DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/16/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165175	A. BUILDING Genesis B. WING	C 04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING	**5608 SW 9TH STREET** **DES MOINES, IA 50315**

(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 Correction date: 6/6/23 The following deficiencies resulted from the investigation of complaints #111036-C, #111097-C, #111367-C, #111424-C, #111705-C, #112137-C, #112349-C, #111382-I, and #111925-I conducted April 10, 2023 to April 27, 2023. Complaints #111036-C, #111097-C, #111367-C, #111424-C, #112137-C, #112349-C, #111382-I, and #111925-I were substantiated. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 6/6/23

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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provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on resident interviews, staff interviews, and Resident Council notes, the facility failed to speak to each resident in a respectful manner for 3 of 3 residents reviewed for dignity (Resident #7, #8, #10). The facility reported a census of 69 residents.

Findings include:

The Minimum Data Set (MDS) for Resident #7, dated 3/17/23, identified a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition.

The MDS for Resident #8, dated 3/31/23, identified a BIMS score of 15 which indicated intact cognition.

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The MDS for Resident #10, dated 3/24/23, identified a BIMS score of 12 which indicated moderate cognitive impairment.

Resident council notes include the following concerns:
Second shift Certified Nurse Aides (CNA) do little resident care. They hide in closets and are always on their personal phones
CNA's use a rude tone of voice when speaking to residents
CNA's talk on their personal phones while in the resident rooms providing cares.

On 4/11/23 at 10:12 am Resident #7 stated that she has never personally been mistreated. She reported she has overheard staff speaking disrespectfully to other residents. She stated she heard a CNA cursing at another resident recently. This matter was reported to the facility administration and investigated.

On 4/11/23 at 10:31 am, Staff C, Licensed Practical Nurse (LPN) stated residents have complained about overhearing cursing in the hallways. She clarified the cursing was not directed at residents but it was in conversations amongst staff members who were discussing their personal lives. She said their voices were loud and carried into the resident's rooms when they were still in bed.

On 4/11/23 at 10:47 am, Resident #10 reported some of the CNAs have been rude to her. She stated she has asked for things like snacks that she knows are available and the staff lie to her and tell her they don't have any. She stated she thinks the staff is just lazy and does not want to get the items.

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On 4/11/23 at 11:07 am, Resident #8 stated some of the staff have an "I'm the boss" attitude. She stated they give orders such as it's time to go to bed rather than offering a choice. She clarified this is mostly on the evening shift.

On 4/11/23 at 1:48 PM, Staff D, CNA stated she has not ever personally witnessed any disrespectful behavior. She reported she has had residents complain to her about other employees. She stated one resident who was a smoker wanted to go outside for a cigarette and a staff member told the resident no and that she just needed to go to bed. Another resident reported to Staff D that a CNA told her she could do more for herself and she was taking advantage of the CNAs asking them to perform cares. Staff D said the residents have only complained about the staff on the evening shift.

F 580 SS=D Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) F 580

§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

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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) 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 record review, family interviews, and policy review, the facility failed to notify the resident representative for 2 of 3 residents who had a change of condition (Resident #3 & #4). The facility reported a census of 69.

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Findings include:

1. The Minimum Data Set (MDS) assessment dated 11/24/22 of Resident #3 identified a Brief Interview of Mental Status (BIMS) score of 8, which indicated moderate cognitive impairment. The MDS revealed the resident independent with no setup help needed for bed mobility. The MDS revealed the resident required limited assistance with help of 1 staff member for transfers.

The Comprehensive Care Plan, with a Target Date of 5/18/2023, for Resident #3 failed to reveal any documentation of the resident being at risk of skin impairment or having any wounds. The Care Plan failed to document any interventions for skin integrity.

The Skin Observation Tool for Resident #3 dated 12/9/22 recorded a pressure ulcer with a "smaller open area inside of the larger open area". The note documented the nurse had removed a dressing dated 12/1/22 of gauze wrapped around heel and ankle and purulent, foul smelling drainage was noted.

On 11/30/22 at 4:59 PM, the MDS Coordinator documented an open area to Resident #3's right heel which was draining. The Progress Note failed to reflect any family notification made of this wound.

On 12/9/22 at 12:24 Staff A, ARNP, documented Resident #3 was seen by the writer for assessment of a right heel wound which was reported to have odor and pus discharge. The Progress Note failed to reflect any family notification made of this wound.

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On 12/9/22 at 5:41 PM the Assistant Director of Nursing (ADON) documented new orders had been received for an antibiotic related to the foot wound for Resident #3. The Progress Note failed to reflect any family notification was made of the wound or the antibiotic.

On 12/28/22 at 9:20 the ADON documented the resident was seen by the wound care physician with no new orders. The Progress Notes failed to reflect any family notification made of the visit.

On 1/6/23 at 1:51 am Staff B, RN documented the resident was found on the floor with a skin tear injury. This Progress note documented Staff B would request family notification be made by the oncoming shift due to the time of day of the fall.

On 1/23/23 at 9:53 PM the Director of Nursing (DON) documented she called Resident #3's daughter and informed her the resident had tested positive for COVID. She also discussed the resident's wound with her at this time. This is the first progress note in the 7.5 weeks since the first documentation of the wound which reflected any family notification.

On 4/12/23 at 2:14 PM a family member of Resident #3 stated she did not receive any phone calls from the facility regarding the wound on Resident #3 until January 23rd. The wound was found on November 30th. She stated she received a phone call from the DON regarding the Resident testing positive for COVID and the discussion led to the wound.

Review of a policy titled Notification of a Change

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in a Resident's Condition, dated 4/28/21 directs the attending physician/physician extender and the Resident Representative will be notified of a change in a resident's condition.

Guidelines of things to be reported include, but not all inclusive:

Significant Change or Unstable Vital Signs.
Emesis/Diarrhea
Onset of Pressure Sores
Any Accident or Incident
Symptoms of any Infectious Process
Abnormal Lab Findings
5% Weight Gain or Loss in 30 days
Repeated refusals to take Prescribed Medication (for two days)
Change in Level of Consciousness
Unusual Behavior
Missing Resident
Glucometer reading below 70 or above 200 unless specific parameters given by physician for reporting.

2. Resident #4's Minimum Data Set (MDS) assessment dated 1/13/23 identified a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition. The MDS indicated Resident #4 required extensive assistance of one person for bed mobility, total assistance of two persons for transferring, and total assistance of one person for toilet use. Resident #4 was always incontinent of bowel and bladder and used oxygen therapy. The MDS included diagnoses of diabetes mellitus, anemia,

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heart failure, multiple sclerosis, non-Alzheimer's dementia, depression, schizophrenia, respiratory failure and osteomyelitis of the vertebrae.

The Care Plan dated 5/13/16 with a revision date of 11/25/22 revealed a focus area related to a potential for alteration in psychosocial wellbeing with a goal of her long term care placement needs being met to her and her Power of Attorney's (POA's) satisfaction. The staff were directed to encourage continued family involvement and support in the plan of care.

The progress notes for Resident #4 revealed the following:
2/12/23 at 8:56 PM, Staff V, LPN documented the resident to be lying on the floor on her back with a pillow under her head and bloody fluid coming from the back of her head. Per the CNA the resident was being transferred from the wheelchair to bed by full mechanical lift and assistance of 2 staff and she fell sideways out of the lift after the Hoyer sling caught on the wheelchair arm. The sling was still on the lift and the bottom straps observed to not be crossed. Vital signs stable and neurological assessment intact. Laceration observed to the back of the head. Emergency Medical Technicians (EMT's) were notified of the need for transfer due to head injury
.
2/13/23 at 1:28 AM, Staff V, LPN documented the resident returned to the facility at 1:10 AM via ambulance. Vital signs: temperature 99.1 degrees Fahrenheit (F.), heart rate 93 beats per minute, respiration rate 20 per minute and blood pressure 103/43. Documentation from the hospital stated resident was treated for injuries sustained from a fall earlier in the shift. Resident

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had a diagnosis of laceration of the scalp, initial encounter. Resident received 5 staples to the laceration on the back of her head. A Computed Tomography (CT) scan of the cervical spine and head without contrast completed with negative results. Hospice was notified of the residents return to the facility and a member of the team was to come to the facility to evaluate and readmit the resident to Hospice. Resident resting in bed with no complaints of distress or pain.

The facility failed to notify Resident #4's POA of the fall, the transfer to the hospital, or the resident's return to the facility after the emergency room visit.

In an interview on 4/25/23 at 11:37 AM, the DON stated it was the expectation that staff call the family or representative and/or leave a message for them to call back with any medication changes, new orders, hospitalizations, changes in condition, and falls. They are expected to follow the facility's Notification of Change in a Resident's Condition policy.

F 600 SS=D

Free from Abuse and Neglect
CFR(s): 483.12(a)(1)

§483.12 Freedom from Abuse, Neglect, and Exploitation
The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

§483.12(a) The facility must-

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F 600	Continued From page 10 §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 clinical record review, staff and resident interviews, and policy review the facility failed to provide resident safety and well-being for 1 of 1 resident reviewed (Resident #2). The facility reported a census of 69 residents. Findings include: The Minimum Data Set (MDS) assessment dated 4/1/23 for Resident #2 identified a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. The MDS revealed the resident required extensive assistance of 1 person with bed mobility and transfers and totally dependent on 1 person for toilet use. The resident was dependent on a wheelchair for mobility and always incontinent of bowel and bladder. The MDS included diagnoses of deep vein thrombosis, arthritis, anxiety disorder, depression, bipolar disorder, schizophrenia, conversion disorder, borderline personality disorder, and spinal stenosis. Resident #2's Care Plan dated 1/17/23 included a focus area for anger, history of harm to others, and poor impulse control. The Care Plan directed staff to provide physical and verbal cues to alleviate anxiety, give positive feedback, assist with verbalization of source of agitation, assist to set goals for more pleasant behavior, and encourage seeking out of staff when agitated. The Care Plan further directed staff to document the observed behavior and attempt interventions	F 600		

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in the behavior log, give as many choices as possible about her care and activities. Known triggers for physical aggression included not being allowed to go outside to smoke and her behaviors were de-escalated by alone time in her room with the door closed and going outside to smoke.

In an interview on 4/13/23 at 9:45 AM, Resident #2 stated on the night of 3/26/23 she had her call light on to be changed and she felt it took a long time for a staff person to answer the light so she was somewhat angry and frustrated when Staff W, Certified Nursing Assistant (CNA) entered the room. She reported they bantered a little bit about the call light taking so long to answer and that was when Staff W, CNA stated "Fucking change yourself", threw a brief and a glove at her, left the room, and never returned. She reported another staff person came in right away and changed her. She recalled a couple of days later the Administrator came in and told her that after visiting with Staff W, CNA, she wanted to extend an apology for her behavior and to let her know she never should have said what she did. Resident #2 stated she had not had any trouble with Staff W, CNA prior to the incident.

In an interview on 4/13/23 at 10:20 AM, the Administrator stated there had been no other reported incidents of this type of behavior with Staff W, CNA. He stated when he interviewed Staff W, CNA, she admitted to the incident and felt very badly about it. She reported she had just returned from taking the smokers out and being berated by them and then walked into Resident #2's room and was being berated by her and it was just more than she could take. The Administrator had terminated Staff W, CNA for

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mental abuse but stated "I don't really feel it was abuse but certainly inappropriate and unacceptable behavior". The Administrator also stated Staff W, CNA had reported to him that she tossed a brief and gloves on the wheelchair but did not throw them at the resident.

In a phone interview on 4/13/23 at 3:22 PM, Staff W, CNA reported she worked 6:00 P.M. to 6:00 A.M. on the evening of 3/26/23. She voiced she felt it was chaotic from the moment she got to work. It was dinner time so she assisted in the dining room and then with passing room trays. After supper was taken care of, the residents that smoked started lining up to go outside. She stated she took them out to smoke as it was on the schedule as one of her duties. When she came back in, one of the CNA's told her Resident #2's light had been on for an hour and asked her to go check on her. When she entered the room, the resident began to yell and curse at her about no one taking care of her and her being their last priority. She said she was using the "F" world a lot. Staff W, CNA stated apologizing to her wasn't effective and she just got frustrated and tossed the brief onto the wheelchair and said "Fuck you! Change yourself!" Then she walked out of the room. She stated Staff X, CNA did enter the resident's room after her and took care of her needs. She reports she returned to the resident's room a couple of hours later and assisted her to change her brief again but did not apologize to her as she should have. Resident #2 was fine with her and didn't seem scared of her or say anything about the earlier incident. Staff W, CNA reported as soon as she said what she said, she regretted it and she immediately called the on-call phone and spoke with Staff Y, Certified Medication Technician (CMT) who told her she

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knew it had been a bad night and to hang in there and they would discuss it tomorrow. Staff W, CNA stated it was her own fault and she knew she had no one to blame except herself. She stated she felt really stupid and was really sorry it happened.

In an interview on 4/13/23 at 2:26 PM, Staff X, CNA stated he did work on the evening of 3/26/23 and was working with Staff W, CNA that evening. He reported he had helped with her residents and she had taken a resident outside to smoke. While she was out monitoring the smokers, others resident smokers lined up to go outside. He requested she take the others out since she was already out there. She became angry and was yelling and cursing at him. He stated she said "I don't give a fuck" and maybe 3 smokers were present when she cursed at him. He stated she did not take the resident he had requested out to smoke. He reported the incident to a male nurse and then to the Assistant Director of Nursing (ADON). The ADON then called him to let him know the incident was being looked in to. He doesn't speak that way and doesn't like to be around that type of language. Resident #2 did not report any issues with Staff W, CNA when he assisted her with incontinence care. He stated her call light was on and he went in and changed her. He reported he and the resident have a good rapport but she didn't mention anything about the incident with Staff W, CNA.

In an interview on 4/18/23 at 9:50 AM, Resident #2 was asked to clarify whether Staff W, CNA had tossed the brief in her direction, thrown it at her, or tossed it on the chair. The resident reported she was lying in bed during the incident and Staff W, CNA threw the brief and a glove at her and hit her in the chest area. She stated she

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did it when she was angry with her and threw the brief at her and said "Fucking change yourself!" and walked out of the room.

In a phone interview on 4/18/23 at 12:33 PM, Staff X, CNA reported he did not see any brief in Resident #2's room that evening after the incident with Staff W, CNA. He said he didn't note a brief in the wheelchair or on the bed. He believed he brought in new bedding and got a new brief out when he was in the room.

In an interview on 4/11/23 at 10:12 AM, Resident #7 stated the call lights were bad and took 15-20 minutes to answer. The resident stated she had not been treated badly but had heard an aide cussing at the residents. Resident #7 reported around 10:00 PM she heard an aide yell "You better get into the fuckin bed" down the hall from her room.

In an interview on 4/11/23 at 10:47 AM, Resident #10 reported some of the aides were rude. They just didn't want to get up and do something when the resident asked for it. The resident reported he told the Administrator about one of the aides but now she's not here anymore. She reported she had never heard anyone cursing at a resident.

