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F 000	INITIAL COMMENTS Correction date: 12/1/23 ✓ JB The following deficiencies resulted from investigation of complaint #116425-C conducted October 25, 2023 to November 01, 2023. Complaints #116425-C was substantiated. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: KM
TITLE: Administrator
(X6) DATE: 12/5/23

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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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 staff interviews, resident interviews, facility documentation, and review of facility policy, the facility failed to provide care for 2 of 6 residents reviewed (Resident #5 and #6) in a manner to promote dignity and respect. Interviews determined that Resident #5 sat visibly incontinent of urine in a common area for visitors and other residents to witness his incontinence for over 2 hours. In addition, Resident #6 felt that the staff ignored her husband when they turned off his call light and she did not hear the staff member state she would be back.

Findings include:

1. Resident #5's Minimum Data Set (MDS) assessment dated 7/13/23 identified no completed Brief Interview for Mental Status (BIMS) score. The Staff Assessment for Mental Status listed Resident #5 as severely impaired for decision making. Resident #5's MDS included diagnoses of moderate intellectual disabilities,

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depression, altered mental status and unspecified symptoms and signs with cognitive functions and awareness. The MDS listed Resident #5 as always incontinent of urine.

The Care Plan with a target date of 11/9/23 revealed Resident #5 had mixed bladder incontinence related to physical limitations and required assistance with activities of daily living related to impaired cognition. The care plan documented Resident #5 depended on one person for toilet use and personal hygiene needs. The care plan directed staff to use assistance of two persons and an EZ stand (machine to assist with standing) for transfers to the toilet and to provide incontinence care when incontinent.

A form titled [Facility Name] Verbal Coaching dated 8/14/23 documented an incident involving Staff A, CNA (Certified Nursing Assistant), and Resident #5. The incident section of the form documented after supper described Resident #5 as incontinent of urine. Staff B, RN (Registered Nurse), told Staff A, Resident #5 was wet. Staff A stated, " Yea, he will be the first one we do". The form documented Resident #5 remained in the central area until HS (hour of sleep) cares with his pants still wet. At 8 PM, Resident #5 remained in the wheelchair. The form further documented that Staff A used her cell phone and/or ate Culvers after her scheduled break. The comments section of the form documented a reminder provided to Staff A of position changes every 2 hours and that all residents need oral care. The Administrator and Staff B signed the form.

On 10/31/23 at 10:44 AM, Staff B acknowledged that she completed a verbal coaching form with

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Staff A on 8/14/23. Staff B reported she had a bad night with Staff A that night. Staff B reported that she told Staff A at approximately 6:00 PM about Resident #5 appeared incontinent of urine and needed changed. Staff B reported that she could visibly see Resident #5 that soiled (incontinent of urine) his pants from the outside of his pants. Staff B reported Staff A stated she would take care of Resident #5 first. Staff B stated Resident #5 sat in a common area by the medication room so they could keep an eye on him. Staff B stated at 8:00 PM, Resident #5 still sat there and remained wet/soiled. Staff B stated obviously Staff A did not take care of Resident #5 first like she said she would. Staff B stated Staff A went to break, used her cell phone, and ate Culvers. Staff B reported she did not know what exact time Resident #5 received care but he remained in the common area wet. Staff B stated she thought the staff completed his cares before 9:00 PM.

On 10/31/23 at 11:35 AM, Staff C, Director of Nursing (DON), reported that she expected the staff to provide dignity to the residents as well as they can.

An undated facility policy titled Enhancing and Maintaining Quality of Life documented that the facility would care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. The policy further documented that staff will focus on treating each resident with dignity and respect in full recognition of his or her individuality as they carry out activities that assist the resident to maintain or enhance his/her self-esteem and self-worth. The policy indicated the facility will provide reasonable accommodations of resident's individual need

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and preference related to their care and environment, directed toward assisting the resident to maintain and/or achieve their highest practicable level of functioning, promoting dignity and well-being.

2. The Minimum Data Set (MDS) for Resident #6 dated 9/14/23 assessment identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. Resident #6's MDS included diagnoses of anxiety, depression, rheumatoid arthritis (chronic inflammation that can affect your joints, skin, eyes, lungs, heart, and blood vessels), anemia (low iron level in the blood), heart failure (heart inability to pump the blood), hypertension (high blood pressure) and renal (kidney) disease.

