STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165222	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORYDON SPECIALTY CARE	745 EAST SOUTH STREET CORYDON, IA 50060

(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 000	INITIAL COMMENTS Type text here Correction date 06/28/2022 Complaints # 101254-A, # 101321-A, # 101453-C, # 101894-C, # 102010-C, # 102882-C, # 104485-C and # 104818-C and facility-reported incidents # 100108-I, # 100422-I and # 102202-I and mandatory report # 101847-M were investigated May 23 - June 16, 2022. Facility-reported incidents # 100108-I and # 102202-I were substantiated. Facility-reported incident # 100422-I was not substantiated. Complaints # 101254-A, # 101321-A, # 101453-C, # 101894-C, # 102010-C, # 102882-C, # 104485-C and # 104818-C were substantiated. Investigation of # 101847-M resulted in deficiency. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Corydon Specialty Care does not admit that the deficiency listed on this form exist, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The facility reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
POC OK 7/5/22 SjS				
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms,	F 604	F604 Right to be free of Physical Restraints Corydon Specialty Care residents have the right to be treated with respect and dignity. Residents have the right to be free from any physical or chemical restraints. Residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Resident #1 was free of restraint	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Markie McElvain — TITLE: Administrator — (X6) DATE: 06/28/2022

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 604	Continued From page 1 consistent with §483.12(a)(2). §483.12 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)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and facility investigation review, the facility failed to ensure residents were kept free from physical restraint imposed for the purpose of convenience for 1 of 5 current residents reviewed (Resident #1). The facility reported a census of 59. Findings include: According to Resident #1's Minimum Data Set (MDS) assessment with a reference date of 10/28/21, Resident #1 had a Brief Interview for Mental Status score of 5 indicating a severely impaired cognitive status. Resident #1 required extensive assistance with transfers, mobility,	F 604	Current residents have the potential to be affected Staff have been educated on abuse and neglect policy. Staff have been educated on abuse reporting policy. Staff education provided on chemical restraints. Concerns identified will be reported and addressed in the facility QAPI committee meetings for additional intervention as indicated.	

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F 604	Continued From page 2	F 604		

dressing, toilet use and personal hygiene needs. Resident #1's diagnoses included Non-Alzheimer's dementia, cerebrovascular accident (stroke) with aphasia and hemiplegia.

Review of Resident #1's care plan revealed Resident #1 as at risk for falls, initiated 4/5/19. The care plan contained no interventions addressing restlessness or the use of physical restraints.

According to a stated provided by Staff C, certified nursing assistant (CNA), dated 12/11/21, Staff C indicated that evening, Resident #1 was restless and not ready for bed, so they brought her back to the dining room and informed the nurses, Staff A and Staff B. Staff C stated she was in and out of the dining room and at one point saw Staff A and Staff B standing next to Resident #1, saying they were not going to get their work done and asking for a gait belt then a bed sheet. Staff C left the dining room for a few minutes and upon returning, witnessed both Staff A and Staff B at Resident #1's wheelchair with a bed sheet. Staff C could not see what they were doing, but after she left the area and returned a few minutes later, Resident #1 was in her wheelchair with a sheet crossed under her legs and tied to the chair arms, restraining her from getting up. Staff C immediately informed another CNA who contacted the Director of Nursing (DON) and initiated an investigation.

According to a statement provided by Staff A, licensed practical nurse (LPN) dated 12/12/21, Staff A indicated Resident #1 had been agitated and restless that evening and they placed a sheet over her to provide comfort. When informed the bed sheet was tied to the chair arms, Staff A did

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not confirm or deny her involvement with tying the bed sheet. On 12/15/21 when asked if she was involved with restraining Resident #1, Staff A stated she helped getting a blanket on the resident, but didn't tie it on. When asked why they were doing this, Staff A stated it was to keep the resident from sliding out of her chair. Even with the Dycem (an anti-slip pad) and one way glide, she was still sliding out of the chair.

According to Staff B's statement from 12/11/21, Staff B recorded she was involved with putting a sheet over Resident #1 because she had been disrobing and the sheet may have gotten tangled up because the resident had been restless and moving a lot. On 12/12/21 Staff B was informed of being suspended and responded by saying the resident's hands were not restrained. When told the sheet had been tied to the wheelchair arms, Staff B did not respond to this but asked if she would be able to come back to finish her scheduled shifts.