In an interview on 4/11/23 at 1:48 PM, Staff Z, CNA, stated she had not personally witnessed it but residents have complained about staff being rude. She reported a resident that smokes said a staff member told her she could not get up to smoke and had to stay in bed and another staff member told her she could do more for herself and she was taking advantage of the CNAs. Staff Z, CNA did not name the staff members but

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reported it took place on the evening shift. Staff Z, CNA stated she heard but did not witness that a staff member came in 45 minutes late upset and wanted to go smoke and other coworkers told her no because she was late. A resident needed to be changed and the CNA and the resident got into an argument and she told the resident to "Fucking change herself " She stated the Resident was Resident #2 and she didn't know the CNA's name but she no longer worked at the facility.

In an interview on 5/2/23 at 2:11 PM, the Administrator stated it is the expectation that the staff treat their residents highly and compassionately.

On 4/13/23 at 10:42 AM, review of Staff W, CNA employee file revealed a hire dated of 3/8/23. A background check was completed on 2/24/23 with no concerns noted. She received social services orientation that included being kind and considerate with voice tone, smiling, good eye contact, and utilizing the privacy curtains, knocking on the door before entering for example. Abuse reporting was gone over: report immediately so that the administrator and the Director of Nursing (DON) are informed as there are only 2 hours after the allegation to file a report with the state. She signed the Abuse Prevention policy on 3/8/23.

The facility provided Abuse Prevention Policy, reviewed and revised on 10/21/22, stated the facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, and staff from other agencies providing services to our residents, family members, legal

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F 600	Continued From page 16 guardians, surrogates, sponsors, friends, visitors, or any other individual. It further identified Mental Abuse as the following: The use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation or degradation including staff taking or using photographs or recordings in any manner that would demean or humiliate a resident(s).	F 600		
F 610 SS=D	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 and resident interviews, and policy review, the facility failed to timely report an alleged abuse to the facility Administrator or designee for 1 of 1 resident reviewed (Resident #2). The facility staff failed to timely report the allegation of abuse	F 610		

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toward a resident to the Administrator or designee and did not suspend the staff person involved at the time to keep the resident safe which prevented facility administration from reporting potential abuse to the Department of Inspections and Appeals within 2 hours as required. The facility reported a census of 69 residents.

Findings include:

The Minimum Data Set (MDS) assessment dated 4/1/23 for Resident #2 identified a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. The MDS revealed the resident required extensive assistance of 1 person with bed mobility and transfers and totally dependent on 1 person for toilet use. The resident was dependent on a wheelchair for mobility and always incontinent of bowel and bladder. The MDS included diagnoses of deep vein thrombosis, arthritis, anxiety disorder, depression, bipolar disorder, schizophrenia, conversion disorder, borderline personality disorder and spinal stenosis.

Resident #2's Care Plan dated 1/17/23 included a focus area for anger, history of harm to others, and poor impulse control. The Care Plan directed staff to provide physical and verbal cues to alleviate anxiety, give positive feedback, assist with verbalization of source of agitation, assist to set goals for more pleasant behavior, and encourage seeking out of staff when agitated. The Care Plan further directed staff to document the observed behavior and attempt interventions in the behavior log, give as many choices as possible about her care and activities. Known triggers for physical aggression included not being allowed to go outside to smoke and her

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behaviors were de-escalated by alone time in her room with the door closed and going outside to smoke.

Review of the progress notes for Resident #2 revealed no documentation of the resident reporting an incident of a staff person yelling and cursing at her.

No facility incident report was completed related to Resident #2's reported incident.

In an interview on 4/13/23 at 9:45 AM, Resident #2 stated on the night of 3/26/23 she had her call light on to be changed and she felt it took a long time for a staff person to answer the light so she was somewhat angry and frustrated when Staff W, Certified Nursing Assistant (CNA) entered the room. She reported they bantered a little bit about the call light taking so long to answer and that was when Staff W, CNA stated "Fucking change yourself", threw a brief and a glove at her, left the room, and never returned. She reported another staff person came in right away and changed her. She recalled a couple of days later the Administrator came in and told her that after visiting with Staff W, CNA, she wanted to extend an apology for her behavior and to let her know she never should have said what she did. Resident #2 stated she had not had any trouble with Staff W, CNA prior to the incident.

In a phone interview on 4/13/23 at 3:22 PM, Staff W, CNA reported she worked 6:00 P.M. to 6:00 A.M. on the evening of 3/26/23. She voiced she felt it was chaotic from the moment she got to work. It was dinner time so she assisted in the dining room and then with passing room trays. After supper was taken care of, the residents that

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smoked started lining up to go outside. She stated she took them out to smoke as it was on the schedule as one of her duties. When she came back in, one of the CNA's told her Resident #2's light had been on for an hour and asked her to go check on her. When she entered the room, the resident began to yell and curse at her about no one taking care of her and her being their last priority. She said she was using the "F" world a lot. Staff W, CNA stated apologizing to her wasn't effective and she just got frustrated and tossed the brief onto the wheelchair and said "Fuck you! Change yourself!" Then she walked out of the room. She stated Staff X, CNA did enter the resident's room after her and took care of her needs. She reports she returned to the resident's room a couple of hours later and assisted her to change her brief again but did not apologize to her as she should have. Resident #2 was fine with her and didn't seem scared of her or say anything about the earlier incident. Staff W, CNA reported as soon as she said what she said, she regretted it and she immediately called the on-call phone and spoke with Staff Y, Certified Medication Technician (CMT) who told her she knew it had been a bad night and to hang in there and they would discuss it tomorrow. Staff W, CNA stated it was her own fault and she knew she had no one to blame except herself. She stated she felt really stupid and was really sorry it happened.

In an interview on 4/18/23 at 9:50 AM, Resident #2 was asked to clarify whether Staff W, CNA had tossed the brief in her direction, thrown it at her, or tossed it on the chair. The resident reported she was lying in bed during the incident and Staff W, CNA threw the brief and a glove at her and hit her in the chest area. She stated she did it when she was angry with her and threw the

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F 610	Continued From page 20 brief at her and said "Fucking change yourself!" and walked out of the room. In a phone interview on 4/18/23 at 12:33 PM, Staff X, CNA reported he did not see any brief in Resident #2's room that evening after the incident with Staff W, CNA. He said he didn't note a brief in the wheelchair or on the bed. He believed he brought in new bedding and got a new brief out when he was in the room. In an interview on 4/13/23 at 3:57 PM, Staff Y, Certified Medication Technician (CMT) reported she did get a call from Staff W, CNA on the evening of 3/26/23 to report she had yelled at Resident #2. She told her that she had said "Fuck you! Change yourself!" or something along that line. She reported she told Staff W, CNA to stay away from the resident for the rest of the night. She reported she texted Staff AA, Scheduler/Medical Records about the situation and Staff AA, Scheduler/Medical Records said she would handle it. She stated she had nothing further to do with it. In a phone interview on 4/17/23 at 11:47 AM, Staff AA, Scheduler/Medical Records stated she believed she was on call that evening. She was aware of an incident between Staff W, CNA and Resident #2. She could not remember if she received word from Staff Y, CMT or from Staff W, CNA or from both. She states she remembered that Staff W, CNA had reportedly refused to change the resident and cussed at her and remembers being told that it was a very stressful night for her and she was irritated with another conflict between a staff person and a resident. She reported she was not notified of the incident until the next morning. At that time she spoke	F 610		

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with the Administrator and he told her to take her off the schedule for that night (Monday). She stated she did contact Staff W, CNA to let her know she would be taken off the schedule for that night. The Director of Nursing (DON) later came and told her to take her off the schedule for the rest of the week. She did not notify Staff W, CNA that she was removed from the schedule for the rest of the week. Once she talked to her initially and removed her from the schedule for the week as directed she had nothing further to do with the situation.

In an interview on 4/17/23 at 3:20 PM, the Administrator reported it was the expectation that any report of abuse be reported to him or the DON immediately. The staff member was to be sent home immediately pending an investigation. The incident would then be submitted to the Department of Inspections and Appeals (DIA) within 2 hours but was usually sent immediately. They would complete their investigation of the report and ensure it was wrapped up within 5 days but usually before that. They would gather up all the information and upload it to DIA. If they felt it was substantiated they would go ahead and terminate the employee before DIA came. If they did not feel it was substantiated they would return the employee to duty. They would try to accommodate the residents' wishes if they did not want that specific staff person to care for them. He reported he was not notified nor was the DON notified of the incident involving Staff W, CNA and Resident #2 the night it happened. He stated he was notified the next morning by Staff Y, CMT or Staff AA, Scheduler/Medical Records. He instructed them to suspend Staff W, CNA and the investigation was initiated. He stated it was an expectation that he be notified immediately of a

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potential abuse situation. He said it was Staff Y, CMT's first time on-call. She was only to be on-call for staffing. She was not the nurse on-call. He stated it should have been the nurse on-call that was notified not the scheduling on-call person. He stated Staff Y, CMT was not trained on what to do and stated they try to do abuse training with staff at least semi-annually. They cover what abuse is and what and who to notify if they see any type of abuse in the facility. He stated he did not believe Staff W, CNA had completed the Mandatory Dependent Adult Abuse Reporter training yet. He reported he did not believe the nurse on-call was notified of the incident at all.

In an interview on 4/17/23 at 3:33 PM, Staff BB, RN acknowledged that she was the nurse on call on 3/26/23. She reported she did not get any calls related to any altercations or regarding Resident #2 and Staff W, CNA that evening. She stated the nurse on-call was posted on the bottom of the schedule that is kept at the 1st floor nurse's station. She reports the phone numbers were right behind the schedules so staff could get the number to call.

In an interview on 4/18/23 at 1:00 PM, Staff Y CMT reported she was on-call for scheduling the evening of this incident, not for nursing and the nurse on-call was in the building at the time. She was unsure why it wasn't reported to her. She stated she told Staff W, CNA to stay away from the resident when she called to report herself and didn't realize how bad it was. She did not ask Staff W, CNA if she had reported it to the nurse on-call but assumed she had talked to the nurse prior to calling her. She reported she thought maybe Staff W, CNA was just more comfortable

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with her than the nurse on-call. She reported she was unaware it needed to be reported to the DON/Administrator at that time, but knows now.

In a phone interview on 4/24/23 at 1:25 PM, Staff Y, CMT stated she did not remember if she signed the abuse policy. She stated they signed a lot of things during orientation but she could not be sure if the abuse policy was one of them. She stated that if she saw or had a resident report abuse to her or suspected abuse that she would report it to her charge nurse immediately. She further stated that she had been educated by administration that if in the future someone would call her when on-call or report abuse or suspected abuse, she was to call the administrator or the DON immediately.

In an interview on 5/2/23 at 2:11 PM, the Administrator stated it was the expectation that staff treat the residents highly and compassionately and that staff report any allegation of abuse to himself or the DON whether it be day or night.

In a facility provided policy titled Abuse Prevention last reviewed on 10/21/22, stated the Administrator and DON must be promptly notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the Administrator and DON must be called at home or must be paged and informed of such incident. It further stated any allegation of abuses, or neglect, misappropriation or exploitation against any employee must result in his/her immediate suspension to protect the resident.

F 656 SS=D Develop/Implement Comprehensive Care Plan F 656
CFR(s): 483.21(b)(1)(3)

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§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care

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plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview, and the Resident Assessment Instrument (RAI) manual v1.17.1_October 2019, the facility failed to ensure full and accurate development of a comprehensive Care Plan for 2 of 3 residents reviewed for Care Plan accuracy (Resident #3, #10). The facility reported a census of 69 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment dated 11/24/22 for Resident #3 revealed the resident was,independent with no setup help needed for bed mobility. The MDS revealed the resident required limited assistance with help of 1 staff member for transfers. The MDS triggered Care Areas included cognitive loss, urinary incontinence, nutritional status, dehydration, dental care, pressure ulcer, and psychotropic drug use. The MDS recorded all of the triggered items would be addressed on the Comprehensive Care Plan.

The Comprehensive Care Plan for Resident #3 with a Taget Date of 5/18/2023 failed to address any of those triggered areas. The Care Plan lacked any documentation of the resident being at risk of skin impairment or having any wounds. The Care Plan failed to document any

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interventions to prevent impaired skin integrity.

The Skin Observation Tool dated 12/9/22 recorded a pressure ulcer with a "smaller open area inside of the larger open area". The note documented the nurse had removed a dressing dated 12/1/22 of gauze wrapped around heel and ankle and purulent, foul smelling drainage was noted.

On 11/30/22 at 4:59 PM, the MDS Coordinator documented an open area to Resident #3's right heel which was draining.

On 12/9/22 at 12:24 Staff A, ARNP, documented Resident #3 was seen by the writer for assessment of a right heel wound which was reported to have odor and pus discharge.

On 12/9/22 at 5:41 PM the Assistant Director of Nursing (ADON) documented new orders had been received for an antibiotic related to the foot wound for Resident #3.

On 12/28/22 at 9:20 the ADON documented the resident was seen by the wound care physician with no new orders.

On 1/23/23 at 9:53 PM the Director of Nursing (DON) documented she called Resident #3's daughter and informed her the resident had tested positive for COVID. She also discussed the resident's wound with her at this time.

On 1/24/23 Resident #3 was discharged to an acute care hospital for a Stage 4 pressure wound.

On 4/18/23 at 9:10 am a physician caring for the resident during this hospitalization stated that

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upon admission to the hospital the wound was a very large ulceration, bone was visible.

2. The MDS assessment dated 9/30/22 of Resident #10 recorded the resident reported she experienced pain on a frequent basis and rated the pain as moderate. The MDS triggered Care Areas included pain. The MDS recorded pain would be addressed on the Comprehensive Care Plan.

The Comprehensive Care Plan for Resident #10 with a Target Date of 9/20/2023 failed to reveal any documentation of the resident having pain or a daily medication regimen for pain.

The RAI manual v1.17.1_October 2019, page 4-11 includes the following direction:

Facilities have 7 days after completing the RAI assessment to develop or revise the resident's care plan.

The resident's care plan must be revised based on changing goals, preferences and needs of the resident and in response to current interventions.

The policy Comprehensive Person-Centered Care Plan, review date 10/23/19 included the following points.

The Comprehensive Person-Centered Care Plan shall be fully developed within 7 days after completion of the Admission MDS Assessment.

The Baseline Care Plan/Comprehensive Person Centered Care Plan is updated to reflect risk/occurrences with a problem area, including

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goals and interventions to reduce the risk/occurrence.

The policy Skin Evaluation dated 12/28/22 included the following point:

The Unit Manager/Wound Nurse will review and sign Skin Observation Tool if documented manually. The signature indicated follow up, documentation and care plan interventions have been implemented.

On 4/19/23 at 1:00 PM the Director of Nursing stated it was her expectation that any wounds would be documented on the Care Plan along with appropriate interventions. Additionally she stated it was her expectation that any item that triggered as a Care Area on the MDS would be in place on the Care Plan.

F 657 SS=D

Care Plan Timing and Revision
CFR(s): 483.21(b)(2)(i)-(iii)

§483.21(b) Comprehensive Care Plans
§483.21(b)(2) A comprehensive care plan must be-
(i) Developed within 7 days after completion of the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s).

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An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview, observation, and policy review the facility failed to update and revise 1 of 3 residents Care Plans reviewed (Resident #1). The facility failed to revise the Care Plan after the resident had falls. The facility reported a census of 69 residents.

