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F 000	INITIAL COMMENTS Amended 4/26/23 following an Informal Dispute Resolution. Correction date: ________________ The following deficiencies resulted from the facility's annual recertification survey and investigation of facility reported incidents #110300-M and #106469-M, conducted February 13, 2023 to February 20, 2023. The findings for facility reported incidents #110300-M and #106469-M will be sent a later date under a separate cover. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.	F 561		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/07/2023

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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§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.

§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on clinical record, facility records, resident interview, and staff interview, the facility failed to allow 1 of 36 residents reviewed choice in bed time (Resident #7). The facility reported a census of 36 residents.

Findings include:

The Minimum Data Set (MDS) dated 12/29/22 revealed Resident #7 had a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS revealed Resident #7 needed the extensive assistance of two persons with bed mobility, transfers, and toilet use. The MDS included diagnoses of osteoarthritis, low back pain, open wound to right foot, chronic non pressure ulcer to right calf, and chronic non pressure ulcer to other part of right foot with bone involvement without evidence of necrosis (dead skin).

In an interview on 2/14/23 at 10:08 AM, Resident #7 reported that she liked to go to bed later in the evening around 9:00 PM to 10:00 PM. Resident #7 explained that when only two Certified Nurse Assistants (CNAs) work, they put her to bed

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between 7:30 PM to 8:00 PM and do not give her a choice for her bedtime. When asked if she reported this to a staff member, Resident #7 said that it would not matter anyway because nothing gets done about the problems she reports.

The Care Plan Focus with a target date of 4/30/23 indicated that Resident #7's daily preferences were important to her. The Goals listed that she would be able to maintain her daily preferences with staff assistance and be able to state satisfaction with her daily preferences. Resident #7 would be able to advocate on her own behalf should she wish to change them. The Intervention directed her sleep preference as Resident #7 would alert staff when she is ready to go to bed. Resident #7 had independence on deciding when she wants to go to bed. Resident #7 usually goes around 9 PM or after.
2. I prefer to go to bed between 9-10PM.

The Care Plan Focus with a target date of 4/30/23 indicated that Resident #7 needs assistance with her activities of daily living (ADLs) related to hereditary and idiopathic neuropathy, wedge compression fracture of first lumbar vertebra, osteoarthritis, deformities of bilateral feet and toes, and diabetes. The Goal instructed that she wants to be able to participate in her care and make her needs known to the caregivers. The Intervention directed that Resident #7 likes to get up at 6 AM, but may request to remain in bed longer. Resident #7 prefers to go to bed between 9 - 10 PM. By bed, Resident #7 means to have her set up in her recliner with pillows and blankets so that she is comfortable.

The Facility Assessment dated 2/10/23 revealed

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F 561	Continued From page 3 that Daily Routine Accommodations include bed time. In an interview on 2/20/23 at 4: 22 PM, Staff H, Director of Nursing (DON), reported that she did not believe Resident #7 would say that she does not get a choice when she goes to bed because Resident #7 does not do anything she does not want to do. In the same interview, Staff H did not disclose any information related to Resident #7's concerns with how staffing affects when she would be put to bed.	F 561		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580		

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is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on clinical record, facility policy, resident interview, and staff interview, the facility failed to report a change in a resident health status to the physician for 1 of 16 residents reviewed (Resident #16). The facility reported a census of 36 residents.

Finding include:

The Minimum Data Set (MDS) dated 1/13/23 revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition.

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The Medication Review Report signed 2/9/23 by a physician revealed Resident #16 had diagnoses of congestive heart failure (CHF), hypertension, pulmonary hypertension, hemiplegia and hemiparesis following cerebral infarction affecting their non-dominant side.

In an interview on 2/13/23 at 11:47 AM, Resident #16 reported that she does not think she has been weighed as often as she should since she started living at the facility last month. She thought that she'd be weighed each time she took a bath, but that hasn't been happening. In addition, Resident #16 reported that no one has told her weight after it's taken.

The Electronic Health Record (EHR) revealed the following:
1. No order for frequency of weight measurement.
2. Resident #16 weights
 a. 154.8 pounds on 1/8/23 at 6:44 AM.
 b. 156.8 pounds on 1/8/23 at 1:22 PM.
 c. 160.5 pounds on 1/9/23 at 7:14 AM.
3. Resident #16's blood pressure was 170/109 on 1/9/23 at 7:19 AM.

The EHR lacked documentation of notifying the physician of Resident #16's weight gain of 5.7 pounds in less than 24 hours along with an elevated blood pressure.

In an interview on 2/15/23 at 2:16 PM, Staff L, Director of Nursing (DON), reported that orders for monthly vital signs include a weight. In addition, each resident is weighed weekly with their bath.

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The Family and Physician Notification Relating to Accident or Change in Medical Condition policy revised April 2012 instructed the following:
1. The facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's responsible party when there is:
a. A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
2. Documentation of the accident or significant change in condition will be recorded in Resident #16's medical record and will include: the date, time of accident or change in condition, a description of the accident or change noted in Resident #16's condition, location of the accident, full assessment of Resident #16 including vital signs (in the event of an accident, ability to move extremities), and resident's physical and mental status at the time of the accident or change in condition.