In an interview on 5/23/22 at 3:55 p.m. the DON stated on the evening of 12/11/21 she received a call informing her there was an allegation of abuse involving Resident #1. The abuse consisted of Resident #1 being restrained to her wheelchair with a bed sheet. During the course of her investigation, 2 nurses, Staff A and Staff B, were identified as the alleged perpetrators. Both Staff A and Staff B admitted to placing the bed sheet over Resident #1 and both Staff A and Staff B denied tying the bed sheet to the wheelchair. Nevertheless, the DON concluded Resident #1 had been restrained in her wheelchair with a bed sheet tied to the wheelchair arms and that it was abuse. However the DON was hesitant to identify whether it was Staff A, Staff B or both involved as

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F 604	Continued From page 4 the perpetrator. In an interview on 5/24/22 at 2:50 p.m. the Administrator stated on 12/11/21 she was contacted by her DON and informed of an allegation of abuse involving Resident #1 and 2 nurses. It was alleged that Resident #1 had been restrained in her wheelchair using a bed sheet. The Administrator reviewed the facility's investigation with their Human Resource management team and determined Staff B as the perpetrator.	F 604		
F 610 SS=J	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §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 clinical record review, staff interviews, and facility investigation, the facility failed to take preventative measures to maintain separation of	F 610	F610 Investigate/Prevent/Correct Alleged Violation Corydon Specialty Care residents have the right to be treated with respect and dignity. Residents have the right to be free from any physical or chemical restraints. Residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Resident #1 was free of restraint Current residents have the potential to be affected Charge Nurse 2 immediately suspended effective 5/25/22. Charge Nurse employment terminated 6/16/22. Staff education will be provided regarding expectation of separation and reporting following any allegation or observation of any form of abuse Monitoring.	

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F 610	Continued From page 5 an alleged perpetrator from residents to ensure residents remained free from potential abuse. The facility also failed to complete a thorough investigation to ensure no abuse occurred prior to the alleged perpetrator being brought back to work. The failure resulted in an Immediate Jeopardy to the health, safety, and security of the residents. A concern was identified for Resident #1 who was tied with a sheet into her wheelchair. The alleged perpetrator returned to work without thorough investigation potentially exposing like residents to be restrained. The facility reported census was 59. Findings include: According to Resident #1's Minimum Data Set (MDS) assessment with assessment reference date of 10/28/21, Resident #1 had a Brief Interview for Mental Status score of 5 indicating a severely impaired cognitive status. Resident #1 required extensive assistance with transfers, mobility, dressing, toilet use and personal hygiene needs. Resident #1's diagnosis included Non-Alzheimer's dementia, cerebrovascular accident (stroke) with aphasia and hemiplegia. Review of care plan notes Resident #1 is at risk for falls. There were no interventions addressing restlessness or using physical restraints. According to the facility's Dependent Adult Abuse Protocols: 1) Abuse includes the willful act to unreasonably confine a resident. 2) Mandatory Reporting Abuse Investigation Procedure includes: a) Allegations are to be reported immediately up the chain of command.	F 610	Staff Education will be provided regarding investigation expectations. Staff education will be provided regarding the definition of a restraint Staff Education will be provided regarding the definition of abuse and neglect. Notification added to facility bulletin board stating the expectation regarding separation and reporting following any allegation or observation of any form of abuse. Concerns identified will be reported and addressed in the facility QAPI committee meetings for additional intervention as indicated.	

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F 610	Continued From page 6 b) The charge nurse shall separate the suspected abuser from the resident. c) The facility shall collect any supporting documentation relative to the incident. d) During the investigation, the facility shall suspend or terminate the accused staff. f) After the facility completes their investigation, the staff member accused may return to work if the nursing facilities investigation did not find founded abuse. e) If returned to the facility, continue to separate the staff member from the victim until there is no investigation determined or the department complete the investigation and is unfounded. According to Staff C's statement from 12/11/21, Staff C indicated that evening, Resident #1 was restless and not ready for bed, so they brought her back to the dining room and informed the nurses, Staff A and Staff B. Staff C stated she was in and out of the dining room and at one point saw Staff A and Staff B standing next to Resident #1, saying they were not going to get their work done and asking for a gait belt then a bed sheet. Staff C left the dining room for a few minutes and upon returning, witnessed both Staff A and Staff B at Resident #1's wheelchair with a bed sheet. Staff C could not see what they were doing, but after she left the area and returned a few minutes later, Resident #1 was observed in her wheelchair with a sheet crossed under her legs and tied to the chair arms, restraining her from getting up. Staff C immediately informed another CNA who contacted the DON and initiated an investigation. The CNA was instructed to untie the sheet and then took Resident #1 to room and the resident was no longer restless and was assisted to bed.	F 610		

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According to Staff P's statement from 12/12/2022, Staff P indicated after Staff C reported that the nurses had taken a bed sheet and tied the resident to wheelchair in the dining room. Staff P went and observed Resident #1 and could see the resident struggling against the white bed sheet that wrapped around chest and it was also wrapped legs. Staff C and Staff were instructed to untie the resident. Staff C struggled to untie the bed sheet especially how it was woven around the resident.

According to Staff A's statement from 12/12/21, Staff A indicated Resident #1 had been agitated and restless that evening and they placed a sheet over her to provide comfort. When informed the bed sheet was tied to the chair arms, Staff A did not confirm or deny she was involved with tying the bed sheet. On 12/15/21 when asked if she was involved with restraining Resident #1, Staff A stated I helped with getting a blanket on her, but I didn't tie it on. When asked why they were doing this, Staff A stated it was to keep her from sliding out of her chair. Even with the dycem and one way glide, she was still sliding out of the chair".