Findings Include:

The Minimum Data Set (MDS) dated 1/27/23 identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 3 indicating severe cognitive impairment. The MDS revealed the resident required the total assistance of 1 person for bed mobility, transfers, and toilet use. The resident was always incontinent of bowel and bladder, had 2 or more falls with no injury, and 2 or more falls with injury since the prior assessment and took an antipsychotic, antianxiety, and antidepressant medication daily. The MDS included diagnoses of non-Alzheimer's dementia, anxiety disorder, schizophrenia, hyperglycemia, cognitive communication deficit, and history of falling.

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The Comprehensive Care Plan dated 4/2/21 with a revision date of 12/26/22 for Resident #1 revealed a focus area for being at risk for falls related to the residents cognition and being unaware of safety needs, gait and balance problems, chronic knee pain bilaterally, and resident climbing out of bed independently into "praying position" on the mat next to the bed. Interventions instructed staff to anticipate and meet the resident's needs, provide education and reminders to call for assistance as needed, educate and provide supervision and reminders to the resident to wear appropriate, non-slip footwear, follow therapy recommendations for transfers and mobility, hipsters to prevent injury in the event of a fall, nonskid strips in place, place call light within reach while in the room, ensure gripper socks are on, physical therapy consult, and review information on past falls and attempt to determine cause of falls.

Resident #1 had falls on 2/27/23 at 3:36 PM, 3/7/23 at 11:00 AM, and 3/20/23 at 12:24 PM.

A progress note on 3/7/23 at 4:37 PM indicated the bed was placed in the lowest position, the call light was in reach and a fall mat was on the floor next to the bed.

A physician progress note on 3/8/23 at 11:16 PM indicated the plan was to have the bed in the low position, floor mattress next to bed, to complete hourly rounding for safety, and to move the resident closer to the nurse's station when a room becomes available.

A progress note on 3/9/23 at 4:05 AM indicated the resident's call light was in reach, the bed was in low position, and the fall mat was on the floor

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F 657	Continued From page 31 next to the bed. A progress note on 3/10/23 at 4:33 AM indicated the bed was in the low position, the fall mat was on the floor next to the bed, and the call light was in the residents reach. A physician progress note on 3/20/23 at 3:46 PM indicated the resident would require one-on-one supervision post hospital stay due to multiple falls with head injuries. A physician progress note dated 3/22/23 at 6:05 PM indicated staff were to continue fall intervention currently in plan of care. The care plan lacked documentation of current interventions being used such as bed in low position, fall mat on floor next to bed, hourly rounding, move resident to a room closer to the nurse's station when one becomes available, and protective helmet when out of bed. In an observation on 4/17/23 at 11:10 AM, Resident #1 noted to be sitting in her wheelchair with her feet on the footrest at a table by the nurses station. Noted to have a helmet on her head at this time related to residents having a history of frequent falls. In an observation on 4/19/23 at 11:35 AM, Resident #1 noted to be sitting in her wheelchair out by the nurse's station. Her helmet was off and sitting beside her on the table. In an interview on 4/19/25 at 11:46 AM, the Director of Nursing (DON) stated the team had tried different things with the resident in an attempt to prevent further falls such as changing	F 657		

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her medication times, 1:1 time provided by the social worker, giving the resident stuffed animals to hold, and helping her attend bible study and music therapy. She reported they did not find any of them to be very effective due to her poor attention span related to her dementia.

In an interview on 4/25/23 at 11:39 AM, the DON stated it was the expectation the MDS Coordinator keep the Care Plans updated with any changes in condition or fall interventions.

The facility provided policy titled Comprehensive Person-Centered Care Plan last reviewed on 10/23/19 stated the Baseline Care Plan/Comprehensive Person Centered Care Plan will be updated to reflect risk/occurrences with a problem area, including goals and interventions to reduce the risk/occurrence.

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 resident interviews, staff interview, and record review, the facility failed to provide showers twice weekly per the resident Care Plans for 2 of 3 residents reviewed (Resident #7, Resident #8). The facility reported a census of 69 residents.

Findings include:

1. The Minimum Data Set (MDS) for Resident

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#7, dated 3/17/23, identified a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented the resident was completely dependant for bathing and needed the assistance of 2 staff members for bathing.

The current Comprehensive Care Plan for Resident #7 directs staff to assist Resident #7 two times a week and as necessary for bathing/showering, dated 8/12/18.

The shower sheets provided by the facility for 2/15/23 through 4/5/23 revealed Resident #7 received a shower on:

2/15/23
2/22/23 (7 days after the previous shower)
3/1/23 (7 days after the previous shower)
3/8/23 (7 days after the previous shower)
3/15/23 (7 days after the previous shower)
3/23/23 (8 days after the previous shower)
3/29/23(6 days after the previous shower)
4/5/23 (7 days after the previous shower)

2. The MDS for Resident #8, dated 3/31/23, identified a BIMS score of 15 which indicated intact cognition. The MDS documented the resident needed the assistance of 1 staff member for part of her bathing activity.

The current Comprehensive Care Plan for Resident #8 directs staff to assist Resident #8 two times a week and as necessary for bathing/showering, dated 5/18/21.

The shower sheets provided by the facility for 2/15/23 through 4/5/23 revealed Resident #8

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F 677	Continued From page 34 received a shower on: 2/15/23 3/1/23 (14 days after the previous shower) 3/8/23 (7 days after the previous shower) 3/15/23 (7 days after the previous shower) 3/23/23 (8 days after the previous shower) 3/29/23 (6 days after the previous shower) 3/31/23(2 days after the previous shower) 4/5/23 (5 days after the previous shower) On 4/11/23 at 11:07 am, Resident #8 stated she normally only receives showers once a week. She further stated this is not her choice, and her preference would be to get showers daily. In an interview on 4/25/23 at 11:40 AM, the Director of Nursing (DON) she stated it was the expectation that baths/showers be offered twice a week or at the residents preference. The Care Plan should reflect what the resident should be getting for scheduled baths/showers. The facility provided policy titled ADL(Activities of Daily Living) Bathing Policy last revised on 7/21/22, did not address the expected frequency residents were to receive baths/showers.	F 677		
F 684 SS=D	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		

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care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interviews and policy review, the facility failed to assess and document a fall and neurological assessments with a head strike for 2 of 3 residents reviewed for falls (Resident #1 and #4). The facility reported a census of 69 residents.

Finding include:

1. The Minimum Data Set (MDS) dated 1/27/23 identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 3 indicating severe cognitive impairment. The MDS revealed the resident required the total assistance of 1 person for bed mobility, transfers and toilet use. The resident was always incontinent of bowel and bladder, had 2 or more falls with no injury, and 2 or more falls with injury since the prior assessment and took an antipsychotic, antianxiety, and antidepressant medication daily. The MDS included diagnoses of non-Alzheimer's dementia, anxiety disorder, schizophrenia, hyperglycemia, cognitive communication deficit, and history of falling.

The Comprehensive Care Plan dated 4/2/21 with a revision date of 12/26/22 for Resident #1 revealed a focus area for being at risk for falls related to the residents cognition and being unaware of safety needs, gait and balance problems, chronic knee pain bilaterally, and resident climbing out of bed independently into "praying position" on the mat next to the bed. Interventions instructed staff to anticipate and meet the resident's needs, provide education and reminders to call for assistance as needed,

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educate and provide supervision and reminders to the resident to wear appropriate, non-slip footwear, follow therapy recommendations for transfers and mobility, hipsters to prevent injury in the event of a fall, nonskid strips in place, place call light within reach while in the room, ensure gripper socks are on, physical therapy consult, and review information on past falls and attempt to determine cause of falls.

An Incident Report dated 2/27/23 at 5:31 PM was completed related to resident's fall and stated vital signs and neurological assessment were at resident's baseline

An Incident Report dated 3/7/23 at 10:39 AM was completed related to resident's fall and stated the resident's neurological assessment and range of motion were within normal limits.

An Incident Report dated 3/20/23 at 12:36 PM was completed related to resident's fall and stated the resident's neurological assessment and vital signs were within normal limits.

A progress note dated 2/27/23 at 3:36 PM documented Resident #1 was lying on her back with a pillow under her head with blood soaked gauze noted to the back of her head. The nurse held pressure to area until the Emergency Medical Technician's (EMT's) arrived and transferred the resident to the emergency room(ER). Family was contacted and will join the resident at the ER.

A progress note dated 2/28/23 at 5:27 AM documented the hospital was called for an update on the resident's condition. The nurses reported the resident was being admitted for a diagnosis of

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left frontal hematoma with hemorrhage.

A progress note dated 3/7/23 at 11:22 AM documented the resident was re-admitted back to the facility from the hospital earlier that morning. At 11:00 AM the resident was found lying on the floor in her room next to her bed on her right side. The right side of her head had contact with the floor and a small new bump to the right side of the forehead. Neurological assessment and range of motion were within normal range. Resident reported pain but was unable to tell staff how she got on the floor related to her cognitive level. Daughter and primary care provider was notified. Received an order to send resident out via ambulance to the ER for evaluation and a computerized tomography (CT) scan.

A progress note dated 3/7/23 at 4:37 PM documented the resident returned to the facility via ambulance.

A progress note on 3/9/23 at 4:05 AM documented the resident voiced no complaints of pain or discomfort. No bump or bruising noted from fall. Neurological check was within normal limits and per resident's baseline.

A progress note on 3/20/23 at 12:24 PM documented the resident fell next to the nurse's station. An assessment revealed a large hematoma to the left forehead and resident reporting neck and back pain. The resident was noted to have a skin tear to the left forearm. Staff placed a pillow under the residents head and covered her with a blanket. Vital signs and neurological assessment were within normal limits. Call placed to 911 and resident sent to the ER for evaluation and treatment. Family and

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primary care provider notified.

The facility failed to provide the documentation of the neurological assessments being completed as documented in the progress notes and per protocol.

2. Resident #4's MDS assessment dated 1/13/23 identified a BIMS score of 8, indicating moderately impaired cognition. The MDS indicated Resident #4 required extensive assistance of one person for bed mobility, total assistance of two persons for transferring, and total assistance of one person for toilet use. Resident #4 was always incontinent of bowel and bladder and used oxygen therapy. The MDS included diagnoses of diabetes mellitus, anemia, heart failure, multiple sclerosis, non-Alzheimer's dementia, depression, schizophrenia, respiratory failure and osteomyelitis of the vertebrae.

The Care Plan for Resident #4 initiated 5/13/16 and a revision date of 2/16/23, had a fall risk focus area, with a goal for the resident to not sustain any preventable serious injury if a fall should occur. Interventions directed staff to be sure the call light was within reach, half side rail in place for ease in bed mobility and safety, encourage participation in activities that promote exercise, physical activity for strengthening and improved mobility, ensure that the resident was wearing appropriate footwear when ambulating or in the wheelchair, follow facility fall protocols, and provide resident a safe environment with even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light. Provide the resident with activities that minimize the potential for falls while providing diversion and distraction and have physical therapy (PT)

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evaluate and treat as ordered and as needed.

An Incident Report dated 2/12/23 at 8:34 PM was completed related to resident's fall from the Hoyer and stated the resident's vital signs were stable and neurological assessment intact with pupils equal and reactive to light.

A progress note dated 2/12/23 at 8:56 PM, documented the resident was found lying on her back with her feet facing the bed on the floor with a pillow under her head. Blood noted to be coming from the back of the residents head. Per the Certified Nursing Assistant (CNA) the resident was being transferred from the wheelchair to bed by full mechanical lift (Hoyer) and assistance of two staff and fell sideways out of lift after the Hoyer sling caught on the wheelchair arm. The Hoyer sling was still on the lift and the bottom straps observed to not be crossed. Vital signs were stable and neurological assessment intact. Laceration observed to back of head. The Emergency Medical Technician's (EMT's) were notified of need for transfer of the resident due to a head injury.

A progress note dated 2/13/23 at 1:28 AM, documented the resident returned to the facility at 1:10 AM via ambulance from the emergency room. Documents received stated the resident was treated for injuries sustained from a fall earlier. Diagnosis of laceration of scalp. The resident received 5 staples to the laceration on the back of her head. The CT scans of the cervical spine and head without contrast were both negative. Resident resting in bed with no complaints of pain, call light in reach, and vital signs stable.

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On 4/18/23, the Administrator provided a written statement from Staff M, CNA stating that he worked in the facility on 2/12/23 and he was walking past a room with a resident slid down in her chair on the opposite hall he was working. He reported it to Staff L, CNA and they both entered the resident's room and helped guide Resident #4 to the floor in a lying position. Staff L, CNA then left to get a Hoyer and brought it into the room and they adjusted the sling behind the residents back as the resident was on the floor. They hooked the resident up to the Hoyer lift. As Staff L, CNA was raising the Hoyer, the resident shifted herself to the right. Staff M, CNA told Staff L, CNA to stop but the resident shifted herself so fast Staff L, CNA did not have time to react causing the resident to fall out of the sling onto the floor hitting her head on the back right of the Hoyer lift. Staff L, CNA immediately went and got the nurse and the nurse called 911 because the fall caused injury to the resident's head. The ambulance arrived and took the resident to the hospital.

In a phone interview on 4/19/23 at 9:23 AM, Staff O, Registered Nurse (RN) stated Staff L, CNA came and got her to report resident #4 fell and was on the floor and had a head laceration. Staff reported to her they were Hoyer transferring the resident from the chair and she fell out the right side of the sling. The resident was on the floor when she entered the room and a pillow was under her head. Staff O, RN reported she completed an assessment, vital signs were taken, and a neurological assessment was completed and were intact. Staff O, RN left the room to get the resident's chart and items for the laceration to the back of her head. Upon return she completed another assessment and vital signs, pulse

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F 684	Continued From page 41 oximeter, and neurological assessment were done. Staff O, RN stated neither staff involved mention to her at all that resident had been lowered to the floor and that they were completing a Hoyer transfer off the floor. They stated it was from the wheelchair and the Hoyer sling had caught on the arm of the wheelchair. In a phone interview on 4/19/23 at 9:55 AM, Staff L, CNA reported she was involved with the fall from the Hoyer for Resident #4. At around 7:40 PM, another CNA notified her that the resident was attempting to get out of her wheelchair or was sliding out of the wheelchair. She entered the room to assist him. She noted the resident was sliding out of the chair and the staff were not able to lift her back up into the chair. They made the decision to lower her to the floor. She was laid on the floor on her back. She then went to find a Hoyer to lift the resident back into her chair. She was unsure if a nurse was notified of the resident being on the floor. She stated she did not notify the nurse. They used the sling that had been under her in the wheelchair and tucked it under her so they could hook her up to the Hoyer. Hooked her up to the machine using the black loops on the top and the green loops on the bottom. She reports she was running the controls and the other male CNA was located behind the wheelchair with the residents feet pointed towards him. She stated she got the resident about half way up and the male CNA stated "Her arm!" She stated she immediately stopped the machine but the resident then slid out the right side of the sling. She reported the residents head, arm, shoulder and chest area came out the side of the sling and she hit her head on the base of the lift. Staff L, CNA then lowered the lift back down and went and found the nurse. The nurse came to	F 684		

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the resident's room and assessed her.