A facility grievance form dated 10/16/23 identified that Resident #6 felt that Staff A ignored her husband. Resident #6 reported that Staff A came in and shut off Resident #2's (husband's) call light without saying anything. The grievance form indicated another staff member returned and helped Resident #2 to the bathroom.

An untitled facility documented dated 10/17/23 at 10:36 AM documented Resident #6 stated the staff treat her with respect and dignity occasionally.

An untitled facility document dated 10/17/23 and signed by Staff D, ADON (Assistant Director of Nursing), documented the following interview with Resident #6:
-Resident #6 doesn't want to get anyone in trouble.
-Resident #6 stated Staff A walked into the room and walked back out without saying a word.

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-Resident #6 stated she could not describe Staff A's attitude because she didn't talk and she did not normally assist them.
-Resident #6 could not remember if Staff A shut off Resident #2's call light or not. She stated she could not remember.
-Resident #6 stated even if Staff A would have just told me she was busy and would be back that would have been acceptable.

A facility form titled Warning Notification dated 10/18/23 documented Staff A received a 3 day unpaid work suspension. The form contained the following information:
a. The Reference to Rule/Regulation section on the form documented:
Insubordination- Failure to work in a cooperative manner with co-worker and team leaders. Disrespectful to co-workers, supervisors and residents. Unprofessional attitude and uncooperative behavior.
b. The Summary section on the form documented: Turning off call lights, not assisting residents or not explaining to them the reason why to reassure them, and not providing good customer service. Residents felt that Staff A ignored them and did not want to help them when they needed assistance.
c. The form was signed by Staff A, Staff D, and Staff E, Regional Nurse Consultant.

On 10/25/23 at 12:34 PM, Staff F, CNA, reported that Resident #2 used an EZ stand to transfer and liked to go from his wheelchair to his recliner after supper. Staff F stated she witnessed Staff A go into Resident #2's room and shut off the call light and not say anything to Resident #2. Staff F stated she wheeled another resident back to his room when it occurred. Staff F reported that she

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went into the room and saw Resident #6 writing information down on a sticky note. Staff F reported Staff A stated that Resident #6 wrote that stuff down to get her kicked out of their room. Staff F reported Resident #6 stated Staff A came in the room three times and did not say anything to them.

On 10/26/23 at 1:56 PM, Staff A explained one time that Resident #2 had his call light on, she asked if he needed to go to the bathroom and he said no so she told him to hold on. Staff A stated he needed a lift and she needed a second person. Staff A stated she went to help another resident and when she went back in the room she saw Resident #6 upset. Resident #6 asked for her name to write it down. Staff A stated she told Staff F she would not go back in the room until a nurse talked to Resident #6, as she felt afraid of Resident #6 reporting her. Staff A stated a nurse talked to Resident #6 and reported she did not hear Staff A say that she would be back.

On 10/30/23 at 8:25 AM, Resident #6 stated she did not remember an incident a couple weeks ago when a CNA entered her room, turned off the call light, and did not say anything. Resident #6 worked on her menu and did not seem interested in talking. This observation appeared different compared to a previous interview conducted the previous week.

On 10/30/23 at 1:04 PM, Staff D reported that she interviewed Resident #6. Staff D stated Resident #6 did not want to talk to her at first as she did not want to get anyone in trouble. Staff D stated Resident #6 reported that she could not comment on Staff A's attitude as she usually does not take care of them or interact with them. She stated

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F 550	Continued From page 7 Resident #6 reported if Staff A would have said she was busy then that would have been okay. Staff D described the main problem as communication. Staff D reported Resident #2 received the care that he needed as another CNA did come into the room and help him.	F 550		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and staff interviews, the facility failed to provide adequate transfers for 2 or 6 residents reviewed (Resident #2 and #1) to ensure a safe transfer according to plan of care. The facility did not provide the number of staff needed for each transfer according to the care plan. The facility reported a census of 37 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #2 dated 9/14/23 identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS identified that Resident #2 required extensive assistance from two persons with bed mobility and toilet use. The MDS identified Resident #2 required extensive assistance of one person with	F 689		

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transfers. Resident #2's MDS included diagnoses of hypertension (high blood pressure), hyperlipidemia, Alzheimer's disease, and history of falling.