According to Staff B's statement from 12/11/21, Staff B indicated she was involved with putting a sheet over Resident #1 because she had been disrobing and the sheet may have gotten tangled up because she had been restless and moving a lot. On 12/12/21 Staff B was informed of being suspended and responded by saying "her hands were not restrained".
When told the sheet had been tied to the wheelchair arms, Staff B did not respond to this but asked if she would be able to come back to finish her scheduled shifts.

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Observation of a photo taken at the time Resident #1 was tied in the wheelchair showed a bed sheet wrapped between the resident's legs and around the legs. The the ends of the bed sheet was tied to the back rest of the wheelchair.

In an interview on 5/23/22 at 3:55 p.m. the Director of Nursing (DON) stated on the evening of 12/11/21 she received a call informing her there was an allegation of abuse involving Resident #1. The DON was informed witnesses saw Resident #1 restrained in her wheelchair with a bed sheet. The DON initiated an investigation and spoke with those present that evening. During the course of her investigation, two nurses, Staff A and Staff B, were identified as the alleged perpetrators. The two nurses were suspended pending the outcome of the facility investigation. Both Staff A and Staff B admitted to placing the bed sheet over Resident #1 and both Staff A and Staff B denied tying the bed sheet to the wheelchair. The DON stated following her investigation, she concluded Resident #1 had been restrained in her wheelchair with a bed sheet tied to the wheelchair arms and that it was abuse, however was hesitant to identify whether it was Staff A, Staff B or both involved as the perpetrator. The DON stated the investigation was discussed with their corporate management team and the team determined Staff A could return to work under conditions which provided better supervision. Staff B was an agency nurse and her contract was up and not renewed.

In an interview on 5/24/22 at 2:50 p.m. The Administrator stated on 12/11/21 she was contacted by her DON and informed of an allegation of abuse involving Resident #1 and two

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nurses. It was alleged that Resident #1 had been restrained in her wheelchair using a bed sheet. The DON interviewed staff present that evening and upon finishing the interviews, she discussed the incident with their Human Resource management team. It was determined Staff A could return to work with conditions and Staff B was believed to be the perpetrator. The Administrator was asked what evidence they had to support that conclusion and she responded Staff A was not cruel and was suitable to return to work. The Administrator was asked if a bed sheet was used to restrain a resident in her wheelchair for the convenience of staff, would she consider that abuse. The Administrator stated yes. The Administrator was asked if she was aware of a picture taken by a witness that evening, showing the resident restrained in her wheelchair. The Administrator stated she was aware Staff C had taken a picture, but had not seen it. Staff C was instructed to delete the photo. The Administrator stated she did not keep the photo as evidence.

According to the facilities investigative summary, an allegation that Resident #1 was restrained in her wheelchair with a bed sheet was made on the evening of 12/11/21 at 8:45 p.m. The DON contacted the facility to ensure Resident #1 was not restrained. She spoke with Staff A, who acted unaware of whether Resident #1 was restrained or not. Then Staff B called the DON stating Resident #1 had not been restrained. Staff B stated Resident #1 had been restless and disrobing and a sheet was placed over her for this reason. The following day additional statements were collected. Staff C stated she had been the one who noticed Resident #1 restrained with a bed sheet and untied the sheet from the wheelchair. The DON had Staff A and Staff B

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F 610	Continued From page 10 suspended pending the investigation. The summary indicated both Staff A and Staff B would be reeducated regarding care and treatment of residents. Written offense were added to the Staff A and Staff B employment file. Reeducation for all staff regarding the use of restraints and what constitutes a restraint. The summary implies Staff A and Staff B are suspected perpetrators, but does not provide a conclusion to their investigation. According to an email addressed to the facility Administrator from the Regional Director of Human Resources dated 12/16/21, it was determined Staff A would be removed from suspension under the following conditions: *Staff A will move to day shifts where she will receive more supervision. *Staff A will not work in the memory care unit at this time until approved by the Administrator. *Additional Relias courses on resident abuse will be assigned to Staff A to be completed by 1/4/22. *EAP will be highly encouraged. *The Administrator and Regional Director of HR will have weekly conversations with Staff A. *The Administrator and DON will visually check on Staff A throughout her shift for 30 days. *The Administrator will check with residents in Staff A's care twice weekly for 30 days. The State Agency notified the facility of the Immediate Jeopardy on 5/25/22 at 3:25 p.m. The Immediate Jeopardy situation started on 12/17/21. The facility removed the Immediate Jeopardy on 5/25/22 by:	F 610		