Per an email sent on 4/25/23 at 4:40 PM, Staff P, Regional Director of Operations reported he had interviewed Staff M, CNA and he had reported he had worked one shift at the facility on 2/13/23 and remembered the incident with Resident #4. He reported the resident was sliding from her chair and so she was lowered by staff to the floor. Staff got the mechanical lift to get her up off of the floor. While the resident was in the lift on the floor she began moving around and hit her head on the tan cover at the base of the lift that covers the leg separation bar. There was no malicious intent by the other staff he was with, the resident just hit her own head.

In a phone interview 4/26/23 at 9:22 AM, Staff M, CNA reported that he did speak with Staff P, Regional Director of Operations yesterday while he was at work. The email statement that was sent by Staff P, Regional Director of Operations from their interview yesterday was reviewed with him. Staff M, CNA's original write up regarding the incident was then reviewed with him. He reported he was not actually working in the hall that the resident was in but noted her to be sliding out of her chair when he walked by. He immediately got a hold of Staff L, CNA and they went into the room to assist her. The resident was slid all the way down in the chair. So they lowered her to the floor and placed her sling under her. At that point Staff L, CNA went to get a Hoyer to lift her up. He stated once she was back with the lift they hooked the resident up to the Hoyer and Staff L, CNA was running the controls and he was located at the residents feet. He said Staff L, CNA began to lift the resident using the controller. He said that the resident

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was maybe a foot or so off the ground and he thought maybe she got scared and jolted herself to the right a bit and her right arm came out and then she jolted to the right one more time before Staff L, CNA could stop the lift and her right arm, then her head and upper body came out of the right side of the sling and fell to the floor and resident struck her head on the base of the Hoyer. He stated her bottom half remained in the sling but her top half came out the side. He stated Staff L, CNA immediately lowered the Hoyer back to the floor. Staff L, CNA then went and got the nurse and he stayed with the resident until the nurse arrived.

The facility failed to provide the documentation of the neurological assessments being completed as documented in the progress notes and per protocol.
The facility CNA's involved in the fall incident with the resident failed to notify a nurse of lowering the resident to the floor so the resident could be assessed prior to being Hoyer lifted off the floor.

In an interview on 4/25/23 at 11:44 AM, the Director of Nursing (DON) stated it was the expectation that after every fall a nurse completed an assessment, made sure the resident was safe, complete vital signs and neurological checks if the fall was unwitnessed or there was a head strike. They were expected to call the family or representative, notify the physician, notify Administration if there is a serious injury, complete an incident report and document the incident in the progress notes.

In an interview on 4/25/23 at 3:36 PM, the Administrator reported they were unable to locate neurological check documentation that were to be

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completed on resident after her falls.

A facility provide policy titled Fall Management Guidelines Overview dated 2/16 with a revision date of 7/14/17 defined falls as unintentionally coming to rest on the ground, floor, or other lower level but not as a result of an overwhelming external force (i.e., resident pushes another resident). An episode where a resident lost his/her balance and would have fallen if not for staff intervention, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred.

A facility provided policy titled Neurological Evaluation dated 3/28/23 and stated The Licensed Nurse shall perform a Neurological Evaluation as followed for a 72 Hour Timeframe, unless otherwise ordered by the Physician. The results will be recorded on the Neurological Evaluation Form.
" Every 15 Minutes X 1 Hour
" Every 30 Minutes X 1 Hour
" Every 1 Hour X 2 Hours
" Every 2 Hours X 8 Hours
" Every 4 Hours X 12 Hours
" Every Shift X 48 Hours

F 686 SS=G

Treatment/Svcs to Prevent/Heal Pressure Ulcer
CFR(s): 483.25(b)(1)(i)(ii)

§483.25(b) Skin Integrity
§483.25(b)(1) Pressure ulcers.
Based on the comprehensive assessment of a resident, the facility must ensure that-
(i) A resident receives care, consistent with professional standards of practice, to prevent

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pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and
(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, family, physician, and staff interviews, and policy review, the facility failed to ensure a resident's pressure ulcer did not worsen through following physician orders and accurately assessing the need for further medical intervention for 1 of 1 residents reviewed (Resident #3). This resulted in harm to the resident due to a boggy heel worsening to a Stage 4 pressure ulcer with bone infection and a prolonged hospitalization.

Findings include:

The Minimum Data Set (MDS) assessment dated 11/24/22 of Resident #3 identified a Brief Interview of Mental Status (BIMS) score of 8, which indicated moderate cognitive impairment. The MDS revealed the resident was independent with no setup help needed for bed mobility. The MDS revealed the resident required limited assistance with help of 1 staff member for transfers. The MDS documented diagnoses that included diabetes, heart failure, non Alzheimer's dementia, and malnutrition.

The current Comprehensive Care Plan of Resident #3 with a Target Date of 5/18/2023 failed to reveal any documentation of the resident being at risk of skin impairment or having any

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wounds. The Care Plan failed to document any interventions for skin integrity or treatment of any skin wounds.

Determining the Stage of Pressure Injury:

Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

Stage 3 Pressure Injury: Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant

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adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Stage 4 Pressure Injury: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal

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the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

On 11/30/22 at 4:59 PM, the MDS Coordinator documented an open area to Resident #3's right heel which was draining.

Orders were received on 12/1/22 for daily wound care with dressing changes to the wound.

On 12/9/22 at 1:11 AM, Staff E, Registered Nurse, documented in a Skin Observation Tool note she removed a dressing from the resident's wound dated 12/1/22. The note documented the wound had purulent, foul smelling drainage and the resident's skin going up the back of her calf was red and warm (signs of infection). This was the only Skin Assessment documented on the resident during her time at the facility.

On 12/9/22 at 12:24 PM Staff A, ARNP, documented Resident #3 was seen for assessment of a right heel wound which was reported to have odor and pus discharge.

On 12/9/22 at 5:41 PM the Assistant Director of Nursing (ADON) documented new orders had been received for an antibiotic related to the foot wound for Resident #3.

On 1/23/23 at 9:53 PM the Director of Nursing (DON) documented she called Resident #3's daughter and informed her the resident had

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tested positive for COVID. She also discussed the resident's wound with her at this time, need for antibiotic and a wound culture.

On 1/24/23 at 5:19 PM, Staff C documented she informed Resident #3's daughter, the Resident was now on two antibiotics, was weak and shaking.

On 1/24/23 at 5:24 PM, Staff C documented Resident #3's daughter requested the Resident be sent to the hospital.

On 1/25/23 at 4:50 PM, Staff C documented Resident #3 was admitted to the hospital, had one surgery on her right heel and was scheduled for a second surgery the next morning.

The facility wound care physician had an initial visit with the resident on 12/14/22. She noted the size of the wound to be 8 cm 8 x cm by a non measurable depth. At that time, the wound was 30% necrotic (non viable, dead tissue) and 70% eschar (dried necrotic tissue).

The wound care physician assessed the wound weekly and gave orders for daily wound care treatments to be completed by the facility staff. Each week the wound notes reflected the wound to be a non measurable depth. Recommendations were made to float her heel when in bed, to wear a prevalon boot, and reposition per facility protocol. On the weekly visit on 1/20/23, the wound was noted to have deteriorated.

On 4/10/23 at 12:45 PM, a family member of Resident #3 stated the resident was still hospitalized from being sent to the hospital on

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1/24/23 from the facility and the wound on her heel was the reason for the prolonged hospitalization.

On 4/12/23 at 2:14 PM a family member of Resident #3 stated the resident had 4 surgeries so far during the prolonged hospitalization including bone grafts. She stated more surgeries were likely going to be needed in the future and the resident currently had a wound vac on the wound. She also stated the facility had never contacted her regarding this wound until a few days prior to the hospitalization.

On 4/13/23 at 8:05 AM the Director of Nursing (DON) stated her expectation if a wound is found on a resident is to report that to the Assistant Director of Nursing (ADON) who also acts as the facility skin/wound nurse. Further her expectation is to notify the nurse practitioner or physician and get orders and interventions in place. At the time of a new wound being found, she stated her expectation to be the wound to be measured and documented using a Skin Assessment and documented weekly.

On 4:13/23 at 9:45 AM the ADON stated the nurse who was first aware of a wound is expected to measure and document the wound and to notify the physician and obtain orders and to initiate for the wound physician to begin weekly visits.

On 4/13/23 at 10:30 AM the MDS Coordinator stated she was working the floor on 11/30/22 when one of the Certified Nurse Aides told her about the heel wound on Resident #3. She stated she remembered looking at the wound and telling the ADON about it. She also said the

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normal procedure if a new wound was found is to note the location and measurements of the wound and give that information to the ADON. The ADON would then notify the facility medical director or wound doctor and get orders and notify the family.

On 4/13/23 at 2:50 PM, Staff A, ARNP stated she recalled one of the staff nurses informing her initially the heel was boggy. She ordered a wound culture and initiated antibiotics. She stated she initiated the wound doctor to begin seeing the Resident.

On 4/13/23 at 4:05 PM Staff E, Registered Nurse (former employee) stated she worked the overnight shift at the facility. She stated she was unaware of the resident's wound until 12/9/22 and had never been told about it in report. She said one of the CNA's mentioned it to her and asked her to assess it. She stated she could smell it when she entered the room and it "smelled like gangrene". She removed a the dressing which was dated 12/1/22. It had a horrid odor and slough was present. She stated she sent faxes to the wound physician and the primary care physician and reported to the day shift the Resident needed to be seen immediately and notified the DON. Staff E said the lack of care the residents in the facility get is why she is no longer an employee. She described the care as horrific. She said when she would arrive to work the night shift, multiple day shift medications were often not given. She noted the resident was a night owl and often would not go to bed until the middle of the night and normally had a sock and a shoe on her foot. Her other leg was amputated and she used that foot to self propel in her wheelchair. She stated she did not have any heel

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protectors or any preventatives in place for the wound until she initiated them the early morning hours of 12/9/22.

On 4/14/23 at 2:11 PM Staff C, LPN stated the first time she saw the heel wound on the Resident it was just boggy and had treatments for betadine. She said for the next several weeks she was scheduled on the other side of the building and did not care for the resident during that time period. When she was next scheduled on the hall the Resident resided on, the wound had significantly worsened and the smell from the wound was present in the hallway. This was on 1/24/23 and she then sent the resident to the hospital. She stated the normal protocol for a new wound is to get orders for a dressing and treatment and place and note in the box for the physician to assess on next rounds to the facility. A skin assessment should be placed in the Electronic Health Record.

On 4/14/23 at 3:08 PM, Staff F, ARNP stated she was aware of the resident but did not know her well. She stated the resident had comorbidities of diabetes and poor nutrition and heart failure and often refused cares. She stated she felt the development of the wound was not avoidable due to comorbidities and behaviors.

On 4/14/23 at 3:52 PM the Wound Care Physician state the wound was very advanced upon her initial assessment of the Resident. She stated during her visits she provided education to the resident to elevate the heel. She was aware the resident did refuse treatments at times. She stated with the resident's diabetes and history of a similar wound leading to amputation on her other leg that complications were likely for the

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Resident.

On 4/18/23 at 9:10 AM, a hospital physician who has cared for the resident throughout the hospitalization stated upon admission to the hospital the wound was a Stage IV pressure ulcer with bone being visible. She stated it may have started out as a diabetic foot ulcer and progressed to a Stage IV pressure wound. She stated she would consider Resident #3 to be a high risk for development of wounds due to her history of this type of wound, her diabetes, and her behaviors. She stated in her medical opinion, Resident #3 should have been hospitalized earlier than she was and surgical intervention was needed earlier. She felt the initial development of the wound was likely not avoidable but a higher level of treatment should have been sought earlier than it was.

On 4/18/23 at 10:50 AM, the DON stated the facility has weekly Risk meetings and skin issues are discussed. She stated the facility has no policy regarding doing regular foot checks on diabetic patients. She stated her expectation if a resident refuses cares is to re-approach the resident later in the shift. If the resident continues to refuse cares the Nurse Practitioner should be notified and follow up with the resident.

On 4/18/23 at 11:10 AM, the Registered Dietitian stated she was only aware the resident had a wound on her foot which required antibiotics. She stated she was not aware it was a pressure wound or that it was severe. She stated during the time frame Resident #3 admitted to the facility weekly skin assessments were not being done which is against corporate policy. She stated this is something the DON has been working on but

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while it's improving it's still a work in progress. She stated wounds are discussed in weekly meetings but she normally attends via telephone and the discussion is normally very brief and not detailed.

On 4/18/23 at 12:45 PM, the Therapy Coordinator stated Resident #3 was very non compliant. She frequently refused therapy due to the pain from the wound. He stated he has seen dressings on residents dated several days old and seen residents not wearing pressure relieving boots as they are supposed to. He further stated he has had conversations with multiple staff regarding these issues.

The policy Skin Evaluation dated 12/28/22 included the following points:

Residents will have a head to toe skin evaluation performed and documented on a routine basis.

Any skin abnormalities identified through this evaluation may be documented in Interdisciplinary Notes.

The Unit Manager/Wound Nurse will review and sign the Skin Observation Tool if documented manually. The signature indicated follow up, documentation and care plan interventions have been implemented.

F 689 SS=K | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) | F 689

§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

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§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 observations, resident, staff and family interviews, record review, and policy review, the facility failed to provide safe mechanical lift transfers for 6 of 7 residents reviewed (Residents #4, #7, #14, #16, #17, and #18). The facility failed to transfer residents safely by not following the Hoyer lift recommendations and locking the lift while raising the resident, not having a clear process in place to ensure staff were using the appropriate sling for transfers, and allowing a non-certified staff to assist in the Hoyer transfer.

The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of January 9, 2023 on April 25, 2023 at 1:44 P.M. The Facility Staff removed the Immediate Jeopardy on April 26, 2023 through the following actions:
a. Education of nursing staff on proper use of Hoyer lift and ensuring the brakes are not locked when raising the resident.
b. Removing the Invacare Hoyer lift from service until compatible slings can be obtained.
c. A new process was implemented to put the size of sling the resident was to use on the Kardex and placed copies at each nurse's station.
d. Nursing staff return demonstrations of a Hoyer lift transfer completed by the Director of Nursing (DON) and Nurse Manager.
e. Education of nursing staff that all mechanical lift transfers are to be completed with two certified nursing staff.

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The scope lowered from a "K" to an "E" at the time of the survey after ensuring the facility implemented education and made appropriate changes to their processes and procedures.

The facility identified a census of 69 residents.

Findings include:

1. Resident #4's Minimum Data Set (MDS) assessment dated 1/13/23 identified a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition. The MDS indicated Resident #4 required extensive assistance of one person for bed mobility, total assistance of two persons for transferring, and total assistance of one person for toilet use. Resident #4 was always incontinent of bowel and bladder and used oxygen therapy. The MDS included diagnoses of diabetes mellitus, anemia, heart failure, multiple sclerosis, non-Alzheimer's dementia, depression, schizophrenia, respiratory failure, and osteomyelitis of the vertebrae.

The Care Plan initiated 5/13/16 and a revision date of 2/16/23, had a fall risk focus area, with a goal for the resident to not sustain any preventable serious injury if a fall should occur. Interventions directed staff to be sure the call light was within reach, half side rail in place for ease in bed mobility and safety, encourage participation in activities that promote exercise, physical activity for strengthening and improved mobility, ensure that resident was wearing appropriate footwear when ambulating or in the wheelchair, follow facility fall protocols, and provide the resident a safe environment with even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light. Provide

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resident with activities that minimize the potential for falls while providing diversion and distraction and have physical therapy (PT) evaluate and treat as ordered and as needed.