In an interview on 2/20/23 at 5:21, Staff H, Director of Nursing (DON), reported that there must have been a problem with the scale used to weigh Resident #16. During the interview, Staff H was not able to identify a possible correlation between Resident #16's weight gain, high blood pressure warning, and Resident #16's bilateral lower extremity edema. When asked about notifying the physician of the change in Resident #16's weight, Staff H reported the progress notes included a weight note on 1/17/23 at 10:03 AM.

The Weight Note dated 1/17/23 at 9:59 AM listed that Resident #16 triggered for a 5% weight gain. Resident #16 returned from home with a weight

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gain and has remained around 160 pounds. Resident #16 continues with 2 plus (+) pitting edema to her bilateral lower extremities and lymphedema in her left arm with a compression sleeve in place. Resident #16 continued to eat fairly well during meals between 25%-100% of each meal. Will continue to monitor.

The EHR lacked documentation of a response from or notification to the Provider.

F 585 SS=E Grievances F 585
CFR(s): 483.10(j)(1)-(4)

§483.10(j) Grievances.
§483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the

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F 585	Continued From page 8 provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source,	F 585		

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F 585	Continued From page 9 and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, facility records, facility policy, resident representative interview, and staff interview, the facility failed to file a grievance for an issue reported by a resident's representative and provide a process in which grievances may be reported anonymously. The facility reported a census of 36 residents. Findings include: On 2/15/23 at 2:37 PM observed a binder out in a	F 585		

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common area of the facility that contained a table of contents with a line item related to grievances. The binder did not contain any other information related to grievances including forms to use to file a grievance. No suggestion box was observed in the facility.

In an interview on 2/20/23 at 1:56 PM, Resident #6's Representative (RR #6) reported the following:
1. having a conversation about a month ago regarding how Resident #6's laundry continued to be missing. RR #6 reported that he laundered part of Resident #6's clothing and during the conversation, the Administrator became verbally aggressive with him and told him that he just laundered Resident #6's clothing.
2. Over the past 2-3 years, RR #6 added that he has reported concerns to staff, including the Administrator, with no resolution. RR #6 explained that he feels put off, that his concerns are not heard, and that the facility does not care when he has a concern.
3. RR #6 is fearful that the care Resident #6 receives could be negatively impacted if he reported further grievances after the treatment experienced with the Administrator.
4. He does not know where grievance information is located in the facility or how to file an anonymous grievance.

The Grievance Log entries from 3/24/22 to 1/30/23 lacked mention of any grievances filed related to laundry or missing clothing.

The Grievances policy dated 1/21/11 revealed the following:
1. Policy: In the interest of protecting all residents' rights, the following individuals or agencies may

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F 585	Continued From page 11 be contacted by any resident, family member, employee or member of the general public-without fear of restraint, coercion, discrimination, or reprisal- to address grievances, to discuss changes in policies and services, or to report allegations of abuse, neglect, misappropriation of resident property or non-compliance with advance directives. 2. Procedure: a. The facility will register and respond to requests for action and assure that residents, families, legal representatives, and staff are protected from threat of reprisal. b. Action forms will be readily available to all persons through the business office, nurses' station(s), employee lounge, and from any team leader. c. Action (previously called "Grievance") is an acronym for "Attentive to Customers and Taking Initiative on Needs." The title is intended to convey our commitment to receiving feedback and information, and to taking action when we receive it. d. Forms may be filed by any person, to any employee, at any time, either verbally or in writing. Additionally, forms may be deposited in the "Suggestion Box" located in the facility lobby area. In an interview on 2/20/23 at 4:18 PM, the Administrator reported that the process to file a grievance was that the form used would be available from any staff member and that the completed form was returned to either any staff member or slid under her office door.	F 585		
F 600 SS=F	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		

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§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 observations, staff interviews, and record reviews, the facility failed to appropriately implement interventions to protect 36 out of 36 residents from possible abuse. The facility reported a census of 36 residents.

Findings include:

Resident #137's Minimum Data Set (MDS) assessment dated 7/16/22 included diagnoses of Alzheimer's disease, altered mental status, anxiety disorder, and adjustment disorder. The MDS identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Resident #137 exhibited verbal behavioral symptoms one to three times in the seven-day lookback period. Resident #137's behaviors caused significant interference with his care and significantly disrupted his care and/or his living environment.

Progress Notes Review

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The Incident Report Note dated 7/24/22 at 11:00 AM identified that Staff E, CNA, notified Staff Q, Registered Nurse (RN) that Staff D, CNA, over Resident#137's mouth and say "shut the fuck up." The preliminary recommendation directed that the nurse separated Staff D and Resident #137. The nurse assigned another CNA to him. The nurse notified the administrative staff, Resident #137's family, and the physician.

The 24 HR Follow Up to Incident Report dated 7/25/22 at 11:28 AM, labeled Late Entry entered on 7/27/22 at 11:30 AM, revealed a CNA placed her hand over resident's mouth and said "shut the fuck up. The assessment determined that Resident #137 did not have apparent injuries and he denied concerns. The CNA could no longer provide care for Resident #137. The facility did not provide additional notifications.

The 1 Week Follow Up to Incident note dated 8/1/22 at 11:24 AM related to the CNA placing her hand over resident's mouth and told him to "shut the fuck up." Resident #137 denied concerns and had no apparent injuries observed.

