchair policy and gait belt policy.

Staff have been educated on food brought in from the outside and will ensure that community members don't bring into the facility foods/items per policy.

The staff have been educated on DME changes and all changes and concerns need to be addressed by the DON for evaluation and approval. Compliance Date: November 12, 2024.

The Director of Nursing/designee will audit care plan compliance x5 weekly, monthly x6 and as needed with results forwarded to the monthly facility QAPI meeting for further review and recommendations.

Responsible Party: Director of Nursing/Designee

Date of Compliance: December 10, 2024

F690 Incontinence and UTI

Keota Health Care Center will continue to provide care to residents who are incontinent and at risk for UTI's. In response to the allegations for improper incontinent care education has been provided to all nursing staff in accordance to Federal, State, and company standards on proper incontinence and UTI treatment. Any issues will be addressed in daily QA meetings.

The Director of Nursing or designee will complete 5 audits weekly for 4 weeks, then twice monthly for 4 weeks, then monthly ongoing until compliance is achieved per DIA, Federal and Company standards. Auditor will review 5 random residents to ensure incontinence care is provided per regulation, and all significant changes are reported to the Director of Nursing. All deficiencies are resolved with resident 12. Alleged compliance day is December 19, 2024.

F700 Bedrails

The facility ensures that correct installation, use, and maintenance of bed rails. Resident #2 has been assessed by nursing staff and have been found to have not suffered any ill effects from this deficient practice.

The facility does do bed rail assessments.

The facility has a Bed Rail Entrapment Zone Measurement Tool. Compliance Date: November 5, 2024.

Responsible Party: Director of Maintenance/ADMIN/DON

The Admin/DON or designee will complete audits weekly for 4 weeks, then twice monthly for 4 weeks, then monthly to ensure all bed rails are assessed and care planned prior to being placed on bed and maintenance will assess as long as they are on for compliance. Alleged compliance day is Compliance Date: November 5, 2024.

F725 Sufficient Nursing Staff

Keota Healthcare Center will continue to monitor and provide adequate staffing based on facility PPD and will continue timely call light responses. Current residents residing here have the potential to be affected. DON or designee will maintain and track staffing daily utilizing facility's daily staffing sheet updated five days a week for four weeks, then three times a week for four weeks, then twice a week for four weeks, and ongoing until compliance is achieved per DIA standards. DON or designee will provide staffing updates in daily QA meeting 5 days a week. Staffing coordinator will communicate all staffing needs to Administrator via email for additional staffing approval needs. Administrator or designee will complete five call light response audits a week for four weeks, then three times a week for four weeks, then twice a week for four weeks, and ongoing until compliance is achieved per DIA standards. Failures in staffing when identified will be reported and addressed in daily QA and quarterly QAPI committee meetings for additional intervention as indicated. Education has been provided to all staff currently scheduled with all other staff on or before their next scheduled shift on alleged compliance date about the policies and procedures for Attendance and efficient call light response.

Keota Healthcare center will continue to provide care to residents who are unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

Current residents residing in the facility have the potential to be affected.

Director of Nursing or designee will complete audits weekly for four weeks, then twice monthly for four weeks, then monthly and ongoing until compliance is achieved per DIA

standards. Auditor will review the bathing list and POC charting for bathing during daily QA meeting. Concerns identified will be reported and addressed in the facility quarterly QAPI committee meetings for additional intervention as indicated. Educated staff on refusal documentation.

Nursing staff have been educated on the policy regarding supporting Activities of Daily Living as of December 19, 2024

Residents #2 & 77 have been assessed by nursing staff and have been found to have not suffered any ill effects from this deficient practice. Alleged compliance day is December 19, 2024.

F740 – Behavior Health Services

Keota Health Care Center will continue to provide care to residents who are in need of Behavioral Health Services. In response to the allegations for provision of psychiatric services. Any issues will be addressed in daily QA meetings.

The Director of Nursing or designee will complete 5 audits weekly for 4 weeks, then twice monthly for 4 weeks, then monthly ongoing until compliance is achieved per DIA, Federal and Company standards. Auditor will review 5 random residents to ensure psychiatric services are provided per regulation, and all significant changes will be addressed in QA meeting. All deficiencies are resolved with resident 17. Alleged compliance day is December 19, 2024.

F759/F760 – Medication errors

Keota Health Care Center will continue to provide care to residents who are in need of us distributing medications for residents with less than 5% errors per regulation. In response to the allegations for medication errors, education has been provided to all nursing staff in accordance to Federal, State, and company standards on proper Medication distribution with error rates less than 5%. Any issues will be addressed in daily QA meetings.