The Care Plan initiated 3/13/16 also had an activities of daily living (ADL) self-care performance deficit focus area related to activity intolerance, muscle weakness, obesity, and fatigue with a goal that the resident would maintain their current level of function in bed mobility, transfers, eating, dressing, toilet use, and personal hygiene. Interventions directed staff to encourage the resident to utilize half side rails for increased bed mobility, encourage resident to be up in the wheelchair for meals, assistance of one staff person for bed mobility and dressing and the resident required mechanical aid (Hoyer) and assistance of two staff for transfers.

A fall Incident Report dated 2/12/23 at 8:34 PM documented the resident was found lying on the floor with her feet facing the bed and a pillow under her head. Blood noted to be coming from the back of the residents head. Per staff the resident was being transferred from the wheelchair to bed by full mechanical lift (Hoyer) and assistance of two staff when she fell sideways out of the lift after the Hoyer sling caught on the wheelchair arm. The Hoyer sling was still on the lift and the bottom straps observed to not be crossed. The resident was assessed and a laceration viewed to the back of the scalp after flushing the area. The ambulance was called to transport to the emergency room for further assessment. Vital signs were stable at (T),Temperature 97.4, (HR) Heart Rate 96, (R) Respirations per minute 20, (BP) Blood Pressure 127/54, and (PO2) pulse oximeter of 94% on

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room air. Neurological assessment intact and pupils were equal and reactive to light. Resident was oriented to person, place, and situation. Predisposing environmental factors included clutter, poor lighting, food on the floor, and crowding. Predisposing physiological factors included impaired memory. The Physician was notified of the fall at 8:57 PM.

A progress note dated 2/12/23 at 8:56 PM, documented the resident was found lying on her back with her feet facing the bed on the floor with a pillow under her head. Blood noted to be coming from the back of the residents head. Per the Certified Nursing Assistant (CNA) the resident was being transferred from the wheelchair to bed by full mechanical lift (Hoyer) and assistance of two staff and fell sideways out of the lift after the Hoyer sling caught on wheelchair arm. The Hoyer sling was still on the lift and the bottom straps observed to not be crossed. Vital signs were stable and neurological assessment intact. Laceration observed to back of the head. The Emergency Medical Technician's (EMT's) were notified of need for transfer of the resident due to a head injury.

A progress note dated 2/13/23 at 1:28 AM, documented the resident returned to the facility at 1:10 AM via ambulance from the emergency room. Documents received stated the resident was treated for injuries sustained from a fall earlier. Diagnosis of laceration of the scalp. The resident received 5 staples to the laceration on the back of her head. The computerized tomography (CT) scans of the cervical spine and head without contrast were both negative. Hospice was notified of residents return to the facility and will come to the facility to assess and

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readmit to hospice. Resident resting in bed with no complaints of pain, call light in reach and vital signs stable.

A physician progress note dated 2/13/23 at 11:58 PM, documented the resident was seen to follow up with an injury to resident's posterior head and post hospital visit. Resident returned to the facility with staples in her posterior head laceration. Surrounding skin was red with no drainage. The resident complained of pain rating at 5 out of 10 and her pain was managed by Tylenol. Resident was awake and alert. Lungs were clear to auscultation, respirations were even and unlabored. Pulse oximeter 97%. Posterior head laceration noted to have some swelling, erythema, and staples. Resident was alert, awake, and oriented to self. Plan was to monitor laceration to posterior head for bleeding, use Tylenol for pain, monitor for signs and symptoms of infection, and notify the provider of metal status changes.

In an observation on 4/13/23 at 1:50 PM, Staff G, Certified Nursing Assistant (CNA) and Staff H, CNA transferred Resident #4 from her wheelchair into her bed. Staff G, CNA removed resident's oxygen and the liberator (portable oxygen tank) was turned off. They hooked the sling up to the locked Hoyer using the green loops on the top and the purple loops on the bottom. The resident was instructed to cross her arms and hug herself and she complied. Staff H, CNA used the remote to raise the resident out of the chair. Staff H, CNA unlocked the Hoyer and steered the Hoyer so the resident was positioned in the center of the bed and lowered her down. The sling was removed from the Hoyer. Oxygen was applied once laid down in bed.

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In an observation on 4/18/23 at 9:40 AM, Staff I, CNA and Staff J, CNA completed a Hoyer transfer for Resident #4 from her wheelchair to bed. Oxygen was removed prior to the transfer. Staff J, CNA placed the Hoyer from the side of the chair with legs apart and it was locked. The sling was a bariatric sling and did not have straps that crisscross under the legs. The staff reported this was the same sling that is always used for this resident. The staff hooked the sling up to the Hoyer using the purple loops on the bottom and the green loops on the top. She was raised up out of the chair, the Hoyer was unlocked and the staff guided to the center of the bed and gently lowered onto the center of the bed. She was rolled side to side and the sling was removed from under her. Staff reapplied resident oxygen and covered her up. The call light was given to resident.

In an interview on 4/12/23 at 12:21 PM with Resident #4's Power of Attorney (POA), he stated that the facility was not always the best at updating him on changes in Resident'#4's condition. He stated he recalled an incident in February when the resident fell from a Hoyer and was sent to the hospital and the facility never notified him. He stated he was notified by the hospital when she was admitted for the night but not by the facility. He stated he had a long conversation with the Administrator about this and it has been better since.

In an interview on 4/18/23 at 12:20 PM, Staff K, CNA reported she did work the evening of 2/12/23 but stated she was not involved with the fall of Resident #4 but remembers hearing about the incident. Staff K, CNA stated she had heard

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Staff L, CNA was transferring the resident with the Hoyer by herself. She stated it was the expectation that the Hoyer and EZ stand transfers are always completed with two staff.

In an interview on 4/18/23 at 12:22 PM, the Assistant Director of Nursing (ADON) stated it is the expectation that all Hoyer and EZ Stand transfers be completed with two staff without exception.

In an interview on 4/18/23 at 1:05 PM, the Administrator acknowledged Staff L, CNA was involved in the fall from the Hoyer with Resident #4. Staff L, CNA terminated her position on the night of the fall (2/12/23). The administrator reported per punch detail, Staff L, CNA punched out at 10:19 PM and wrote a note stating that was her last day. He stated she was very upset over the fall and she was not transferring Resident #4 with the Hoyer by herself, she had another staff person with her (Staff M, CNA). The Administrator did report that she had been involved in a fall from a Hoyer a few weeks prior in which she was transferring using the Hoyer by herself. He stated they had done a lot of education with Staff L, CNA on this and she was not doing Hoyer transfers by herself any longer.

In an interview on 4/18/23 at 12:25 PM, Staff N, OTA/Therapy Coordinator reported he had heard that Staff L, CNA had transferred a resident with a Hoyer by herself. He reported he did mass education with staff on always using two staff for all Hoyer and EZ Stand transfers.

On 4/18/23, the Administrator provided a written statement from Staff M, CNA stating that he worked in the facility on 2/12/23 and he was

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walking past a room with a resident slid down in her chair on the opposite hall he was working. He reported it to Staff L, CNA and they both entered the resident's room and helped guide Resident #4 to the floor in a lying position. Staff L, CNA then left to get a Hoyer and brought it into the room and they adjusted the sling behind the residents back as the resident was on the floor. They hooked the resident up to the Hoyer lift. As Staff L, CNA was raising the Hoyer, the resident shifted herself to the right. Staff M, CNA told Staff L, CNA to stop but the resident shifted herself so fast Staff L, CNA did not have time to react causing the resident to fall out of the sling onto the floor hitting her head on the back right of the Hoyer lift. Staff L, CNA immediately went and got the nurse and the nurse called 911 because the fall caused injury to the resident's head. The ambulance arrived and took the resident to the hospital.

In a phone interview on 4/19/23 at 9:23 AM, Staff O, Registered Nurse (RN) stated Staff L, CNA came and got her to report resident #4 fell and was on the floor and had a head laceration. Staff O, RN was agency and she did not know the resident so was unsure of her baseline. Staff reported to her they were Hoyer transferring the resident from the chair and she fell out the right side of the sling. The resident was on the floor when she entered the room and a pillow was under her head. Resident #4 was covered with a blanket as she reported feeling cold. Staff O, RN reported she completed an assessment, vital signs were taken and a neurological assessment was completed and were intact. Staff O, RN left the room to get the resident's chart and items for the laceration to the back of her head. Upon return she completed another assessment and

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vital signs, pulse oximeter, and neurological assessment were done. Resident remained on the floor in the same position until the ambulance arrived as she didn't want to move her. Staff O, RN stated neither staff involved mention to her at all that resident had been lowered to the floor and that they were completing a Hoyer transfer off the floor. They stated it was from the wheelchair and the Hoyer sling had caught on the arm of the wheelchair. She questioned if the sling was to be crisscrossed under the resident's leg and she was informed the resident didn't use that type of sling and that the sling was correctly put under the resident and she was correctly hooked up to the lift.

In a phone interview on 4/19/23 at 9:55 AM, Staff L, CNA reported she did work on 2/12/23 and was involved with the fall from the Hoyer for Resident #4. She reported she was working with another CNA who was agency and a male (Staff M, CNA). At around 7:40 PM, he notified her that the resident was attempting to get out of her wheelchair or was sliding out of the wheelchair. She entered the room to assist him. She noted the resident was sliding out of the chair and the staff were not able to lift her back up into the chair. They made the decision to lower her to the floor. She was laid on the floor on her back. She then went to find a Hoyer to lift the resident back into her chair but it took her about 5 minutes to locate and get the Hoyer back to the room. She was unsure if a nurse was notified of the resident being on the floor. She stated she did not notify the nurse. They used the sling that had been under her in the wheelchair and tucked it under her so they could hook her up to the Hoyer. Hooked her up to the machine using the black loops on the top and the green loops on the

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bottom. She was positive the sling was correctly hooked to the lift and they left the sling attached to the machine after the incident. She reported she was running the controls and the other male CNA was located behind the wheelchair with the residents feet pointed towards him. She stated the resident's head was pointed toward her and no one was touching her as they couldn't reach her. The wheelchair was in the way for him and she couldn't reach around Hoyer to touch her while running the control. She stated she got the resident about half way up and the male CNA stated "Her arm!" She stated she immediately stopped the machine but the resident then slid out the right side of the sling. She reported the residents head, arm, shoulder, and chest area came out the side of the sling and she hit her head on the base of the lift. Staff L, CNA then lowered the lift back down and went and found the nurse on the 100 hall. The nurse came to the resident's room and assessed her. Staff L, CNA reported she did raise the residents head enough to put a pillow under it for comfort. She reported she left the room to go answer a light and assist another resident. She stated they used the sling that had been under her in the wheelchair and she was not aware of a chart for sizing of Hoyer slings. She stated she was not aware of any other residents falling out of a Hoyer and never anyone under her care.

In an interview on 4/19/23 at 11:51 AM, the DON stated that Staff M, CNA (agency) was involved in the fall from the Hoyer for Resident #4, and returned to the facility the next morning and talked to them about the incident. He took the DON and Staff N, OTA/Therapy Coordinator to the room and showed them with the Hoyer what had happened.

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Per an email sent on 4/25/23 at 4:40 PM, Staff P, Regional Director of Operations reported he had interviewed Staff M, CNA and he had reported he had worked one shift at the facility on 2/13/23 and remembered the incident with Resident #4. He reported the resident was sliding from her chair and so she was lowered by staff to the floor. Staff got the mechanical lift to get her up off of the floor. While the resident was in the lift on the floor she began moving around and hit her head on the tan cover at the base of the lift that covers the leg separation bar. There was no malicious intent by the other staff he was with, the resident just hit her own head.

In a phone interview 4/26/23 at 9:22 AM, Staff M, CNA reported that he did speak with Staff P, Regional Director of Operations yesterday while he was at work. The email statement that was sent by Staff P, Regional Director of Operations from their interview yesterday and was reviewed with him. Staff M, CNA's original write up regarding the incident was then reviewed with him. He stated he remembers the night as it was Super Bowl Sunday. He stated he felt the place was very short staffed. He reported he was not actually working in the hall that the resident was in but noted her to be sliding out of her chair when he walked by. He immediately got a hold of Staff L, CNA and they went into the room to assist her. The resident was slid all the way down in the chair. So they lowered her to the floor and placed her sling under her. At that point Staff L, CNA went to get a Hoyer to lift her up. He stated once she was back with the lift they hooked the resident up to the Hoyer and Staff L, CNA was running the controls and he was located at the residents feet. He stated he felt that Staff L, CNA

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may not have been paying the closest attention to what she was doing as she was arguing with the roommate at the same time she was running the lift. He stated he did not feel that she had any malicious intentions but maybe wasn't paying the closest attention to what she was doing. He said Staff L, CNA began to lift the resident using the controller. He said that the resident was maybe a foot or so off the ground and he thought maybe she got scared and jolted herself to the right a bit and her right arm came out and then she jolted to the right one more time before Staff L, CNA could stop the lift and her right arm, then her head and upper body came out of the right side of the sling and fell to the floor and resident struck her head on the base of the Hoyer. He stated her bottom half remained in the sling but her top half came out the side. He stated Staff L, CNA immediately lowered the Hoyer back to the floor. Staff L, CNA then went and got the nurse and he stayed with the resident until the nurse arrived. He could see the back of her head was bleeding. He also reported he asked both Staff L, CNA and the nurse what kind of action needed to be taken with an incident like this and they both said nothing different than any other fall.

2. Resident #7's MDS assessment dated 3/17/23 identified a BIMS score of 14, indicating intact cognition. The MDS indicated Resident #7 required extensive assistance of one person for bed mobility, total dependence of two people for transfers, and total dependence of one person for toilet use. Resident #7 was wheelchair dependent and always incontinent of bowel and bladder. The MDS included diagnoses of diabetes mellitus, thyroid disorder, Alzheimer's dementia, cerebral palsy, non-Alzheimer's dementia, seizure disorder, depression,

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schizophrenia and suicidal ideation.

The Care Plan initiated on 7/27/18 with a revision date of 4/7/23, revealed a fall risk focus area related to cognition and being unaware of safety needs and cerebral palsy and a goal that the resident will have no unaddressed falls. Interventions directed staff to anticipate and meet resident needs, encourage resident to wear gripper socks, follow therapy recommendations for transfers and mobility - assist of two people for Hoyer lift transfers, place call light in reach, and skid strips next to bed.

The Care Plan initiated on 7/27/18 with a revision date of 4/7/23, also had an ADL self-care performance deficit focus area related to cerebral palsy with a goal the resident maintain their current level of function. Interventions directed staff to encourage the resident to utilize half side rails for increased bed mobility, one person assistance with bed mobility and assistance of two staff with transfers - Hoyer lift only.