The Care Plan with target date of 1/10/24 revealed Resident #2 had mixed bladder incontinence and required assistance with activity of daily living (ADLs) related to Alzheimer's disease and weakness. The care plan directed staff to aid of two people with a gait belt and 4 wheeled walker with all transfers and ambulation including to the bathroom. The care plan directed staff that they may use an EZ stand (machine that assists with standing) as needed for transfers.

On 10/30/23 at 11 AM, observed Staff I, CNA (certified nursing assistant), apply a gait belt around Resident #2's waist. Staff I elevated the lift chair and provided cues/direction for Resident #2 to stand up from the lift chair. Staff I then ambulated Resident #2 to the BR with a gait belt, a 4 wheeled walker, and the assistance of one. Staff I assisted Resident #2 with pulling down his pants and sitting on the toilet. Staff I reported Resident #2 required the assistance of one person with transfers and ambulation. Staff I stated Resident #2 used the EZ stand as needed. Staff I reported that if Resident #2 did not stand well after three attempts then she would use the EZ stand. Staff I reported Resident #2 received therapy and an ultrasound to his left shoulder. Staff I stated that the staff used to walk Resident #2 to meals but that was too far now. Resident #6 (Wife) was present in the room and stated it depended on which staff member did the transfer on whether the EZ stand was used or not. Staff I reported she started working at the facility in March 2023 and Resident #2 required assistance

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of one person the entire time and the EZ stand as needed.

On 10/31/23 at 8:34 AM, Staff C, DON (Director of Nursing), reported she followed-up with therapy and Resident #2 required the assistance of two persons with transfer and ambulation. Staff C reported she completed verbal coaching with Staff I regarding following resident care plans. She stated the verbal coaching form had not been signed by Staff I as she has not been back to work. The DON reported the CNAs can use their professional judgment on if they need to use the EZ stand or not. The Staff C stated the decision to use the EZ stand was based on if Resident #2 was standing or transferring well.

An undated facility form tilted [Facility Name] Rehabilitation Center Verbal Coaching form revealed Staff I received verbal coaching. The incident section on the form documented Staff I transferred Resident #2 with assistance of one when the care plan stated to utilize staff assistance of two for transfers. The form directed Staff I to ensure to follow resident care per their Care Plan. The Administrator, Staff C, and Staff I signed the form.

On 10/31/23 at 11:40 PM, the Administrator reported the facility did not have a facility policy regarding transfers, ADLs or accidents/supervision.

On 10/31/23 at 1:04 PM, the Administrator reported in general the nurses and aides know the care plan and where to find it. She stated each situation is different and we still must use professional judgment.

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2. The Minimum Data Set (MDS) for Resident #1 dated 9/27/23 assessment identified a BIMS score of 4, indicating severely impaired decision making. The MDS identified Resident #1 required extensive assistance of one person with bed mobility and transfers. The MDS identified Resident #1 required extensive assistance of two with toilet use. Resident #1's MDS included diagnoses anemia, hypertension, diabetes mellitus, osteoporosis, hip fracture, other fracture, anxiety disorder, non-Alzheimer's dementia, presence of right artificial hip joint and same level fall.

A Progress note titled Incident Report dated on 9/21/23 at 1:37 AM revealed staff observed Resident #1 lying on the floor in her room. According to the note, no physical injuries were noted at the time of the fall.

A Health Status noted dated 9/21/23 at 3:13 PM documented Resident #1 had left hip pain with movement and was adducted. The note documented hospice and the primary care physician (PCP) was notified of fall and assessment. The PCP directed the facility to give Acetaminophen 500 mg (milligrams) by mouth every 6 hours as needed and to send for an X-ray if the Power of Attorney (POA) chooses. According to the note, the POA wanted Resident #1 to decide and Resident #1 wanted to remain at the facility.