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F 610	Continued From page 11 Staff A was immediately suspended effective 5/25/22 Staff education will be provided regarding expectation of separation and reporting following any allegation or observation of any form of abuse Monitoring. Staff Education will be provided regarding investigation expectations. Staff education will be provided regarding the definition of a restraint Staff Education will be provided regarding the definition of abuse and neglect. Notification added to facility bulletin board stating the expectation regarding separation and reporting following any allegation or observation of any form of abuse. The scope lowered from "J" to "D" at the time of the survey after ensuring the facility implemented staff education.	F 610		
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 and staff interviews, the facility failed to provide grooming needs including oral hygiene, nail care and incontinence care for 3 of 3 residents reviewed who were dependent upon staff. (Resident #10, #13, #14) The facility reported census was 59. Findings include:	F 677	F677 ADL Care Provided for Dependent Residents Corydon Specialty Care will continue to provide activities of daily living services to maintain good nutrition, grooming, and personal and oral hygiene. Resident #10 was provided oral care Resident #10 was provided nail care Resident # 10 was provided peri care	

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F 677	Continued From page 12 1. According to Resident #10's Minimum Data Set (MDS) assessment dated 5/18/22, Resident #10 had a brief interview for mental status (BIMS) score of 3 indicating a severely impaired cognitive status. Resident #10 required limited assistance with bed mobility, transfers and dressing and extensive assistance with toilet use and personal hygiene needs. Resident #10's diagnoses included Non-Alzheimer's dementia, arthritis, cancer and malnutrition. According to Resident #10's care plan, Resident #10 had the potential for altered nutritional status and had upper and lower dentures. Resident #10 was frequently incontinent with interventions which included assisting with using the toilet or commode as needed and providing perineal cleansing as needed. Observation on 6/2/22 at 3:12 p.m. revealed Resident #10 walking independently in the hallway with her wheel walker. Resident 10's brief had soaked through and her pants were visibly wet. Observation on 6/8/22 at 7:24 p.m. noted Resident #10 assisted to the toilet using a gait belt and wheel walker. Resident #10 used the toilet and changed into new brief and pajamas. Resident #10 then escorted back to her chair without oral cares offered or provided. Empty denture cup sitting at sink. Observation on 6/15/22 at 3:10 p.m. noted Resident #10 sitting at a dining room table following a Bingo activity. Resident #10's finger nails were full of dark colored debris.	F 677	Resident # 10 hair was groomed Resident #13 was provided oral care Resident #13 hair was groomed Resident #13 face was washed Resident #14 hair was groomed Resident #14 face was washed Resident #14 was provided oral care Resident #14 was provided peri-care Current residents have the potential to be affected Nursing staff have been educated on providing oral care, peri care, grooming, and nail care. Director of Nursing or designee will monitor peri care audits, oral care audits, nail care audits, and grooming audits during stand down meeting. Director of Nursing and or designee will audit three resident oral care audits per week for four weeks then two audits for three weeks. Director of Nursing and or designee will audit three residents peri care audits per week for four weeks then two audits for three weeks. Director of Nursing or designee will audit three residents grooming/face washing/	

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F 677	Continued From page 13 Observation on 6/16/22 at 8:56 a.m. revealed staff getting Resident #10 up for the morning. Resident #10 was assisted up into a sitting position on her bed. Staff J, certified nurse aide, removed her pajama top, and put a bra on and pink sweat shirt on. Resident #10 was provided a wash cloth and washed her face. Resident #10 then assisted to standing and ambulated to toilet with assist of one staff, using a gait belt and wheel walker. Resident #10's soiled brief removed. Resident #10 had had a bowel movement and Staff J cleansed her inner thigh and bottom, but failed to cleanse her front peri area and groin area and did not apply a barrier cream. Resident #10 stood at the toilet and Staff J pulled her fresh brief and blue sweat pants up. Resident #10 then ambulated to the dining room with assistance of Staff J, using a gait belt and wheel walker. Resident #10's hair was not combed and staff failed to offer oral and denture care. 2. According to Resident #13's MDS assessment dated 4/7/22, Resident #13 had a BIMS score of 0 indicating a severely impaired cognitive status. Resident #13 required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #13's diagnoses included Parkinson's disease, renal insufficiency Alzheimer's, and Non-Alzheimer's dementia. Observation on 6/7/22 at 8:08 a.m. revealed Staff E, temporary nurse aide, had just removed Resident #13's soiled brief. Staff E called for assistance. The observation revealed Resident #13's toenails as long, curled and unclipped. After several minutes and no one arriving to assist, Staff E sat Resident #13 up at bedside	F 677	Nail Care audits per week for four weeks then two audits for three weeks. Concerns identified will be reported and addressed in the facility QAPI committee meetings for additional intervention as indicated.	

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and placed a new brief, sweat pants and shirt on Resident #13. Staff F then arrived and together Staff E and Staff F assisted Resident #13 to a standing position, pulled up his brief and pants and pivot-transferred him into his wheelchair. Wheelchair pedals were applied and Staff F propelled Resident #13 to the dining room. Resident #13 was not groomed. Staff failed to comb his hair, wash his hands and face, provide oral care or perineal care before propelling him to the dining room.