In an observation on 4/12/23 at 2:00 PM, Staff Q, CNA and Staff R, CNA completed a Hoyer transfer for Resident #7. The resident was sitting in her wheelchair and had the Hoyer sling in place under her. They brought the Hoyer in and hooked her up to it using the blue loops on the top and the purple loops on the bottom. The Hoyer legs were spread and the Hoyer machine was locked. Staff Q, CNA then used the remote to raise the resident into the air and then the machine was unlocked and steered around with Staff R, CNA assisting to guide the resident until she was centered over the bed. She was encouraged to give herself a hug during the transfer. Once she was centered over the bed

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she was lowered onto the bed and unhooked from the machine. The resident tolerated the process well. The sling was removed from under her by rolling her side to side.

3. Resident #14's MDS assessment dated 3/1/23 identified a BIMS score of 15, indicating intact cognition. The MDS indicated Resident #14 required total dependence of one person for bed mobility and toilet use and total dependence of two people for transfers. Resident was always incontinent of bowel and bladder and was wheelchair dependent. The MDS included diagnoses of atrial fibrillation, diabetes mellitus, thyroid disorder, arthritis, anxiety disorder, depression, respiratory failure, and morbid obesity.

The Care Plan initiated on 2/28/22 with a revision date of 4/7/23, revealed an ADL self-care performance deficit activity intolerance focus area related to impaired balance and limited mobility and a goal to maintain current level of function with ADL. Interventions directed staff to assist with bed mobility using two people, encourage to discuss feelings about self-care deficit, praise all efforts at self-care, and Hoyer transfers with assistance of two people.

In an interview on 4/19/23 at 2:35 PM, Resident #14 stated she had been a Hoyer lift transfer since admitting to the facility. Staff used the same style and size sling for all transfers. They normally use two staff for her transfers but Staff L, CNA had transferred her alone a couple of times but nothing recent. Felt secure most of the time with her transfers except when the transfer was being completed with one staff person. When at the previous nursing home the resident

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reported she was dropped from the Hoyer and fractured her knee, so if she did not feel secure, she would tell them to stop and reposition her.

4. Resident #16's MDS assessment dated 2/13/23 identified a BIMS score of 15, indicating intact cognition. The MDS indicated Resident #16 required extensive assistance of one person for bed mobility, total dependence of two people for transfers, and total dependence of one person for toilet use. She was wheelchair dependent, used oxygen, and always incontinent of bowel and bladder. The MDS included diagnoses of heart failure, renal insufficiency, cerebrovascular accident, hemiplegia, anxiety disorder, depression, bipolar disorder, schizophrenia, and chronic obstructive pulmonary disease.

The Care Plan initiated on 2/10/22 with a revision date of 4/20/22, revealed an ADL self-performance deficit with a goal to maintain current level of function with ADL's. Interventions directed staff to assist resident to turn and reposition in bed, encourage use of enabling bars/side rails to maximize independence with turning and repositioning in bed, allow sufficient time for dressing and undressing, and requires the assistance of two people for Hoyer transfers.

A fall Incident Report dated 1/9/23 at 3:04 PM, documented the nurse was alerted to Resident #16's room by a loud noise and yelling coming from the resident's room. The nurse arrived and observed the resident resting with her head and torso supported in the lift sling and her legs in the wheelchair under the armrest. The Hoyer sling was attached to the lift and the Hoyer lift was tipped sideways with the lift portion between the resident's legs and on her groin. The resident

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F 689	Continued From page 70 was assisted to the floor with the sling and the assistance of six staff. Resident was assess for injury and it was noted the resident had bruising and raised and abraded areas on her inner thigh. Resident had functional range of motion per her baseline but complained of left hip pain. While being assessed, the resident's eyes rolled back and her body began to shake. Her eyes were fixed open and she was not responsive to verbal or physical stimuli. The nurse directed staff to call 911 and the resident was having suspected seizure activity. Paramedics arrived and transported the resident to the hospital for evaluation. Immediate action: Resident was assisted to the floor, assessed for injury and sent to hospital via ambulance. Resident noted to have an abrasion to front of left thigh. Resident oriented to person. Predisposing environmental factors included clutter, furniture, crowding, and equipment malfunction. Physician was notified of incident. A progress note date 1/9/23 at 3:41 PM, documented the nurse was alerted to Resident #16's room by a loud noise and yelling coming from the room. The nurse arrived and observed the resident resting with her head and torso supported in the lift sling and her legs in the wheelchair under the armrest. The Hoyer sling was attached to the lift and the Hoyer lift was tipped sideways with the lift portion between the resident's legs and on her groin. Resident was assisted to the floor with the lift sling and the assistance of six staff. Resident was assessed for injury and it was noted that she had bruising and pinched areas on her inner thigh. Resident had functional range of motion per her baseline but complained of pain. While being assessed, the resident's eyes rolled back and her body	F 689		

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began to shake. Her eyes were fixed open and she was not responsive to verbal or physical stimuli. The nurse directed staff to call 911 as the resident was having suspected seizure activity. Paramedics arrived and transported the resident to the emergency room for evaluation.

A progress note dated 1/9/23 at 11:24 PM, documented Resident #16 returned to the facility at approximately 10:00 PM via ambulance. Resident was found to have a clear CT scan and x-rays showed no broken bones or fractures. The resident reported her tailbone and bottom were sore. Resident was given her bedtime medications which included pain medication. Vital signs were stable upon arrival back to the facility (T - 97.8, HR - 74, R - 20, BP - 122/86, and oxygen level was 96% on room air). Resident voiced no other concerns at that time.

A physician progress note dated 1/11/23 at 6:29 PM, documented resident had a fall on 1/9/23 from a malfunction of the Hoyer and landed on her back. She was transported to the emergency room. A head CT, back and hip x-ray was done. Hip x-ray was negative for fracture but it did show a contusion of the hip. The head CT was unremarkable. Today she complained of occipital headache, onset was after the fall on 1/9/23, describes it as intermittent throbbing and rates the pain at a 5. She was seen for post emergency room visit. No acute distress and oriented x 4. Plan: Celebrex 100 milligrams (mg) by mouth twice daily as needed for headache as previously ordered, utilize Tylenol as previously ordered and notify the provider with any changes.

In an interview on 4/19/23 at 11:51 AM, the DON acknowledged the fall from a Hoyer involving

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Resident #16 had occurred when Staff L, CNA was operating the Hoyer without a second person at the time. She stated she was not aware of other staff operating mechanical lifts independently.

In an interview on 4/25/23 at 8:10 AM, Staff N, OTA/Therapy Coordinator reported he held several in-services throughout the week following the incident with the Hoyer tipping and a staff person using the mechanical lift independently. He stated the in-service consisted of them watching a YouTube video and then they worked in groups of two and practiced Hoyer transfers of a person from the bed to the wheelchair and then back to bed. He stated he observed and let them do the transfers unless he saw a concern, then he would educate and correct at the time. He stated Staff L, CNA did attend the in-service and completed the transfer perfectly. He stated that he feels she knew exactly how to complete the transfers but it was a behavior thing that she chose to take short cuts.

5. Resident #17's MDS assessment dated 2/5/23 identified a BIMS score of 15, indicating intact cognition. The MDS indicated Resident #17 required total dependence of one person for bed mobility and total dependence of two people for transfers, and toilet use. Resident was wheelchair dependent and used oxygen. Resident #17 was always incontinent of bowel and bladder. The MDS included diagnoses of heart failure, cerebral palsy, seizure disorder, anxiety disorder, depression, psychotic disorder, respiratory failure, unspecified intellectual disabilities, and disruptive mood dysregulation disorder.

The Care Plan initiated on 7/9/18 with a revision

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date of 4/21/23, revealed a fall risk focus area related to incontinence with a goal of fall related injuries will be minimized. Interventions directed staff to inspect Hoyer slings before use, anticipate and meet the resident's needs, encourage resident to wear appropriate footwear, follow therapy recommendations for transfers and mobility, place call light in residents reach while in room and review information on past falls and attempt to determine cause of falls.

The Care Plan initiated on 9/1/13 with a revision date of 4/21/23, revealed an ADL self-care performance deficit focus area related to cerebral palsy with a goal to have no unaddressed/preventable decline in the resident's current level of function in ADL's. Interventions directed staff to ensure foot board is on the residents wheelchair, use two people to assist with Hoyer transfers, use one or two people for toilet use needs, praise all efforts for self-care, skid strips in front of the bed, use two people to assist in repositioning and turning in bed, and use one person to assist with personal hygiene and oral care.

A fall Incident Report dated 1/12/23 at 8:00 AM documented CNA's reported they were transferring the resident from the bed to her motorized wheelchair with the Hoyer lift and the lift tipped over. One of the CNA's reported she was able to catch the lift to prevent the resident from falling onto the floor. The resident instead fell into her motorized wheelchair and hit her left leg on the wheelchair arm rest. The resident was repositioned in the motorized wheelchair, vital signs were obtained, and neurological assessment was completed. The provider and family were notified of the incident. No injuries

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were noted at the time of the incident. The resident was noted to be lethargic. Predisposing physiological factors included resident being confused, incontinent, impaired memory and a gait imbalance.

A progress note dated 1/12/23 at 9:15 AM, documented two staff members were transferring the resident from her bed into her motorized wheelchair, as one staff member was pulling back on the lift and the lift began to tip over. The other CNA was able to catch the lift to prevent the patient from hitting the floor. The resident was guided to the motorized wheelchair, hitting her left leg on the armrest. The Resident complained of pain to her left leg, rating it at a 10 out of 10. Resident was unable to move her left leg at the time related to pain. A neurological assessment was completed and was within normal limits. Blood pressure was 126/84, temperature was 97.4, respirations were 20 per minute, even and unlabored and heart rate was 86 beats per minute. The provider was notified of the incident. A verbal order was given to obtain an x-ray of the left leg. The family was notified.

A progress note dated 1/12/23 at 4:03 PM, documented Resident #17's vital signs were within normal limits for resident. The resident continued to holler out in pain. The provider and Power of Attorney (POA) were notified. The resident was administered a dose of Tramadol, a Lidocaine patch to the left thigh, and an as needed dose of Icy Hot. The POA did not feel the resident needed to be sent to the hospital at this time. POA stated she would like the x-ray obtained and then re-address the issue next week. The x-ray was obtained and awaiting the x-ray results.

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A physician progress note dated 1/12/23 at 9:21 PM, documented it was reported the resident hit her left leg on her motorized wheelchair during transfer when the Hoyer lift malfunctioned. The resident reported pain in the left leg which was achy and the resident rated the pain at a 9. The resident had Tramadol, Tylenol, and Lidocaine Patch for pain. Resident was weak and had partial full range of motion to the left leg. Resident was noted to be awake and confused most of the time. Plan: Obtain left leg x-ray (4 view) for pain, utilize Tramadol, Tylenol, and Lidocaine Patch as previously ordered and notify with any changes.

A Progress note dated 1/13/23 at 2:39 PM, documented the provider received and noted the x-ray of the left leg, no new orders given at this time.

A physician progress noted dated 1/13/23 at 7:12 PM, documented the left leg x-ray showed no fracture and degenerative changes in the medial knee.

6. Resident #18's MDS assessment dated 2/17/23 identified a BIMS score of 3, indicating severely impaired cognition. The MDS indicated Resident #18 required total dependence of one person for bed mobility and toilet use and total dependence of two people for transfers. Resident was wheelchair dependent and had a feeding tube. Resident was always incontinent of bowel and bladder. The MDS included diagnoses of anemia, cerebrovascular accident, altered mental status, and dysphagia.

The Care Plan initiated on 9/9/13 with a revision

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date of 12/9/21, revealed a fall risk focus area related to dementia, inability to recognize safety issues, poor gait/balance, and need for assistance with transfers with a goal to not sustain any preventable serious injury. Interventions directed staff to ensure proper footwear with transfers or in wheelchair, anticipate and meet resident needs, ensure call light is available and encourage to use for assistance, encourage participation in activities that promote exercise, physical activity for strengthening and improve mobility, non-skid strips in place next to bed, and half side rail on bed to help roll herself from side to side.

The Care Plan initiated on 9/9/13 with a revision date of 12/9/21, revealed an ADL self-care performance deficit focus area related to a history of transient ischemic attack, muscle weakness, contractures/hemiparesis, and cognitive deficits related to dementia with a goal to not have any preventable decline in the resident's current level of function in ADL's. Interventions directed staff to utilize one person to check and change resident, anti-slip one way slide in wheelchair at all times due to repeated falls, use her wheelchair for locomotion, use two people for all Hoyer transfers, and encourage the resident to participate to the fullest extent possible with each interaction.

In an observation on 4/20/23 3:50 PM, Staff S, CNA and Staff T, Hospitality Aide performed a Hoyer transfer for Resident #18. The resident was sitting in her wheelchair with the Hoyer sling in place. The resident's daughter present for transfer. Staff T, Hospitality Aide was running the Hoyer. Staff S, CNA was placing the sling on the boom of the Hoyer. Top loops were on the green

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and the bottom loops were on purple. The Hoyer was not locked. Staff T, Hospitality Aide raised the boom of the lift and the resident's daughter assisted as the resident's left foot had foot drop and started to get stuck under the lift. The daughter assist in guiding the resident's legs. The wheelchair was pushed back towards the other side of the room and the resident was lowered to the bed.

Staff T, Hospitality Aide has been employed at the facility since 11/23/22 and worked as a dietary aide and moved into the hospitality aide position on 2/26/23.

In an interview on 4/20/23 at 4:23 PM, The Administrator stated Staff T, Hospitality Aide would be sent to CNA class. She hadn't started things yet so they hadn't enrolled her yet.

The facility provide Hospitality Aide policy identified that no hands on care is allowed in this position.

In an interview on 4/19/23 at 11:51 AM, the DON stated she wasn't sure but thought staff measured the resident to decide what kind and size of sling a resident should use with the Hoyer lift. She stated there is normally one sling in the room unless it gets dirty and then it is replaced with the same type and size sling that was in there previously.

In an interview on 4/19/23 at 1:00 PM, the Administrator reported the Maintenance Supervisor performed monthly preventative maintenance on the Hoyer lifts in the facility to ensure they are functioning properly and that the wheels are cleaned.

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The facility provided copies of the mobile lift safety inspection completed monthly by the Maintenance Supervisor on the following dates: 12/19/22, 1/20/23, 2/27/23, and 3/20/23. It instructed that any items identified as poor condition should be removed from service.

In an interview on 4/19/23 4:15 PM, Staff U, CNA reported she had worked at the facility for 18 years. She stated it was her practice to place the Hoyer lift in the position to transfer the resident and locked the wheels. She then secured the resident in the sling and left the wheels locked. Once the resident was raised in the lift, the wheels were unlocked to transfer the resident to the bed/chair. She stated two people should complete all Hoyer transfers.

In an interview on 4/24/23 at 9:44 AM, the Administrator reported that the type and size of Hoyer sling used was based on height and weight.

In an interview on 4/25/23 at 11:42 AM, the DON stated it was the expectation that all mechanical lifts be completed utilizing two staff members. She stated it should be either nurses or CNA's completing the transfers.