The Care Plan with a target date of 1/10/24 revealed Resident #1 needed assistance with ADLs related to weakness and overall physical decline. The care plan revealed Resident #1 elected to receive hospice services. The care plan directed staff to do the following on 10/11/23:

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-Provide extensive assistance of 2 staff members and a gait belt for transfers.
-Provide extensive assistance of 2 staff members for toileting needs.

The Care Plan with a target date of 1/10/24 directed staff to do the following on 10/26/23:
-Provide assistance of 1 staff member for all transfers and ADL's. Resident #1 may require additional staff assistance with increased pain or behaviors.
-Provide extensive assistance of 1-2 staff members and gait belt with transfers.
-Provide extensive assistance of 1-2 staff members for toileting needs.

An untitled/unsigned facility document dated 10/24/23 provided by the Administrator documented Staff F, CNA, transferred Resident #1 by herself. According to the note, the Administrator had Staff D, ADON (Assistant Director of Nursing) review Resident #1's Care Plan to see how Resident #1 transferred. The Care Plan determined Resident #1 needed 2 people to assist with transfers. The note documented Staff F was educated on the level of assistance required.

On 10/25/23 at 12:34 PM, Staff F reported she has transferred Resident #1 by herself. Staff F stated she tried to have two people in Resident #1's room during transfers. Staff F reported she thought Resident #1 was care planned to be assistance of two with transfers. Staff F stated she only transferred Resident #1 by herself when the facility was short staffed and other staff members were stuck in another room.

On 10/25/23 at 2:37 PM, Staff B, RN (Registered

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Nurse) reported Resident #1 required assistance from one staff member with transfers but Resident #1 did not always remember she needed assistance. Staff B stated the staff will use a bear-hug method with pivot transfers to support/bear as much of Resident #1's weight as much as possible. Staff B stated the staff will have Resident #1 put her arms around their neck and shoulders during the transfer.

On 10/25/23 at 4:13 PM, Staff A, CNA, reported that on 10/23/23 at 3:30 PM she got Resident #1 up by herself in her wheelchair and brought Resident #1 out to the center with her alarm on. Staff A reported later Resident #1 wanted to go back to bed so she asked Staff K, LPN to help her with the transfer because she had noticed the brake on Resident #1's wheelchair did not stay locked during the last transfer that she did by herself. Staff A reported that there are other staff members that transfer Resident #1 by themselves.

On 10/30/23 at 3:05 PM, Staff C reported that she had updated Resident #1's Care Plan the week prior on 10/26/23 for assistance of 1-2 staff members with transfers and toilet use as her condition and behaviors fluctuate. The DON stated there are days that one person can transfer Resident #1 with assistance of one, gait belt and walker and other days due to her behaviors she may need more assistance.

On 10/31/23 at 8:34 AM, when asked how the CNAs determine to use assistance of 1 or 2 with transfers with Resident #1, she replied stated if the transfer did not go well then, the staff can use more assistance. When asked if the CNAs can assess the level of assistance required with a

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	165343	A. BUILDING _____ B. WING _____	C 11/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW REHABILITATION CENTER	601 PARK AVENUE SAC CITY, IA 50583

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F 689	Continued From page 13 transfer, Staff C stated no. Staff C stated if the transfer is not going well, the CNAs can always get a nurse to determine the assistance level. When asked what the CNAs were expected to do if they are in the middle of a transfer with assistance of one and the transfer did not go well, Staff C stated there was always that potential with any resident or person.	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 (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.	F 690		

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F 690	Continued From page 14 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interviews, and policy review the facility failed to provide adequate incontinence care in a timely manner for 1 of 5 resident reviewed (Resident #5). Findings include: Resident #5's Minimum Data Set (MDS) assessment dated 7/13/23 identified no completed Brief Interview for Mental Status (BIMS) score. The Staff Assessment for Mental Status listed Resident #5 as severely impaired for decision making. Resident #5's MDS included diagnoses of moderate intellectual disabilities, depression, altered mental status and unspecified symptoms and signs with cognitive functions and awareness. The MDS identified Resident #5 required extensive assistance of two persons with bed mobility, transfers, and toilet use. The MDS listed Resident #5 as always incontinent of urine. The Care Plan with a target date of 11/9/23 revealed Resident #5 had mixed bladder incontinence related to physical limitations and required assistance with activities of daily living related to impaired cognition. The care plan documented Resident #5 depended on one person for toilet use and personal hygiene needs. The care plan directed staff to use assistance of	F 690		

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F 690	Continued From page 15	F 690		

two persons and an EZ stand (machine to assist with standing) for transfers to the toilet and to provide incontinence care when incontinent.