Care Plan Review with target date of 10/9/22

The Care Plan Focus indicated that Resident #137 used psychotropic medications related to his cognition and smoking status. The Intervention instructed that at time Resident #137 becomes angry with staff and uses foul language, please redirect him if that does not work, then give him space or alternate staff.

The Care Plan Focus related to mood describes that Resident #137 may exhibit mood symptoms

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such as feeling down, depressed or hopeless; easily irritated; depression, anxiety, and grief. Resident #137's diagnoses include major depressive disorder, recurrent, moderate, generalized anxiety disorder and depression, unspecified. The interventions directed that sometimes
a. Resident #137 curses at staff when he gets frustrated please redirect him so he is not hurtful toward others.
b. Resident #137 may yell continuously, make sure his basic needs are met. Then allow him to settle down and reproach at a later time. The staff may also try changing caregivers.

The Care Plan Focus described that sometimes Resident #137 had problems with communicating related to a hearing deficit. The intervention related to communication directed the staff to allow him adequate time to respond and repeat as necessary, Do not rush, request clarification from him to ensure understanding. Face him when speaking, make eye contact as able. Turn off TV/radio to reduce environmental noise, ask him yes/no questions if appropriate. Use simple, brief, consistent words/cues. Use alternative communication tools as needed.

The Care Plan Focus related to Memory/ Disorientation/Decision Making - listed that Resident #137 had impaired cognition such as impaired short term/long term memory, easily confused, disoriented to situation, needing assistance with decisions, difficulty in understanding at times. The Intervention instructed staff to monitor his nonverbals, provide cues verbally, give him time to respond, ask yes or no questions.

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On 2/15/23 at 10:13 AM, Staff E revealed that she worked on 7/24/22 with Staff D, CNA, during a COVID outbreak in the facility. Staff E explained that Resident #137 would repeatedly yell out words. Staff E added that Resident #137 does not always allow staff to assist him with care. Staff E assisted Staff D with transferring Resident #137. During the transfer Staff E reported Resident #137 yelled the entire time and Staff D placed her four fingers across his mouth and told him to shut the fuck up. Staff E added that after the incident she left the room while Staff E remained in the room alone with Resident #137.

On 2/15/23 at 2:02 PM, Staff D explained that she took care of Resident #137 on 7/24/22. Staff D reported that the facility had a COVID outbreak at the time and she had heard Resident #137 yelling bathroom, bathroom. Staff D assisted Resident #137 to the bathroom and when after he finished he continued to yell out in his room. Staff D consulted with a nurse who advised Staff D to transfer Resident #137 to the bathroom with a lift. Staff D asked Staff D to assist her with the transfer. Staff D revealed Resident #137 yelled the entire time they were assisting him. Staff D explained that she took her hand and covered his mouth and told him to shut the fuck up. Staff D demonstrated covering his mouth with her 4 fingers. Staff D added that she knows this is abuse and what she did was wrong. Staff D stated that she did not receive any discipline for the incident but did receive some additional education. Staff D revealed that she did apologize to Resident #137 and his family.

On 2/16/23 at 11:45 AM the Nurse Consultant and Staff H, LPN Co-Director of Nursing, revealed the only restriction Staff D had after the

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7/24/22 reported incident with Resident #137 was to not have Staff D care for Resident #137. The Nurse Consultant and Staff H confirmed that Staff D did not have to have another CNA in the room with her while she provided care to other residents in the building. Staff D's assignment changed to another hallway. After Resident #137 passed away Staff D had no further hall assignment restrictions. The staff provided counseling and education to Staff D as well.

On 2/16/23 at 12:00 PM Staff F, Licensed Practical Nurse (LPN), revealed that she felt it was abusive, but so out of character for Staff C who is usually so pleasant, and nice to the residents, but stated if she had seen someone else do the same thing she would feel it was abusive.

Facility Policy Review

The Abuse prevention, training and investigations policy revised 12/30/20 instructed the following:

a. The facility has a comprehensive system of practices and procedures designed to prevent occurrences of mistreatment, abuse, neglect, and/or misappropriation of resident property, monitor, identify and investigate injuries of unknown source and any allegations of suspected abuse, and insure that reasonable suspicions are reported to the appropriate law enforcement and regulatory oversight agencies.
b. Employees are required to report incidents-anything unusual or unexpected-- at the time of the occurrence, to their supervisor or person in charge of the facility for further investigation, regardless of whether the incident results in obvious or visible injury.