In an interview on 6/7/22 at 8:45 a.m. when asked whether she provided peri care prior to this surveyor arriving, Staff E hesitated to respond and then stated yes, but they used only one wipe. The surveyor then removed the trash finding a soiled brief, several gloves, but no used wipe(s).

Observation on 6/9/22 at 8:25 a.m. noted Resident #13 was assisted out of bed and ambulated to the toilet with assistance of two staff using a gait belt and wheel walker. Staff provided a change of clothes and fresh brief. Resident #13's hair was combed and face and hands washed. Resident #13 stood at the toilet and his bottom was wiped with a wet wipe. Resident #13's clothes were adjusted and he was then escorted with assistance of two staff using a gait belt and wheel walker into the hallway and then into his wheelchair. No oral care was offered or provided.

3. According to Resident #14's MDS assessment with assessment reference date of 4/21/22, Resident #14 had a brief BIMS score of 6 indicating a severely impaired cognitive status. Resident #14 required extensive assistance with bed mobility, transfers, dressing, toilet use and

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F 677	Continued From page 15 personal hygiene needs. Resident #14's diagnoses included hip fracture and malnutrition. According to Resident #14's care plan, she had the potential for altered nutritional risk and had full upper and partial lower dentures which were not at the facility. Observation on 6/8/22 at 6:33 p.m. noted Resident #14 ambulating to the bathroom with assist of one staff using a gait belt and wheel walker. Resident #14 was toileted, provided incontinence care and a fresh brief. Clothes changed into a night gown. Resident #14 then escorted back to bed with head of bed at 45 degrees. No oral care offered or provided. Observation on 6/9/22 at 6:35 a.m. noted Resident #14 assisted to the toilet with assistance of one staff using a gait belt and wheel walker. Resident #14 was toileted and clothes changed. Staff wiped bottom with tissue, but did not provide perineal cleansing. Resident #14 ambulated with assistance, gait belt and wheel walker to wheel chair and then propelled to dining room. No grooming, washing of hands and face or oral care was provided.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 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	F 684	F684 Quality of Care Corydon Specialty Care will continue to provide treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the residents choice. Resident #8 skin assessments were completed with description	

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F 684	Continued From page 16 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interviews, the facility failed to ensure residents receive treatment and care in accordance with their assessed needs and professional standards of practice for 2 of 4 residents reviewed (Residents #8, #10). The facility reported census was 59. Findings include: 1. According to Resident #8's Minimum Data Set (MDS) assessment with a reference date of 1/13/22, Resident #8 had a brief interview for mental status (BIMS) score of 15 indicating an intact cognitive status. Resident #8 was independent with bed mobility, transfers, toilet use and personal hygiene needs. Resident #8's diagnoses included gastroesophageal reflux disease and arthritis. According to facility skin evaluations, on 11/1/21, Resident #8 developed a blistered area measuring 3 centimeters by 3 centimeters on his left calf area. The evaluations initially were completed weekly, but by 12/21 became less consistent. On 2/10/22 the skin assessment noted a 3.5 centimeter by 2 centimeter area, but provided no description of the wound's condition, drainage or effectiveness of treatment. Staff did not assess the wound again until 2/28/22 and that assessment lacked specific details of a thorough assessment. According to a progress note 2/17/22 at 2:52 p.m. Resident #8's physician faxed an order to cleanse Resident #8's left shin with normal saline, fill the	F 684	Resident #8 treatment was completed Resident #10 treatment was completed Current residents have the potential to be affected Nursing staff have been educated on providing treatments and skin evaluations Director of Nursing and or designee will monitor treatment audits during stand down meeting. Director of Nursing and or designee will audit three resident treatment audits per week for four weeks then two audits for three weeks. Director of Nursing and or designee will audit 3 residents skin evaluations per week for 4 weeks then two audits for three weeks. Concerns identified will be reported and addressed in the facility QAPI committee meetings for additional intervention as indicated.	

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wound with silvercel gel and cover it with a non stick telfa daily.

According to a progress note 2/26/22 at 2:30 p.m. Resident #8 had difficulty standing and was sneezing with an elevated temperature of 101.6 Fahrenheit.

According to a progress note 2/28/22 at 1:00 p.m. Resident #8's left leg was assessed. The resident's left leg was swollen and the nurse encouraged Resident #8 to be seen by a physician. Resident #8 refused, noting his physician told him to get Lasix (a diuretic) to treat the swelling. The progress note did not describe the wound condition or signs and symptoms of infection.

According to the next progress note dated 3/1/22 at 6:13 p.m. Resident #8 had been sent to the emergency room and they were consulting a physician to have Resident #8 admitted with possible left leg infection.