The Director of Nursing or designee will complete 5 audits weekly for 4 weeks, then twice monthly for 4 weeks, then monthly ongoing until compliance is achieved per DIA, Federal and Company standards. Auditor will review 5 random residents to ensure proper medication distribution. All nursing staff has been educated on proper medication distribution documentation. All deficiencies are resolved with resident 2, and 4. Alleged compliance day is December 19, 2024.

F761 – Storage of drugs and biologicals

Keota Health Care Center will continue to provide care to residents who need assistance with all drugs. In response to the allegations for Storage of drugs and biologicals, education has been provided to all nursing staff in accordance of all medications and biologicals being stored, labeled, and distributed properly. Any issues will be addressed in daily QA meetings.

The Director of Nursing or designee will complete 5 audits weekly for 4 weeks, then twice monthly for 4 weeks, then monthly ongoing until compliance is achieved per DIA standards. Auditor will review 5 random residents to ensure all drugs are provided and stored per regulation. All deficiencies are resolved with residents 2, 9, 11, and 12. Alleged compliance day is December 19, 2024.

F803 Menus Meet Resident Needs

The facility's menu meets the nutritional needs of residents in accordance with established national guidelines.

Residents #1,3 and 226 were free of harm from our deficient practice.

Proper meal administration education was given to all staff on November 6, 2024.

Meal cards, adaptive equipment, and therapeutic diets have been updated with notifications posted in the dietary department.

The Dietary Manager will audit the menu weekly x4, monthly x5, and as needed with results forwarded and reviewed at the monthly facility QAPI meeting. Alleged compliance day is December 10, 2024.

F805 – Food and Drink

Keota Health Care Center will continue to provide care to residents who have dietary restrictions. In response to the allegations for food and drinks education has been provided to all nursing staff, and dietary staff on following diet orders on or before December 10, 2024. Any issues will be addressed in daily QA meetings.

The Administrator or designee will complete 5 audits weekly for 4 weeks, then twice monthly for 4 weeks, then monthly ongoing until compliance is achieved per DIA standards. Auditor will review 5 random residents to ensure all diet orders are followed during mealtimes. All deficiencies are resolved with resident 11 and 226. Alleged compliance day is December 10, 2024.

F842 – Resident records

Keota Health Care Center will continue to provide care to residents. In response to the allegation for resident records education has been provided to all staff of retaining medical records and keeping correct and timely records when a change is identified for a resident. Any issues will be addressed in daily QA meetings.

The Administrator or designee will complete 5 audits weekly for 4 weeks, then twice monthly for 4 weeks, then monthly ongoing until compliance is achieved per DIA standards. Auditor will review 5 random residents to ensure that the facility has all records per regulation and accurate information. All deficiencies are resolved with resident 9, and 20. Alleged compliance day is December 19, 2024.

F865 QAPI Program/Plan-Good Faith Attempt

The facility does ensure an effective QAPI process to address previously identified quality deficiencies, resulting in repeat deficiencies identified during past surveys.

The QAPI plan has been reviewed and updated on November 7, 14, 21, 27 and facility will hold next monthly QAPI on December 23, 2024.

All deficiencies for the past 2 years will be addressed in future QAPI meetings.

All staff have been educated on the QAPI process December 6, 2024.

Admin/DON/Designee will perform audits related to effective QAPI meetings monthly x12 months with results discussed at the next QA meeting for further review of continued compliance.

Responsible Party: Admin

Compliance Date: December 19, 2024

F868 QAA Committee

The facility does ensure that quarterly QAPI meetings are held.

No residents experienced any ill effects from a deficient practice.

Our facility holds monthly meetings on and our next scheduled monthly QAPI meeting is scheduled for December 23, 2024.

The Administrator will audit the follow-up and meeting topics from the annual survey and from previous meetings and will monitor results monthly to ensure compliance with this regulation.

Responsible Party: Admin

Compliance Date: December 19, 2024

F880 Infection Prevention and Control

The facility does implement an infection control surveillance plan to identify, track, monitor, and report infections.

The DON has her Infection Prevention Certificate. Compliance Date: December 6th, 2024

Residents #6 have been assessed by nursing staff and have been found to have not suffered any ill effects from this deficient practice.

Responsible Party: DON/Certified Infection Preventionist

Compliance Date: December 19, 2024

F882 Infection Preventionist Qualifications Role

"states no plan of correction is required"