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F 600	Continued From page 17 c. Employees are required to immediately intervene to distract, halt and/or prevent harm to the extent that they can do so without placing themselves at risk of injury if they observe what they suspect is abuse or other criminal behavior to be occurring. They are also required to report allegations or suspicions of mistreatment, abuse or other crimes perpetrated by any person-- including a staff member, caregiver, resident/tenant, volunteer, or visitor-- immediately and without hesitation directly to the person in charge of the facility at the time. If that person is not the Administrator, the employee is also required to report the allegation to the Administrator within one (1) hour of first becoming aware. d. The person in charge of the facility shall immediately: i. Separate the alleged perpetrator, if known, from the victim and maintain this separation without exception, pending completion of the investigation; ii. Assess the victim for injury requiring immediate medical assistance and provide or arrange for needed care and treatment; iii. Implement precautions to preserve physical evidence that might be present at the site and/or on the victim or alleged perpetrator; iv. Interview the victim, if possible, for his/her statement related to the occurrence; v. Interview the alleged perpetrator, if known and on-site, to obtain a statement of his/her knowledge and involvement; vi. If appropriate due to the seriousness of the allegation, relieve the alleged perpetrator of further work duties and place the person in an unpaid, suspended work status pending further investigation; vii. Unless the resident /tenant directs otherwise,	F 600		

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F 600	Continued From page 18 notify the victim's responsible party of injuries incurred; viii. Notify the victim's attending physician if the allegation could impact the resident's physical or mental well-being; 1. Notify the local Police if there is a reasonable suspicion that a crime has occurred. ix. Document all of the above. 1. Investigation: 2. Every abuse allegation needs to be thoroughly investigated, including: interviewing all potential witnesses to the occurrence, interviewing all potential witnesses to the reporting of the occurrence, AND interviewing other persons who might have witnessed similar events where the alleged behavior could have occurred with the same likeness as this one-- i.e. other tenants, or roommates of residents the alleged perpetrator has cared for, or other employees who have worked closely with the alleged perpetrator-- in order to determine scope and frequency. 3. Interviews may be recorded or, if that is not possible, a 2nd person may sit in for taking notes to document the questions and responses. Witnesses will be interviewed individually, one at a time, to minimize "group thinking" or any one person influencing the statement of another; 4. Interviews will be conducted in private, and participants will be advised that information shared is confidential to the extent that the investigation will allow it and to the extent permitted by law. Initial questions should be phrased in an "open-ended" and non-leading format to allow the interviewee to share whatever information he/she believes to be pertinent (i.e. "Tell me about...." "And then what happened?") 5. The interviewer should ask follow-up questions	F 600		

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to clarify vague or general or subjective terms (i.e. "he was acting inappropriately" "How so?") and ask the witness to re-enact the occurrence through role-playing, if possible. (i.e. show me exactly where her hand was on his hip.) Pictures and video may also be helpful to document each witness's statement or re-enactment. The most important objective is to get to the truth of what each witness perceived to have occurred in full context-- including what preceded and led up to the event and what else might have been occurring at the same time-- and to accurately capture and preserve that information.

6. Do not share information provided by one interviewee with another, but do ask pointed, specific follow-up questions to clarify any information that is contradictory to another person's statement or to cover any topics or issues that the interviewee does not readily volunteer (i.e. "Are you sure that you and your co-worker left the tenant's apartment together, or did your co-worker stay behind for a minute or so and then catch up with you?" ....)

7. Following the individual interview, each participant (the interviewer, interviewee and note taker) should be asked to review the interview notes and to sign each page of the documents as verification of their accuracy and comprehensiveness.

8. Upon completion of the internal investigation, the Administrator should prepare a written summary report containing a description of the allegation; a chronological listing-- by date and time-- of the steps taken to investigate it; an overview of the findings; identification of the names, titles, and contact information for each person who was interviewed and for each notification and interaction with law enforcement and regulatory oversight agencies.

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9. Original documents, pictures, recordings, etc. developed in the process of the investigation are internal risk management files and attorney/client work papers and should be so labeled prior to delivering to the Corporate home office to the attention of [Corporation Name] Risk Management Attorney.
The written Summary Report will be retained in an Allegation Investigation file folder maintained by the Administrator.

F 610 SS=L

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, observations, facility investigation review and staff interview the facility failed to conduct a thorough investigation of an allegation of abuse. On 7/25/22, the nurse learned of a Certified Nurse Aide (CNA) placing

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their hand over Resident #137's mouth and told them to "shut the fuck up." After learning of this allegation of abuse, the facility told the CNA to not help Resident #137 but allowed them to work unattended behind closed doors with other residents. This failure resulted in residents living at the facility to be exposed to the potential of abuse therefore causing an Immediate Jeopardy to the health, safety, and security of the resident.

The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of July 24, 2022 on February 16, 2023 at 12:30 PM. The Facility Staff removed the Immediate Jeopardy on February 16, 2023 through the following actions:
a. Provided education on the following dates:
- 9/14/22 - Positive Approaches in Caring for Dementia Patients
- Due 7/31/22 - Understanding Mental Illness
- Due 7/31/22 - The Elder Justice Act
- Due 8/31/22 - Navigating the Workplace with Emotional Intelligence
b. On 2/16/23 the facility suspended Staff D, CNA.

The scope lowered from a "L" to "F" at the time of the survey after ensuring the facility implemented education and their policy and procedures.

The facility identified a census of 36 residents.

Findings Include:

Resident #137's Minimum Data Set (MDS) assessment dated 7/16/22 included diagnoses of Alzheimer's disease, altered mental status, anxiety disorder, and adjustment disorder. The MDS identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive

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impairment. Resident #137 exhibited verbal behavioral symptoms one to three times in the seven-day lookback period. Resident #137's behaviors caused significant interference with his care and significantly disrupted his care and/or his living environment.