Per an email received from the Administrator on 4/25/23 at 12:18 PM, he stated the facility did not have any Hoyer education provided to agency staff because they had not used any CNA agency staff since March 6, 2023. He further stated the process for assigning slings to resident that utilized mechanical lifts for transfers was that it was identified on admission if any residents was going to need special equipment by the

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F 689	Continued From page 79 Admission Coordinator, DON, and ADON. He also stated most resident use a medium size Hoyer sling. The Drive Medical Hoyer 4A2101000153D, Model 13244 had a warning sticker on the lift stating the wheels must remain unlocked during transfers. If the wheels are in the locked position it can affect stabilization during the lift procedure. On 5/1/23 at 11:06 AM, the Administrator reported the facility did not have any policy related to Hoyer transfers.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and	F 690		

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(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, observation, staff interview, and policy review the facility failed to provide incontinence care to minimize the occurrence of urinary tract infections and to ensure the perineal area was kept clean and dry for 2 of 4 residents reviewed (Resident #2 and #4). The facility reported a census of 69 residents.

Finding include:

1. The Minimum Data Set (MDS) assessment dated 4/1/23 for Resident #2 identified a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. The MDS revealed the resident required extensive assistance of 1 person with bed mobility and transfers and totally dependent on 1 person for toilet use. The resident was dependent on a wheelchair for mobility and always incontinent of bowel and bladder. The MDS included diagnoses of deep vein thrombosis, arthritis, anxiety disorder, depression, bipolar disorder, schizophrenia, conversion disorder, borderline personality disorder and spinal stenosis.

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A Care Plan dated 1/5/20 with a revision date of 7/15/22 for Resident #2 revealed a focus area for bowel and bladder incontinence and being at risk for urinary tract infections (UTI) and/or skin breakdown with a goal the resident would be kept clean, dry, and comfortable daily with the use of incontinence products. Interventions directed staff to check the resident before and after meals and as needed for incontinent episodes, communicate changes in urine odor, color, bleeding, or pain with urination to the nurse, provide incontinence care after each incontinent episode, and use barrier cream to perineal area.

Review of progress notes revealed the resident had been treated for UTI's the following dates since 2/1/23:
2/18/23 Resident was sent to the emergency room and admitted with diagnosis of UTI and encephalopathy.
2/27/23 Resident returned from the hospital
3/38/23 Resident started on Cipro 250 milligrams (MG) (antibiotic) by mouth twice daily for 10 days for diagnosis of UTI.
3/29/23 Order was received to discontinue the Cipro related to resistance to the organism causing the UTI and to start Rocephin 1 Gram (G) (antibiotic) intramuscularly (IM) every day for 5 days.

4/11/23 Resident was started on Keflex 500 MG (antibiotic) by mouth four times a day for 10 days for a diagnosis of UTI.
In an observation on 4/12/23 at 7:52 AM, Staff I, CNA and Staff CC, CNA completed cares on resident before breakfast. The two staff members knocked and entered the room. They did not wash their hands but applied gloves and

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F 690	Continued From page 82 asked the resident if she was ready to get dressed. She stated she was ready and needed to be boosted up in bed and her brief needed changed as she was "soaking wet". The staff immediately removed her blanket and began to undo her wet brief. Both staff assisted with undoing the wet brief and Staff I, CNA used wet wipes to cleanse the perineal area. She used the one wipe - one swipe method to cleanse from front to back but did not wash the mons pubis area. The wet brief remained under her at that time. Staff CC, CNA requested and assisted resident to turn onto her left side and the wet brief was removed from under her at that time. The comply underpad was noted to be wet but left under her at this point. Staff I, CNA cleansed the buttock area and right hip using the one wipe - one swipe method. The left hip was never cleansed. Once done, a new brief was put under her and she was assisted to her back and the clean brief was pulled through on the left side and then pulled up between her legs and attached with the pull tabs. Staff I, CNA changed her gloves at this time but no hand hygiene was completed. Staff CC, CNA assisted the resident to roll to the side again and the wet comply underpad was tucked under her and she was assisted to her back and the comply underpad was removed from the left side. It was noted that the residents brief, comply pad, sheet and gown were all wet with urine. Staff CC, CNA went to the closet and picked out clothes for the resident. Staff I, CNA was putting dirty clothes and soiled items in a garbage bag. Staff CC, CNA handed a pair of pants to Staff I, CNA who assisted the resident in putting them on. Staff CC, CNA found a shirt for the resident and removed the dirty urine soaked hospital gown from the resident. She assisted the resident to put on her shirt.	F 690		

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Staff CC, CNA had not changed her gloves at all. The two staff assisted the resident to sit on the side of the bed in preparation for the transfer into the resident's wheelchair.

2. Resident #4's Minimum Data Set (MDS) assessment dated 1/13/23 identified a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition. The MDS indicated Resident #4 required extensive assistance of one person for bed mobility, total assistance of two persons for transferring, and total assistance of one person for toilet use. Resident #4 was always incontinent of bowel and bladder and used oxygen therapy. The MDS included diagnoses of diabetes mellitus, anemia, heart failure, multiple sclerosis, non-Alzheimer's dementia, depression, schizophrenia, respiratory failure and osteomyelitis of the vertebrae.

A Care Plan dated 7/21/19 with a revision date of 11/25/22 for Resident #4 revealed a focus area for bowel and bladder incontinence and is at risk for signs and symptoms of UTI and/or skin breakdown related to the incontinence and diuretic use. The interventions directed staff to check resident before and after meals and as needed for incontinent episodes, communicate changes in urine odor, color, bleeding, or pain with urination to the nurse, administer medications as ordered, place the call light or other communication devices within reach at all times, provide incontinence/perineal care after each incontinent episode, and use barrier cream to the perineal area.

Review of progress notes does not indicate the resident had been diagnosed with a UTI since 2/1/23.

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F 690	Continued From page 84 In an observation on 4/13/23 at 1:50 PM, Staff G, CNA and Staff H, CNA complete incontinence care for resident #4. The staff transferred the resident from her wheelchair into her bed using the Hoyer lift. Hand hygiene was completed upon entering the room and they both applied gloves. Staff reported that the resident was laid down after every meal and checked and changed at that time. The Resident was rolled to the right and the resident's brief was undone and tucked as well as the Hoyer sling under her. It was noted the resident did not have a dressing on her coccyx area and it was bleeding. The brief was soaked and her pants and the sling were wet as well. Staff assisted the resident to roll to the left and the brief and sling were removed. Staff did not change their gloves or sanitize their hands. A new brief was tucked under the resident. Peri-fresh was sprayed onto the resident's buttocks and her buttocks was cleansed using the one wipe - one swipe method from front to back while on her side. Staff slightly spread her legs while on her side and wiped perineal area front to back using one wipe - one swipe. The resident was turned onto her back and the brief was pulled up between her legs. The brief was not fastened. The resident's groins, pubis and outer buttock cheeks were not cleansed. Gloves were removed by CNA's but no hand hygiene completed. Staff applied the resident's pants and pulled them up to her upper thighs as they were waiting for the nurse to come and apply a dressing to the open area on the coccyx. Staff H, CNA washed her hands and left the room to go get the nurse to apply the dressing. Staff DD, Licensed Practical Nurse (LPN) entered the room to complete the dressing change to her coccyx. Hand hygiene completed upon entering the room	F 690		

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and supplies set up on a tray table with a towel for a barrier. No gloves were worn. She used 4 x 4's to wipe the bloody drainage away. She then got a Mepilex dressing and applied it to the area. The patch was dated and initialed after applied to the wound. The resident was positioned on her right side for the treatment. Staff H, CNA applied gloves but did not complete hand hygiene prior to applying her gloves and applied Periguard to the resident's inner thighs and buttocks area. She removed her gloves and positioned her onto her back. Pants were removed at resident's request. Covered with a sheet, the head of bed was elevated, and call light placed in reach. No hand hygiene completed by the CNA's when leaving the room.

In an interview on 4/25/23 at 11:48 AM, the Director of Nursing (DON) she stated it was the expectation that staff complete rounds frequently and check and change residents. Staff should also be toileting residents and changing them at their request, and before and after meals. Staff know the residents that are heavy wetters and should check them more frequently. Staff should also watch for cues that a resident may need to use the toilet, like trying to get up out of the chair or bed.

A facility provided policy titled Perineal/Incontinence Care dated 1/1/14 stated incontinence perineal/incontinence care was to be done to provide cleanliness and comfort to the resident, prevent infections and skin irritation, and observe the resident's skin condition.

F 842 SS=D Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) F 842

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§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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

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

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility failed to maintain medical records which were readily accessible and systematically organized during the survey process for 1 resident (Resident #3). The facility reported a census of 69 residents.

Findings include:

During the investigation of a Stage 4 pressure ulcer acquired by Resident #3, requests were made of the facility multiple times to provide

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Medication Administration Records (MAR) and Treatment Administration Records (TAR) for Resident #3 for the month of December, 2022.

On 4/12/23 at 1:39 PM the request was made for the MAR and TAR records for the hall of the 100 room numbers for December of 2022 via an email request to the Administrator.

On 4/13/23 at 9:30 AM the Director of Nursing (DON) provided a stack of MARS and TARS. She stated they included every resident who resided on the 100 hall in the month of December 2022. The provided records failed to include the records for Resident #3.

Per the census in the Electronic Health Record of Resident #3, she resided in room 109 12/1/22-12/12/22 and moved to room 118 on 12/13/22.

On the afternoon of 4/14/23, the Administrator stated they had gathered the records for Resident #3 for a prior survey in February of 2023 and they were in a separate area and they were in the process of looking for them.

On 4/18/23 at 10:35 AM the DON stated she would look to see if she was able to locate the records. She stated she would also look for any skin assessments that were done on paper.

On 4/20/23 at 3:00 PM the December of 2022 MARS and TARS were provided, 8 days following the initial request being made. No skin sheets were provided.

The Skin Observation Tool dated 12/9/22 for Resident #3 included a note documenting the

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GENESIS SENIOR LIVING	5608 SW 9TH STREET DES MOINES, IA 50315

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F 842	Continued From page 89 author had removed a dressing dated 12/1/22. Purulent, foul smelling drainage was noted. The Order Summary Report for Resident #3 documented the resident had orders for dressing changes to be done daily beginning on 12/2/22. The Report further documented the resident received orders on 12/9/22 for a 10 day course of antibiotics for a skin ulcer. On 1/24/23 Resident #3 was admitted to an acute care hospital for the care of a Stage 4 pressure ulcer which resulted in multiple surgeries. The policy Medical Records, Review date 4/25/19 included the following points: Each resident will have a medical record. The record shall be kept current, complete, legible and available at all times. When a resident is admitted to the hospital on a bed hold status, the Medical Record is to be kept open until discharged to home, another level of care, or elsewhere. If the resident is discharged, the Medical Record is closed, and a new record is to be opened using the same Medical Record number upon return. The policy Skin Evaluation dated 12/28/22 included the following point: Manual Skin Observations Evaluations are to be kept with the Treatment Record and filed in the Medication/Treatment section of the Medical Record.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

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§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment 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,

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depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

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

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of 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 clinical record review, observation, staff interview and policy review, the facility failed to maintain proper infection control practices to prevent cross contamination and potential infection when completing perineal care and wound care for 2 of 4 residents reviewed (Residents #2 and #4). The facility reported a census of 69 residents.

Findings include:

1. The MDS assessment dated 4/1/23 for

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Resident #2 identified a BIMS score of 9, indicating moderately impaired cognition. The MDS revealed the resident required extensive assistance of 1 person with bed mobility and transfers and totally dependent on 1 person for toileting. The resident was dependent on wheelchair for mobility and always incontinent of bowel and bladder. The MDS included diagnoses of deep vein thrombosis, arthritis, anxiety disorder, depression, bipolar disorder, schizophrenia, conversion disorder, borderline personality disorder, and spinal stenosis.

A Care Plan dated 1/5/20 with a revision date of 7/15/22 for Resident #2 revealed a focus area for bowel and bladder incontinence and being at risk for urinary tract infections (UTI) and/or skin breakdown with a goal the resident would be kept clean, dry, and comfortable daily with the use of incontinence products. Interventions directed staff to check resident before and after meals and as needed for incontinent episodes, communicate changes in urine odor, color, bleeding, or pain with urination to the nurse, provide incontinence care after each incontinent episode, and use barrier cream to perineal area.

In an observation on 4/12/23 at 7:52 AM, Staff I, CNA and Staff CC, CNA completed cares on resident before breakfast. The two staff members knocked and entered the room. They did not wash their hands but applied gloves and asked the resident if she was ready to get dressed. She stated she was ready and needed to be boosted up in bed and her brief needed changed as she was "soaking wet". The staff immediately removed her blanket and began to undo her wet brief. Both staff assisted with undoing the wet brief and Staff I, CNA used wet wipes to cleanse

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the perineal area. She used the one wipe - one swipe method to cleanse from front to back but did not wash the mons pubis area. The wet brief remained under her at that time. Staff CC, CNA requested and assisted resident to turn onto her left side and the wet brief was removed from under her at that time. The comply underpad was noted to be wet but left under her at this point. Staff I, CNA cleansed the buttock area and right hip using the one wipe - one swipe method. The left hip was never cleansed. Once done, a new brief was put under her and she was assisted to her back and the clean brief was pulled through on the left side and then pulled up between her legs and attached with the pull tabs. Staff I, CNA changed her gloves at this time but no hand hygiene was completed. Staff CC, CNA assisted the resident to roll to the side again and the wet comply underpad was tucked under her and she was assisted to her back and the comply underpad was removed from the left side. It was noted that the residents brief, comply pad, sheet, and gown were all wet with urine. Staff CC, CNA went to the closet and picked out clothes for the resident. Staff I, CNA was putting dirty clothes and soiled items in a garbage bag. Staff CC, CNA handed a pair of pants to Staff I, CNA who assisted the resident in putting them on. Staff CC, CNA found a shirt for the resident and removed the dirty urine soaked hospital gown from the resident. She assisted the resident to put on her shirt. Staff CC, CNA had not changed her gloves at all. The two staff assisted the resident to sit on the side of the bed in preparation for the transfer into the resident's wheelchair.

2. Resident #4's Minimum Data Set (MDS) assessment dated 1/13/23 identified a Brief

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Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition. The MDS indicated Resident #4 required extensive assistance of one person for bed mobility, total assistance of two persons for transferring, and total assistance of one person for toilet use. Resident #4 was always incontinent of bowel and bladder and used oxygen therapy. The MDS included diagnoses of diabetes mellitus, anemia, heart failure, multiple sclerosis, non-Alzheimer's dementia, depression, schizophrenia, respiratory failure and osteomyelitis of the vertebrae.

A Care Plan dated 7/21/19 with a revision date of 11/25/22 for Resident #4 revealed a focus area for bowel and bladder incontinence and is at risk for signs and symptoms of UTI and/or skin breakdown related to the incontinence and diuretic use. The interventions directed staff to check the resident before and after meals and as needed for incontinent episodes, communicate changes in urine odor, color, bleeding, or pain with urination to the nurse, administer medications as ordered, place the call light or other communication devices within reach at all times, provide incontinence/perineal care after each incontinent episode, and use barrier cream to the perineal area.