According to Resident #8's 2/22 Treatment Administration Record (TAR), staff were instructed to cleanse the resident's leg wounds with normal saline and apply a non-stick dressing every day and as needed. The order changed on 2/17/22 to include a Silvercel gel to fill the wound on his left lower leg and apply a non-stick Telfa dressing over the wound daily. The TAR indicated 7 days in 2/22 (6, 8, 15, 18, 20, 23, 25) in which the treatment was not recorded as completed.

According to the hospital discharge summary dated 4/7/22, Resident #8 admitted with chronic history of lower extremity wounds and presented

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in the emergency room with a fever and purulent, bloody drainage. Resident #8 indicated in the last 4 weeks he started having leg pain. Resident #8 spiked a 104 Fahrenheit temperature (3/1/22) and went to the hospital for evaluation. While there, hospital staff extracted 400 milliliters of pus from the left lower extremity wound.

In an interview on 6/13/22 at 2:59 p.m. Staff G, licensed practical nurse, stated she worked as the wound nurse for a period of time and was familiar with Resident #8 and his multiple wounds. Staff G stated Resident #8 would not use their house physician and refused to see a wound specialist. Staff G stated Resident #8 would also not agree to various treatments and often refused wound assessments and pictures. Staff G stated she did not believe the wounds became infected until prior to his hospitalization.

2. According to Resident #10's MDS assessment with a reference date of 5/18/22, Resident #10 had a BIMS score of 3 indicating a severely impaired cognitive status. Resident #10 required limited assistance with bed mobility, transfers and dressing and extensive assistance with toilet use and personal hygiene needs. Resident #10's diagnosis included Non-Alzheimer's dementia, arthritis, cancer and malnutrition.

According to Resident #10's care plan, she had potential and actual skin impairment related to moisture associated skin damage (MASD) in her groin area (5/23/22) with interventions which included treating the effected area per physician orders, to monitor weekly and document measurements, type of tissue, exudates and any other notable changes or observations. Resident #10 had frequent incontinence of urine with

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interventions which included perineal cleansing as needed and observe skin daily for irritation and redness.

Observation on 6/16/22 at 8:56 a.m. noted staff getting Resident #10 up for the morning. Resident #10 was assisted up into a sitting position on her bed. Staff J, certified nurse aide, removed her pajama top, put a bra on and pink sweat shirt on. Resident #10 was provided a wash cloth and washed her face. Resident #10 then assisted to standing and ambulated to toilet with assist of one staff, using a gait belt and wheel walker. Resident #10's soiled brief removed. Resident #10 had had a bowel movement and Staff J cleansed her inner thigh and bottom, but failed to cleanse her front peri area and groin area and failed to apply a barrier cream as ordered.

According to Resident #10's treatment administration record (TAR) for 2022, she is to have Calmoseptine applied to her groin and buttocks twice daily and have her buttocks cleansed gently and dried and a durable moisture barrier cream applied every 8 hours in between the Calmoseptine every shift for skin protection. The TAR indicated these treatments were completed on 6/16/22 day shift by Staff K.

In an interview on 6/16/22 at 1:55 p.m. Staff K, registered nurse, stated she worked the day shift today from 6:00 a.m. to 2:00 p.m. Staff K asked if she had treated Resident #10's skin during her shift. Staff #10 stated she did not apply the Calmoseptine today, despite recording it as completed on the TAR. Staff K stated she relies on the aides to complete the cleansing of the buttocks and applying the durable moisture

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F 684	Continued From page 20 barrier cream and she was not involved in any of those tasks, despite recording it as completed on the TAR.	F 684		
F 689 SS=G	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 record review and staff interviews, the facility failed to provide adequate supervision of a resident who was at high risk for falls and who was getting up frequently unassisted while in the dining room and failed to properly supervise residents who were physically aggressive towards other residents for 3 of 4 incidents reviewed. (Residents #2, #6, #9, #4, #5) The facility reported census was 59. Findings include: 1. According to Resident #6's Minimum Data Set (MDS) assessment with assessment reference date of 10/5/21, Resident #6 had a brief interview for mental status (BIMS) score of 5 indicating a severely impaired cognitive status. Resident #6 required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #6's diagnosis included Alzheimer's, Non Alzheimer's dementia, congestive heart failure, renal insufficiency and	F 689	F689 Free of Accident Hazards/Supervision/Devices Corydon Specialty Care will continue to provide an environment free of accident hazards as is possible and each resident receives adequate supervision and assistive devices to prevent accidents. Resident #6 was provided supervision at time of fall Residents #2 and #9 was provided separation Resident #4 and #5 was provided separation Current residents have the potential to be affected Administrator has removed doorbell to facility. Nursing staff have been educated on providing separation of residents who are exhibiting aggressive behaviors. Nursing staff have been education on supervision of residents who exhibit restless behavior. Director of Nursing and or designee will monitor during stand down meeting.	