Progress Notes Review:

The Incident Report Note dated 7/24/22 at 11:00 AM identified that Staff E, CNA, notified Staff Q, Registered Nurse (RN) that Staff D, CNA, over Resident#137's mouth and say "shut the fuck up." The preliminary recommendation directed that the nurse separated Staff D and Resident #137. The nurse assigned another CNA to him. The nurse notified the administrative staff, Resident #137's family, and the physician.

The 24 HR Follow Up to Incident Report dated 7/25/22 at 11:28 AM, labeled Late Entry entered on 7/27/22 at 11:30 AM, revealed a CNA placed her hand over resident's mouth and said "shut the fuck up. The assessment determined that Resident #137 did not have apparent injuries and he denied concerns. The CNA could no longer provide care for Resident #137. The facility did not provide additional notifications.

The 1 Week Follow Up to Incident note dated 8/1/22 at 11:24 AM related to the CNA placing her hand over resident's mouth and told him to "shut the fuck up." Resident #137 denied concerns and had no apparent injuries observed.

Staff Interviews

On 2/15/23 at 10:13 AM, Staff E revealed that she worked on 7/24/22 with Staff D, CNA, during

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a COVID outbreak in the facility. Staff E explained that Resident #137 would repeatedly yell out words. Staff E added that Resident #137 does not always allow staff to assist him with care. Staff E assisted Staff D with transferring Resident #137. During the transfer Staff E reported Resident #137 yelled the entire time and Staff D placed her four fingers across his mouth and told him to shut the fuck up. Staff E added that after the incident she left the room while Staff E remained in the room alone with Resident #137.

On 2/15/23 at 2:02 PM, Staff D explained that she took care of Resident #137 on 7/24/22. Staff D reported that the facility had a COVID outbreak at the time and she had heard Resident #137 yelling bathroom, bathroom. Staff D assisted Resident #137 to the bathroom and when after he finished he continued to yell out in his room. Staff D consulted with a nurse who advised Staff D to transfer Resident #137 to the bathroom with a lift. Staff D asked Staff D to assist her with the transfer. Staff D revealed Resident #137 yelled the entire time they were assisting him. Staff D explained that she took her hand and covered his mouth and told him to shut the fuck up. Staff D demonstrated covering his mouth with her 4 fingers. Staff D added that she knows this is abuse and what she did was wrong. Staff D stated that she did not receive any discipline for the incident but did receive some additional education. Staff D revealed that she did apologize to Resident #137 and his family.

On 2/16/23 at 11:45 AM the Nurse Consultant and Staff H, LPN Co-Director of Nursing, revealed the only restriction Staff D had after the 7/24/22 reported incident with Resident #137 was to not have Staff D care for Resident #137. The

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Nurse Consultant and Staff H confirmed that Staff D did not have to have another CNA in the room with her while she provided care to other residents in the building. Staff D's assignment changed to another hallway. After Resident #137 passed away Staff D had no further hall assignment restrictions. The staff provided counseling and education to Staff D as well.

On 2/16/23 at 1:27 PM Staff I, CNA, reported that she works frequently with Staff D. Staff D is always able to do her assignment by herself and is not aware of any rooms Staff D cannot go in.

On 2/16/23 at 1:33 PM Staff J, CNA, explained that Staff D always worked on a certain hallway by herself and would call if she needed assistance with a two-person transfer. Staff J did not know of any staff with restrictions on where they can work, or whom they can work with.

On 2/16/23 at 1:37 PM Staff K, CNA, revealed that Staff D is usually in a hall by herself and would call if she needed assistance with a two-person transfer. Staff K did not know of any staff with restrictions on where they can work or with whom they can work with.

Facility Policy Review

The Abuse prevention, training and investigations policy revised 12/30/20 instructed the following:

a. The facility has a comprehensive system of practices and procedures designed to prevent occurrences of mistreatment, abuse, neglect, and/or misappropriation of resident property, monitor, identify and investigate injuries of unknown source and any allegations of

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F 610	Continued From page 25 suspected abuse, and insure that reasonable suspicions are reported to the appropriate law enforcement and regulatory oversight agencies. b. Employees are required to report incidents-anything unusual or unexpected-- at the time of the occurrence, to their supervisor or person in charge of the facility for further investigation, regardless of whether the incident results in obvious or visible injury. c. Employees are required to immediately intervene to distract, halt and/or prevent harm to the extent that they can do so without placing themselves at risk of injury if they observe what they suspect is abuse or other criminal behavior to be occurring. They are also required to report allegations or suspicions of mistreatment, abuse or other crimes perpetrated by any person-- including a staff member, caregiver, resident/tenant, volunteer, or visitor-- immediately and without hesitation directly to the person in charge of the facility at the time. If that person is not the Administrator, the employee is also required to report the allegation to the Administrator within one (1) hour of first becoming aware. d. The person in charge of the facility shall immediately: i. Separate the alleged perpetrator, if known, from the victim and maintain this separation without exception, pending completion of the investigation; ii. Assess the victim for injury requiring immediate medical assistance and provide or arrange for needed care and treatment; iii. Implement precautions to preserve physical evidence that might be present at the site and/or on the victim or alleged perpetrator; iv. Interview the victim, if possible, for his/her statement related to the occurrence;	F 610		