In an observation on 4/13/23 at 1:50 PM, Staff G, CNA and Staff H, CNA complete incontinence care for resident #4. The staff transferred the resident from her wheelchair into her bed using the Hoyer lift. Hand hygiene was completed upon entering the room and they both applied gloves. Staff reported that the resident was laid down after every meal and checked and changed at that time. The resident was rolled to the right and the resident's brief was undone and tucked as

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F 880	Continued From page 95 well as the Hoyer sling under her. It was noted the resident did not have a dressing on her coccyx area and it was bleeding. The brief was soaked and her pants and the sling were wet as well. Staff assisted the resident to roll to the left and the brief and sling were removed. Staff did not change their glove or sanitize their hands. A new brief was tucked under the resident. Peri-fresh was sprayed onto the resident's buttocks and her buttocks was cleansed using the one wipe - one swipe method from front to back while on her side. Staff slightly spread her legs while on her side and wiped perineal area front to back using one wipe - one swipe. The resident was turned onto her back and the brief was pulled up between her legs. The brief was not fastened. The resident's groins, pubis and outer buttock cheeks were not cleaned. Gloves were removed by CNA's but no hand hygiene completed. Staff applied the resident's pants and pulled them up to her upper thighs as they were waiting for the nurse to come and apply a dressing to the open area on the coccyx. Staff H, CNA washed her hands and left the room to get the nurse to apply the dressing. Staff DD, Licensed Practical Nurse (LPN) entered the room to complete the dressing change to her coccyx. Hand hygiene completed upon entering the room and supplies set up on a tray table with a towel for a barrier. No gloves were worn. She used 4 x 4's to wipe the bloody drainage away. She then got a Mepilex dressing and applied it to the area. The patch was dated and initialed after applied to the wound. The resident was positioned on her right side for the treatment. Staff H, CNA applied gloves but did not complete hand hygiene prior to applying her gloves and applied Periguard to the resident's inner thighs and buttocks area. She removed her gloves and positioned her onto her	F 880		

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back. Pants were removed at resident's request. Covered with a sheet, the head of bed was elevated, and call light in reach. No hand hygiene completed by the CNA's when leaving the room.

In an interview on 4/25/23 at 11:51 AM, the Director of Nursing (DON) stated it was the expectation that staff wash their hand or use hand sanitizer before touching a resident and every time they take off their gloves. Staff were to use gloves for all incontinence care and wound care. They were expected to change their gloves and complete hand hygiene when moving from dirty to clean with incontinence care and wound care and should complete hand hygiene prior to leaving the residents room.

A facility provided policy titled Perineal/Incontinence Care dated 1/1/14 stated the following procedure for completing perineal/incontinence care:

" Place equipment on clean surface within easy reach
" Provide hand hygiene and apply gloves
" Remove soiled brief/underpad from resident by rolling the brief/underpad to contain as much fecal matter as possible
" Cleanse the resident's perineal area using an approved no-rinse incontinence cleansing product
" For female resident, separate labia and cleanse one side, the other, then the center of the labia toward the rectal area. Cleanse the perineal area from front to back. The rectal area and buttocks should be cleansed as well.
" Use a clean area of cloth for each area cleansed.
" Assure all areas affected by incontinence have been cleansed

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F 880	Continued From page 97 " Remove gloves and perform hand hygiene " Apply clean gloves " Apply protective ointment as part of incontinence care " Remove gloves and perform hand hygiene, Apply clean gloves " Apply clean brief and reapply clothing " Discard contaminated items in approved containers " Remove gloves and perform hand hygiene " Reposition resident into a safe and comfortable position and return the bed to the lowest position, unless contraindicated " Place call light within reach	F 880		

Plan of Correction

Genesis Senior Living Center

Survey: April 10, 2023 to April 27, 2023

Correction Date: 6/6/2023

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies were executed solely because provisions of State and Federal law require it.

1) Immediate Fix

2) Potential Residents Affected

3) System Changes

4) Monitoring/QAPI

5) Date Of Compliance

F 550 Resident Rights/Exercise of Rights:

1) Resident #7, #8, and #10 are being spoke to in a dignified and respectful manner.
2) This had the potential to affect all residents.
3) Staff were educated on 5/25/2023 of the need to speak to residents, other staff, and anyone in the facility in a dignified and respectful manner. Staff were educated on Resident Rights on **5/25/2023** to assist in ensuring residents are treated in a dignified and respectful manner in all aspects of their living in the facility.
4) Management will monitor staff behavior and speak to residents on how they are being treated making sure being treated in a dignified and respectful manner. Management will talk with residents as part of their PUI rounds to monitor that residents are being cared for in a dignified manner.
5) Date of Compliance: 6/6/2023

F 580 Notify of Changes (Injury/Decline/Room, etc.)

1) Resident #3 no longer resides in the facility. Resident #4 is having responsible party notified for changes in condition.
2) This had the potential to affect all residents.
3) Staff were educated on **5/25/2023** of the requirement to notify residents family/responsible party of changes in condition which may include new medications and or med/treatment changes.

4) Nurse management will monitor 24-hour report and ISTA report as part of clinical preparation to see if family/responsible party were notified of changes in conditions and if not will be notified at that time. Will also discuss changes in conditions as part of AM meeting and family/responsible party notification will be part of those meetings. Problems will be corrected as they are observed.
5) Date of Compliance: 6/6/2023

F 600 Free from Abuse and Neglect:

1) Resident #2 is being treated safely and dignified in the facility. Staff W does not work in the facility any longer.
2) This had the potential to affect all residents
3) Staff were educated on **5/25/2023** on the fact that all residents must be considered in a kind and considerate manner. This included the use of profane language to residents as well as around residents. Staff were educated on **5/25/2023** that the use of profane language can result in termination.
4) Facility management will monitor with resident interviews as part of their rounds to ensure that profane language is not be used at resident or their surroundings. Problems will be corrected as they are observed. Finding will be discussed at IDT meetings and problems will be corrected as they are observed.

F 610 Investigate/Prevent/Correct Alleged Violation:

1) Resident #2 is having any allegations of abuse reported timely and per requirements.
2) This had the potential to affect all residents.
3) Staff were educated on the requirements of timely reporting of alleged abuse on **5/25/2023** per federal and state regulations. Staff were educated on **5/25/2023** of types of abuse and what is considered abuse by state and federal guidelines.
4) Management will monitor for any suspected abuse and ensure that proper reporting guidelines are followed per state and federal guidelines. Online reporting will be used as needed and called in if needed to meet timely reporting requirements. Problems will be corrected as they are observed.
5) Date of compliance: 6/6/2023

F 656 Develop/Implement Comprehensive Care Plan:

1) Resident #3 no longer resides in the facility. Resident #10 has a comprehensive care plan to reflect her current care needs.
2) This had the potential to affect all residents.
3) Staff were educated on **5/25/2023** of the process of developing comprehensive care plan per the RAI process. Care Plans need to reflect the care needs of the residents and must be kept up to date as resident conditions change or develop new conditions. Staff were educated on **5/25/2023** that if the care plan is updated the Kardex must be as well

for aides to follow. Care plans will be reviewed to ensure that they are up to date and reflect residents current care needs.

4) IDT will monitor that care plans are comprehensive and updated with resident changes in condition by am meeting discussion over clinical portion of meeting. Care plans will be updated at that time as needed to assist in ensuring residents receive the care that is needed.
5) Compliance Date: 6/6/2023

F 657 Care Plan Timing and Revision:

1) Resident #1's care plan is up to date with all fall interventions and care needs.
2) This had the potential to affect all residents.
3) Staff were educated on updating Care Plans on **5/25/2023**. This included care plans must be updated following falls for potential new interventions as well as with changes in conditions and or any care needs, and also needs to be reflected on the Kardex as well. Care plans were reviewed to assist in ensuring care needs are up to date as well as needed fall interventions.
4) Facility will monitor care plan needs per IDT meetings as well as Risk meetings. Care Plans will be updated at that time as will be Kardex. Care plans will also be monitored as part of the RAI process and reviewed and updated as needed quarterly as well.
5) Date of Compliance: 6/6/2023

F 677 ADL Care Provided for Dependent Residents:

1) Residents #7 and #8 are getting their scheduled showers/baths on their assigned days.
2) This had the potential to affect all residents.
3) Staff were educated on **5/25/2023** of the requirement of offering residents 2 showers/baths a week minimum. This included if a resident refuses they must sign the bath sheet that they refused and this must be turned into charge nurse. Bath sheets will be collected at the end of the shift and put in the ADON box. ADON will review q day to see that baths were completed as scheduled as well as bath skin sheet that the residents must sign if they refuse the bath. ADON will take bath sheets to AM IDT meeting to discuss bath completion.
4) IDT will monitor that baths are completed by ADON brining bath sheets to am meeting. Baths will be made up where possible. Missed baths will take president over refused baths.
5) Date of Compliance: 6/6/2023

F 684 Quality of Care:

1) Resident #1 and #4 will be assessed and Neuro evals will be conducted with future falls if they occur.
2) This had the potential to affect all residents who may have fallen.

3) Staff were educated on **5/25/2023** on the requirement for post fall assessments and Neuro Evaluations for unwitnessed fall and falls where the resident struck their head. This included family and physician notification as well. Staff were educated on **5/25/2023** that if anyone is seen on the floor to get a charge nurse so that a proper assessment can be conducted by charge nurse before they are gotten up.
4) Nurse Management will review falls daily in preparation for clinical meeting to ensure that assessments were completed, physician and family notification completed, and neuro evaluations were completed. Problems will be corrected at that time so assessments are completed as needed.
5) Date of Compliance: 6/6/2023

F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer

1) Resident #3 no longer resided at the facility.
2) This had the potential to affect all residents.
3) Staff were educated on facility skin protocol on **5/25/2023** to ensure wounds/Pressure Injuries are assessed weekly by nursing staff as well as local wound care physicians. Staff were educated on **5/25/2023** on facility protocol of wound rounds and following up on weekly wound assessment findings for any order changes for new treatments to assist in healing any pressure injuries/wounds. Staff were educated on ***5/25/2023*** on the importance of reviewing bath skin checks as well to assist in ensuring identification of wounds rapidly and getting appropriate treatments as soon as possible is part of the facility's wound protocols. The facility will contact Telligan for additional information/training on pressure sore prevention for facility staff. St
4) Nurse management will audit weekly skin assessments are completed as well as appropriate treatments are available to residents with pressure injuries and or other wounds. Nurse management will review physician wound assessments to assist in ensuring appropriate treatment orders are follow up on as needed. Problems will be corrected as they are identified. Facility's AM meeting will discuss pressure injuries at meeting to ensure assessments and wound follow up takes place. Problems will be corrected as they are identified.
5) Date of Compliance: 6/6/2023

F 689 Free of Accident Hazards/Supervision/Devices:

1) Resident #16 no longer resides in the facility. Residents #4, #7, #14, #17 and #18 are being transferred appropriately with mechanical lift assistance.
2) This had the potential to affect all resident who require the use of mechanical lifts for transfers/Positioning.
3) Staff were educated on 4/25 and 4/26/2023 on the proper use of mechanical lifts and which slings are appropriate for the use on the mechanical lifts. This education also included when the mechanical lift's wheels were to be lock and unlocked. Staff were audited on proper lift usage on 4/20-4/26/2023 to assist in ensuring appropriate lift

usage/sling usage was being maintained. These audits also included locking of wheels on lifts and the use of appropriate slings.

4) Nurse Management will continue to audit staff on the appropriate use of mechanical lifts/slings and locking of wheels on current staff and on new hires as part of their orientation process to assist in ensuring appropriate use of mechanical lifts are maintained. Problems will be corrected as they are observed. IDT will ensure audits occur and problems will be corrected as they are observed.
5) Date of Compliance: 6/6/2023

F 690 Bowel/Bladder Incontinence, Catheter, UTI:

1) Residents #2 and #4 are receiving appropriate incontinence care to assist in UTI prevention.
2) This had the potential for all residents who require staff to assist in providing incontinence care.
3) Staff were educated on proper incontinence care procedures on **5/25/2023** to assist in UTI prevention. This education included establishing clean and dirty areas as well as washing inner and outer thighs while providing incontinence care.
4) Staff will be audited on providing appropriate incontinence care to assist in preventing UTIs. Problems will be corrected as they are observed. IDT will ensure audits take place and that appropriate corrective actions was taken.

F 842 Resident Records - Identifiable Information:

1) Resident #3 no longer resides in the facility. Resident medical records are available at the facility.
2) This had the potential to affect all residents.
3) The facility has recently let the Medical Records person go from the facility and training a new person on the job of Medical Records and organizing medical records. Medical records are available for residents in the facility as well as in PCC software. Medical records will continue to be stored in the facility and PCC per facility protocols.
4) IDT will monitor that medical records are stored appropriately per audits of medical records storage. Problems will be corrected as they are observed.
5) Date of compliance: 6/6/2023

F 880 Infection Prevention & Control:

1) Residents #2 and #4 are receiving cares and treatments per facility protocols to maintain infection control practices.
2) This had the potential to affect all residents.
3) Staff was educated on **4/25/2023** on the importance of maintaining proper infection control practices such as hand washing, glove usage, hand sanitizer use, and the handling of soiled briefs/clothing/linen when providing cares to residents. Staff will be

audited by Nurse Management to assist in ensuring proper infection control is maintained during cares/treatments. Problems will be corrected as they are observed.

4) IDT will ensure that audits occur and appropriate corrective actions were taken by nurse management. Problems will be corrected as they are observed.

58.19(2)b 58.19(135C): 58.19(2):

1) Resident #3 no longer resided at the facility.

2) This had the potential to affect all residents.

3) Staff were educated on facility skin protocol on 4/25/2023 to ensure wounds/Pressure Injuries are assessed weekly by nursing staff as well as local wound care physicians. Staff were educated on insert correct date on facility protocol of wound rounds and following up on weekly wound assessment findings for any order changes for new treatments to assist in healing any pressure injuries/wounds. Staff were educated on insert correct date on the importance of reviewing bath skin checks as well to assist in ensuring identification of wounds rapidly and getting appropriate treatments as soon as possible is part of the facility's wound protocols. The facility will contact Telligan for additional information/training on pressure sore prevention for facility staff. St

4) Nurse management will audit weekly skin assessments are completed as well as appropriate treatments are available to residents with pressure injuries and or other wounds. Nurse management will review physician wound assessments to assist in ensuring appropriate treatment orders are follow up on as needed. Problems will be corrected as they are identified. Facility's AM meeting will discuss pressure injuries at meeting to ensure assessments and wound follow up takes place. Problems will be corrected as they are identified.

5) Date of Compliance: 6/6/2023

58.28(3)e: 481—58.28(135C) Safety:

1) Resident #16 no longer resides in the facility. Residents #4, #7, #14, #17 and #18 are being transferred appropriately with mechanical lift assistance.

2) This had the potential to affect all resident who require the use of mechanical lifts for transfers/Positioning.

3) Staff were educated on 4/25 and 4/26/2023 on the proper use of mechanical lifts and which slings are appropriate for the use on the mechanical lifts. This education also included when the mechanical lift's wheels were to be lock and unlocked. Staff were audited on proper lift usage on 4/20-4/26/2023 to assist in ensuring appropriate lift usage/sling usage was being maintained. These audits also included locking of wheels on lifts and the use of appropriate slings.

4) Nurse Management will continue to audit staff on the appropriate use of mechanical lifts/slings and locking of wheels on current staff and on new hires as part of their orientation process to assist in ensuring appropriate use of mechanical lifts are maintained. Problems will be corrected as they are observed. IDT will ensure audits occur and problems will be corrected as they are observed.

5) Date of Compliance: 6/6/2023