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F 689	Continued From page 21 chronic obstructive pulmonary disease. Resident #6's plan of care indicated a focus area on risk for falls with interventions which included making sure Resident #6 was wearing proper footwear, provided a safe environment without clutter, provided grippy strips at bedside and in front of recliner, provided dycem for her recliner wheelchair and place a black mat at bedside to decrease risk for injury. According to incident reports from 7/1/21 through 11/27/21, Resident #6 had 17 recorded falls. 5 falls occurred in November alone. The incident report dated 11/27/21 at 4:20 p.m. indicated it was near dinner time and the dining room was noisy with several visitors entering the building and using the doorbell. Resident #6 had got up unassisted on several occasions to answer the doorbell and was redirected back to her chair each time. At 4:20 p.m. Resident #6 was discovered on the floor. Resident #6 had a hematoma above her right eye and her left hip appeared out of socket. Resident #6 screamed in pain when touched. The physician was notified and Resident #6 was sent out to the emergency room for evaluation. According to the Emergency Room Note: Assessment dated 11/27/21, Resident #6 sustained an acute fracture of the pubic ramus (pelvis) and was also diagnosed with pulmonary edema, possible bacterial pneumonia, end stage Alzheimer's disease and end stage lung disease. The family decision was made for Resident #6 to return to the facility with a focus on comfort care. The emergency room physician did not expect Resident #6 to thrive much longer at the care center given this new fracture. Resident #6	F 689	Concerns identified will be reported and addressed in the facility QAPI committee meetings for additional intervention as indicated.	

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eventually expired on 12/5/21.

In an interview on 6/16/22 at 12:13 p.m. Staff L, licensed practical nurse, stated on 11/27/21 she was at the nurse's station when Resident #6 stood up unassisted in the dining room and fell. Staff L stated one moment Resident #6 was sitting and when she turned around she was on the floor. Staff L stated Resident #6 had been up unassisted multiple times answering the door bell, which was near her table. Staff L stated she was uncertain where the aides were at the time of the fall, noting they only had 2-3 aides that evening. Staff L stated Resident #6 probably needed a 1:1. but there was not enough staff and other residents care and supervision would have suffered.

In an interview on 6/16/22 at 1:07 p.m. Staff M, certified nurse aide, stated she usually does not work beyond 2:00 p.m., but on 11/27/21 she must have, because she recalls walking down hall three towards the dining room and coming upon Resident #6, who had just fallen. Staff M stated there were only three aides working which is usual, but not adequate to meet resident needs, noting it takes at least four.

In an interview on 6/16/22 at 12:55 p.m. Staff N, certified nurse aide, stated on the afternoon of 11/27/21 she recalled walking down hall 4 towards the dining room when Resident #6 had fallen. Staff N stated there were only three aides working that evening. Staff N stated she was assigned hall 4 and Resident 6 was not on that hall.

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2. According to Resident #2's Minimum Data Set (MDS) assessment with assessment reference date of 8/17/21, Resident #2 had a brief interview for mental status (BIMS) score of 4 indicating a severely impaired cognitive status. Resident #2 was independent with bed mobility and transfers and required limited assistance with dressing, toilet use and personal hygiene needs. Resident #2's diagnosis included Alzheimer's and Non Alzheimer's dementia and she resided on a memory care unit.

Resident #2's plan of care indicates a focus area of impaired cognitive function/dementia or impaired thought process related to dementia, noting Resident #2 may strike out at staff, use profanity and on 12/11/20 and 7/1/21 was hit in the face by Resident #9. Interventions 12/11/20 included keep Resident #2 and Resident #9 separated.

According to Resident #9's Minimum Data Set (MDS) assessment with assessment reference date of 9/14/21, Resident #9 had a brief interview for mental status (BIMS) score of 3 indicating a severely impaired cognitive status. Resident #9 was independent with bed mobility and transfers and required minimal assistance with dressing, toilet use and personal hygiene needs. Resident #9's diagnosis included Alzheimer's and Non Alzheimer's dementia and he resided on a memory care unit.

Resident #9's plan of care indicates a focus area of impaired cognitive function related to Alzheimer's disease noting Resident #9 has struck Resident #2 in the face on 12/11/20, 7/1/21 and 9/19/21. Interventions 12/11/20 included

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F 689	Continued From page 24 keep Resident #2 and Resident #9 separated and Resident #9 has sundowning and seems more restless and agitated and may need someone to walk with him. In an interview on 6/1/22 at 1:56 p.m. Staff H, certified nurse aide, stated on 9/19/21, she was working on the memory care unit. Staff H states she was sitting at a table next to Resident #2, who was rambling. Resident #9 approached Resident #2, told her to shut up and immediately slapped her across the face. Staff H stated she separated the residents and informed the nurse. Staff H stated she was unaware of the history between the two residents or of the care plan intervention to keep them separated from one another. 3. According to Resident #4's Minimum Data Set (MDS) assessment with assessment reference date of 12/30/21, Resident #4 had a brief interview for mental status (BIMS) score of 3 indicating a severely impaired cognitive status. Resident #4 was independent with bed mobility and transfers, required limited assistance with dressing and extensive assistance with toilet use and personal hygiene needs. Resident #4's diagnosis included Alzheimer's and Non Alzheimer's dementia and he resided on a memory care unit. According to Resident #5's Minimum Data Set (MDS) assessment with assessment reference date of 11/25/21, Resident #5 had a brief interview for mental status (BIMS) score of 3 indicating a severely impaired cognitive status.	F 689		

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	165222	A. BUILDING _____ B. WING _____	C 06/16/2022

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F 689	Continued From page 25	F 689		

Resident #5 required limited assistance with bed mobility, transfers and dressing and required extensive assistance with toilet use and personal hygiene needs. Resident #5's diagnosis included Alzheimer's and Non Alzheimer's dementia and she resided on a memory care unit.