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v. Interview the alleged perpetrator, if known and on-site, to obtain a statement of his/her knowledge and involvement;
vi. If appropriate due to the seriousness of the allegation, relieve the alleged perpetrator of further work duties and place the person in an unpaid, suspended work status pending further investigation;
vii. Unless the resident /tenant directs otherwise, notify the victim's responsible party of injuries incurred;
viii. Notify the victim's attending physician if the allegation could impact the resident's physical or mental well-being;
1. Notify the local Police if there is a reasonable suspicion that a crime has occurred.
ix. Document all of the above.
1. Investigation:
2. Every abuse allegation needs to be thoroughly investigated, including:
interviewing all potential witnesses to the occurrence,
interviewing all potential witnesses to the reporting of the occurrence, AND
interviewing other persons who might have witnessed similar events where the alleged behavior could have occurred with the same likeness as this one-- i.e. other tenants, or roommates of residents the alleged perpetrator has cared for, or other employees who have worked closely with the alleged perpetrator-- in order to determine scope and frequency.
3. Interviews may be recorded or, if that is not possible, a 2nd person may sit in for taking notes to document the questions and responses. Witnesses will be interviewed individually, one at a time, to minimize "group thinking" or any one person influencing the statement of another;
4. Interviews will be conducted in private, and

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participants will be advised that information shared is confidential to the extent that the investigation will allow it and to the extent permitted by law. Initial questions should be phrased in an "open-ended" and non-leading format to allow the interviewee to share whatever information he/she believes to be pertinent (i.e. "Tell me about...." "And then what happened?")
5. The interviewer should ask follow-up questions to clarify vague or general or subjective terms (i.e. "he was acting inappropriately" "How so?") and ask the witness to re-enact the occurrence through role-playing, if possible. (i.e. show me exactly where her hand was on his hip.) Pictures and video may also be helpful to document each witness's statement or re-enactment. The most important objective is to get to the truth of what each witness perceived to have occurred in full context-- including what preceded and led up to the event and what else might have been occurring at the same time-- and to accurately capture and preserve that information.
6. Do not share information provided by one interviewee with another, but do ask pointed, specific follow-up questions to clarify any information that is contradictory to another person's statement or to cover any topics or issues that the interviewee does not readily volunteer (i.e. "Are you sure that you and your co-worker left the tenant's apartment together, or did your co-worker stay behind for a minute or so and then catch up with you?" ....)
7. Following the individual interview, each participant (the interviewer, interviewee and note taker) should be asked to review the interview notes and to sign each page of the documents as verification of their accuracy and comprehensiveness.
8. Upon completion of the internal investigation,

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F 610	Continued From page 28 the Administrator should prepare a written summary report containing a description of the allegation; a chronological listing-- by date and time-- of the steps taken to investigate it; an overview of the findings; identification of the names, titles, and contact information for each person who was interviewed and for each notification and interaction with law enforcement and regulatory oversight agencies. 9. Original documents, pictures, recordings, etc. developed in the process of the investigation are internal risk management files and attorney/client work papers and should be so labeled prior to delivering to the Corporate home office to the attention of [Corporation Name] Risk Management Attorney. The written Summary Report will be retained in an Allegation Investigation file folder maintained by the Administrator.	F 610		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...	F 676		

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F 676	Continued From page 29 §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on clinical record, facility policy, resident interview, and staff interview, the facility failed to perform restorative therapy for 1 of 3 resident reviewed (Resident #7). The facility reported a census of 36 residents. Findings include: The Minimum Data Set (MDS) dated 12/29/22 revealed Resident #7 had a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS revealed Resident #7 needed the extensive assistance of two persons with bed mobility, transfers, and toilet use. The MDS included diagnoses of osteoarthritis, low back pain, open wound to right foot, chronic non pressure ulcer to right calf, and chronic non	F 676		

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pressure ulcer to other part of right foot with bone involvement without evidence of necrosis (dead skin).

The Care Plan Focus with a Target date of 4/30/23 identified that Resident #7 had a Restorative Nursing Program to help achieve and maintain optimal physical, mental, and psychosocial functioning. The Care Plan included two goals
a. Bilateral Lower Extremity Lymphatic drainage: goal is to decrease bilateral lower extremity chronic lymphedema.
b. Active Range of Motion: goal is to maintain upper and lower extremity range of motion and strength.
The Interventions directed the following
1. Active Range of Motion (AROM) Restorative
i.Upper extremity strengthening with red and green theraband including shoulder horizontal abduction/adduction flexion/extension and abduction/adduction, and bicep curls times 15-20 times
ii.Left hand digiflex, yellow x 15-20 reps
iii. Right hand digiflex, green x 15-20 reps
2. Active Range of Motion (AROM) Restorative Nursing Program
Lower extremity seated strengthening with 3# weights including marches, long arc quads, hip abduction, heel/toe raises, and ball squeezes 2x15 times 1x a day
i. Bilateral Lower extremity lymphedema drainage techniques
Program: manual lymphedema drainage
Frequency: provide patient with manual lymphatic drainage technique to bilateral lower extremities 3 times a week. if patient is out at wound clinic for treatment, do not provide Resident #7 with lymphatic drainage that

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day.

In an interview on 2/14/23 at 10:19 AM, Resident #7 reported that she was supposed to have exercises for her arms starting yesterday but no one has done this yet, she feels this is important to be able to gain strength to return to transfers using the EZ Stand.

In an interview on 2/17/23 at 12:03 PM, Staff N, Physical Therapist (PT) reported that Resident #7 started a restorative program April 2022 for both upper and lower body exercises with the number of weekly sessions scheduled with the nursing department. Staff N reported that Resident #7 asked Occupational Therapy (OT) for arm strengthening, but Staff N cannot find orders for OT as this is something that the nursing department has control of.

The Plan of Care Response History from 1/19/23 to 2/16/23 related to the intervention of Active Range of Motion (AROM) Restorative for Resident #7's upper extremities included a follow-up question about if the program was performed. All 14 dates had a no as the response.

The Electronic Health Record (EHR) lacked documentation regarding Resident #7's refusal for restorative therapy sessions or that Resident #7 had orders to hold her upper extremity exercises.

The Nursing Rehabilitation/Restorative Care policy revised 1/20/11 directed that the purpose of restorative therapy was to:
1. To promote the resident's ability to adapt and adjust to living as independently and safely as

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F 676	Continued From page 32 possible. 2. To improve or maintain function in physical abilities, ADL's (Activities of Daily Living), and prevent further impairment. 3. To achieve and maintain optimal physical, mental, and psychosocial function. In an interview on 2/20/23 at 4:23 PM, Staff H, Director of Nursing (DON), reported that Resident #7 had orders to hold therapy due to blood clots. In the same interview, when asked if this order included a hold on therapy for upper extremity exercises, Staff H reported therapy held this activity as well. In an email on 2/20/23 at 4:55 PM, the Administrator reported that therapy communicated to the Restorative Aide that she was not to do Resident #7's program until the program was re-evaluated by therapy. The same email lacked specific information related to upper extremity exercises.	F 676		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, facility record review and resident and staff interviews the facility failed to	F 804		

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F 804	Continued From page 33 ensure proper temperatures for foods served to residents. The facility reported a census of 36 residents. Finding Include: On 2/13/23 at 11:14 AM observed Staff C, Cook, remove the carrots from the steam table, she added them to the blender with hot broth, and pureed the portions. Staff C poured the carrots into a measuring cup, looked at the measuring cup, and poured out what she stated was half and placed it into another container, for service. She then covered the carrots with aluminum foil. As Staff C walked towards the door to leave the kitchen question if she planned to serve that portion to the residents and she stated yes. Asked her if she would take the temperature of the carrots. Staff C opened up the container and placed the thermometer into the pureed mixture with the end of the thermometer going into a whole carrot in the bottom of the pureed carrots. Staff C looked at the thermometer with a temperature of 119 degrees and stated oh these are not hot enough, I am going to put them into the steamer before we serve them to heat them back up. Staff C placed the carrots into the steamer to bring the food to temperature prior to serving. On 2/13/23 at 2:17 p.m. Resident #8 reported that the food that should be hot, is not always hot when the meal is served. On 2/13/23 at 2:46 PM Resident #17 revealed the hot food is not always hot when the meal is served. On 2/13/23 at 1:43 PM Resident #20 explained	F 804		

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that she eats a pureed diet and the food does not always taste like it should and the hot food is not always ho when she receives her meal.

Review of meal temperature logs revealed the following information:

12/25/22-12/31/22:
Lacked documentation of temperatures recorded for dinner on:
Wednesday 12/28/22
Friday 12/30/22

1/1/23-1/7/23:
Lacked documentation of temperatures recorded for dinner on:
Sunday 1/1/23
Saturday 1/7/23

1/8/23-1/14/23:
Lacked documentation of temperatures recorded for dinner on:
Sunday 1/8/23
Thursday 1/12/23

1/15/23-1/21/23:
Lacked documentation of temperatures recorded for dinner on:
Tuesday 1/17/23

Undated:
Lacked documentation of temperatures recorded for dinner On:
Sunday
Wednesday

1/29/23-2/4/23:
Lacked documentation of temperatures recorded for dinner on:

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F 804	Continued From page 35 Monday 1/30/23 Thursday 2/2/23 Saturday 2/3/23 2/5/23-2/11/23: Lacked documentation of temperatures recorded for dinner on: Sunday 2/5/23 Friday 2/10/23 The Food Temperatures policy dated 9/1/09 directed that the Dietary Manager shall obtain and audit test meal trays randomly. The temperatures of food items will be taken and properly recorded on the food temperature record before foods are served. The facility may also choose to record food temperatures after meal service. On 2/14/23 at 2:21 p.m. the Dietary Manager (DM) reported that food temperatures are only taken prior to service and the staff does not check temperatures after the meal. The DM added that she expects the staff to check and record temperatures for all meals.	F 804		
F 805 SS=E	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 and resident and staff interviews the facility failed to ensure residents received the proper diet texture to meet the residents needs in 1 of 1 residents reviewed	F 805		

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(Resident #20). The facility reported a census of 36 residents.