Resident #5's plan of care indicates a focus area on potential for physical aggression related to dementia with an intervention including when Resident #5 is agitated with another resident, intervene and redirect resident to another activity.

In an interview on 6/1/22 at 12:10 p.m. Staff I, certified nurse aide, stated she and another aide were working on the memory care unit on 1/29/22. Resident #5 had just returned after being out with family for a week. At 4:10 p.m. Resident #4 was standing in the hallway near the dining room, when without notice, Resident #5 approached him and struck him in his abdomen. Staff I immediately separated the two residents, sending Resident #5 back to her room and Resident #4 to a chair near his room. Staff I stated she reported the incident to the charge nurse. A few minutes later, at 4:18 p.m., Resident #5 ambulated out of her room with her wheel walker and rammed the walker into Resident #4. Staff I stated she was standing next to Resident #4 at the time. The residents were again separated and Resident #4 was moved to a chair closer to the dining room. Resident #5 returned to her room. Minutes later at 4:25 p.m. Resident #5 returned to the hallway and as Resident #4 stood, Resident #5 struck Resident #4's arm. Residents were separated and the nurse notified. At that time they added an intervention for staff to remain with Resident #4 when in the dining room and to keep Resident #4

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F 689	Continued From page 26 away from Resident #5 and for staff to provide stand by supervision of Resident #5 when she is in the dining room. Staff I stated there were no further incidents that afternoon.	F 689		
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 diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §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 observation, clinical record review, staff interviews and resident interviews, the facility	F 725	F 725 Sufficient Nursing Staff Corydon Specialty Care will continue to meet Sufficient Staffing needs. Resident #11 call light was responded to within fifteen minutes Current residents have the potential to be affected Nursing staff have been educated on answering call light within fifteen minutes or less. Director of Nursing and or designee will monitor during stand down meeting. Director of Nursing and or designee will audit call lights for 3 residents daily per week for four weeks and then two audits for three weeks. Random audits their after. Concerns identified will be reported and addressed in the facility QAPI committee meetings for additional interventions as indicated.	

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F 725	Continued From page 27 failed to provide prompt response for a resident's use of the nurse call system for 1 of 5 current residents reviewed (Resident #11). The facility reported census was 59. Findings include: According to Resident #11's Minimum Data Set (MDS) assessment with a reference date of 4/11/22, Resident #11 had a brief interview for mental status (BIMS) score of 15 indicating an intact cognitive status. Resident #11 required extensive assistance with bed mobility, transfers, dressing and toilet use and is independent with personal hygiene needs. Resident #11's diagnoses included morbid obesity, diabetes mellitus, chronic obstructive pulmonary disease, respiratory failure and gastroesophageal reflux disease. During an observation on 6/2/22, Resident #11's call light is activated at 2:50 p.m. At 3:10 p.m. this surveyor asked Resident #11 what she needed help with. Resident #11 stated she was on a bed pan and that her call light had been on for 20 minutes or so. At 3:45 p.m. Resident #11's call light was answered some 45 minutes later and her needs met by Staff D, certified nursing assistant. Staff D stated she was assigned the hall, but did not know Resident #11 had been placed on a bed pan.	F 725		
F 730 SS=C	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service	F 730	F730 Nurse Aide Perform Review-12hr/yr In-Service Corydon Specialty Care will continue to meet regular in-service training to meet annual requirements	

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F 730	Continued From page 28 education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on facility record review and staff interview, the facility failed to ensure every nurse aide receives, at minimum, 12 hours of in-service education annually for 3 of 10 nurse aide records reviewed (Staff D, Staff M and Staff O). The facility reported census was 59. Findings include: Review of 10 nurse aide training records found 3 with less than the minimum 12 hours required (Staff D, Staff M and Staff O). In an interview on 6/1/22 at 11 AM, the Administrator stated they use an on-line training system for their staff. The Administrator stated they were unable to find any additional in-service education for the 3 nurse aides identified with inadequate training.	F 730	Staff D, Staff M, Staff O completed annual staff training Staff have been educated on completing annual training requirements. Administrator or designee will audit staff training hours weekly for four weeks and random audits their after. Concerns identified will be reported and addressed in the facility QAPI committee meetings for additional interventions as indicated.	