Finding Include:

On 2/13/23 at 11:14 AM observed Staff C, Cook, placed 2 servings of carrots into the blender, added hot chicken broth and closed the top. Staff C proceeded to blend the carrots until she had a smooth texture. Staff C poured the carrots into a measuring cup, looked at the measuring cup, and poured out what she stated was half and placed it into another container, for service. She then covered the carrots with aluminum foil. As Staff C walked towards the door to leave the kitchen, she confirmed that was the portion she was going to serve to the resident. Asked her if she would take the temperature of the carrots. Staff C opened up the container and placed the thermometer into the pureed mixture with the end of the thermometer going into a carrot approximately the size of a quarter in the pureed carrots. Staff C looked at the thermometer with a temperature of 119 degrees and stated oh these are not hot enough, I am going to put them into the steamer before we serve them to heat them back up. Staff C placed the carrots into the steamer to bring the food to temperature prior to serving. When questioned about the whole carrot in the bottom she confirmed it was not a pureed carrot. Staff C took the container with the portion to be served to the resident along with the leftover and placed it back into the blender and blended it again until smooth. Staff C again poured the pureed carrots into the measuring cup, poured what she said was half the amount into the serving dish, and covered it with aluminum foil. Afterwards she placed it into the steamer to bring it back up to temperature. Staff C took two servings of dessert

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F 805

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and placed into the blender with milk and blended the amount to puree consistency. Staff C poured out of what Staff C stated was half of the portion into a serving dish to be served to the resident. Staff C then took two potatoes and ham and added it to the blender. Staff C did not add any extra liquid to the blender. Staff C blended until smooth and poured out what she reported as half of the portion into a serving pan to place into the steamer to bring up to temperature before serving to the resident.

The facility did not provide a policy on diets.

On 2/16/23 at 10:15 a.m. the Dietary Manager (DM) revealed that she had concerns with the puree process with Staff C and that she completed education with her right away. The DM explained that the pureed food should be measured out for the appropriate serving and should not have a whole carrot in the pan ready to serve to a resident.

F 805

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:

F 880

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F 880	Continued From page 38 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) 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.	F 880		

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F 880	Continued From page 39 §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 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, clinical record, facility policy, and staff interview, the facility failed to perform hand hygiene during resident care procedures for 2 of 5 residents reviewed (Resident #7 and #22). The facility reported a census of 36 residents. Findings include: 1. The Minimum Data Set (MDS) dated 12/29/22 revealed Resident #7 had a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS revealed Resident #7 needed the extensive assistance of two persons with bed mobility, transfers, and toilet use. The MDS included diagnoses of osteoarthritis, low back pain, open wound to right foot, chronic non pressure ulcer to right calf, and chronic non pressure ulcer to other part of right foot with bone involvement without evidence of necrosis (dead skin). On 2/14/23 at 10:42 AM watched Staff A, Licensed Practical Nurse (LPN), perform dressing changes to Resident #7's wounds on both of her	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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lower legs and feet Staff L, Director of Nursing (DON) observed. Without hand hygiene, Staff A entered the room and began to prepare dressing supplies. Staff A left Resident #7's room to obtain additional supplies, after she returned she did not perform hand hygiene before completing the supply preparation. As Staff A did the dressing change witnessed her touch the inside of a trash can liner when she threw away tape. As Staff A changed her gloves, four times she failed to perform hand hygiene. Staff A completed the dressing change along with the clean up of supplies. After Staff A left the room two drops of blood remained on the floor under Resident #7's left foot about the size of a quarter.

The Nursing Home visit note dated 2/10/23 signed by a physician revealed that Resident #7 had a current diagnosis of MRSA (methicillin resistant Staphylococcus aureus) carrier.

On 2/15/23 at 10:34 AM, Staff A reported that she went back to Resident #7's room to clean the blood on Resident #7's floor.

2. The Minimum Data Set (MDS) dated 12/2/22 revealed Resident #22 had a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS included diagnoses of absence of left leg above the knee, low back pain, and reduced mobility. The MDS indicated that Resident #22 required extensive assistance of two persons with toilet use.

On 2/14/23 at 8:27 AM observed Staff D, Certified Nurse Assistant (CNA), touched the inside of the trash liner with her gloved hands. Without completing hand hygiene or removing her gloves, watched Staff D perform perineal (peri) care to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165343	A. BUILDING ______ B. WING ______	C 02/20/2023

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Resident #22. Staff D still did not perform hand hygiene when she removed her gloves after completing peri care and then assisted Resident #22 in putting on a new disposable brief. Staff M, CNA, did not perform hand hygiene after removing her gloves when she finished assisting Staff D with Resident #7's peri care.

The Infection Prevention and Control Program (IPCP) Guidelines revised September 2022 directed that staff perform hand hygiene at the following times
1. When hands are visibly soiled (wash with soap and water).
2. Before and after direct resident contact
3. Before and after performing any invasive procedure (i.e. fingerstick blood sampling)
4. Before and after changing a dressing.
5. After contact with a resident's mucous membranes and body fluids or secretions.
6. After handling soiled or used linens, dressings, bedpans, catheters and urinals.
7. After handling soiled equipment or utensils.
8. After removing gloves.

On 2/14/23 at 11:48 AM, Staff L reported that she did not see the two drops of blood on the floor under Resident #7's left foot, she then reported this to Staff A for cleaning. Staff L explained that she observed towards the end of the procedure things got sloppy. In addition Staff L agreed that hand hygiene should be performed when a staff member enters a resident's room, after touching the inside of trash liners, and with glove changes.