A form titled [Facility Name] Verbal Coaching dated 8/14/23 documented an incident involving Staff A, CNA (Certified Nursing Assistant), and Resident #5. The incident section of the form documented after supper described Resident #5 as incontinent of urine. Staff B, RN (Registered Nurse), told Staff A, Resident #5 was wet. Staff A stated, " Yea, he will be the first one we do". The form documented Resident #5 remained in the central area until HS (hour of sleep) cares with his pants still wet. At 8 PM, Resident #5 remained in the wheelchair. The form further documented that Staff A used her cell phone and/or ate Culvers after her scheduled break. The comments section of the form documented a reminder provided to Staff A of position changes every 2 hours and that all residents need oral care. The Administrator and Staff B signed the form.

On 10/25/23 at 12:34 PM, Staff F, CNA, reported that she had concerns with Staff A leaving Resident #5 in his soiled brief (disposable underwear full of urine) the whole shift.

On 10/26/23 at 1:56 PM, Staff A said that she has been told that she did not check Resident #5 enough when it comes to incontinence care. Staff A reported that Resident #5 had a tendency of moving his brief. Staff A stated Resident #5 used to sit on the toilet and now he is just incontinent. Staff A stated Resident #5 will start urinating while changing him.

On 10/31/23 at 12:14 PM, Staff G, CNA stated

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F 690	Continued From page 16	F 690		

she worked after Staff A when working on the overnight shift up to last month. Staff G reported she came in at 10:00 PM, Staff A refused at times to take care of Resident #5. Staff G stated Staff A refused to put Resident #5 in bed and there has been times she left him in his pee (his wet brief). Staff G reported that Staff A told her, Resident #5 had been too much for her so she did not change him at all during the shift. Staff G explained that around 5-10 times she discovered that Resident #5 required a full bed change at the beginning of her shift.

On 10/30/23 at 8:58 AM, Staff H, CNA, reported that she had concerns with Staff A as she did not always meet all the resident needs. Staff H stated Staff A did not always do peri care. She added that Staff A would remove the soiled briefs and apply a clean brief without providing perineal (peri) care.

During a follow-up interview on 10/31/23 at 10:25 AM, Staff H stated she worked after Staff A on the overnight shift and sometimes at the beginning of her shift, she found Resident #5 wet. Staff H reported that she did not feel that Staff A checked on Resident #5 enough.

On 10/31/23 at 10:44 AM, Staff B acknowledged that she completed a verbal coaching form with Staff A on 8/14/23. Staff B reported she had a bad night with Staff A that night. Staff B reported that she told Staff A at approximately 6:00 PM about Resident #5 appeared incontinent of urine and needed changed. Staff B reported that she could visibly see Resident #5 that soiled (incontinent of urine) his pants from the outside of his pants. Staff B reported Staff A stated she would take care of Resident #5 first. Staff B stated Resident

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F 690	Continued From page 17	F 690		

#5 sat in a common area by the medication room so they could keep an eye on him. Staff B stated at 8:00 PM, Resident #5 still sat there and remained wet/soiled. Staff B stated obviously Staff A did not take care of Resident #5 first like she said she would. Staff B stated Staff A went to break, used her cell phone, and ate Culvers. Staff B reported she did not know what exact time Resident #5 received care but he remained in the common area wet. Staff B stated she thought the staff completed his cares before 9:00 PM.

On 10/31/23 at 1:04 PM, the Administrator reported staff are to complete end of shift rounds with each other to help identify any issues from shift to shift that may occur so they can be addressed at that time.

An undated facility policy titled Bowel and Bladder Continence Status and Retraining Assessment documented incontinent care will be completed after each episode of bowel and/or bladder incontinency. The policy further documented that residents who are not candidates for re-training or unable to recognize the need to void or defecate, checking for incontinence will occur upon rising, within an hour before and/or after meals, before attending activities, before retiring for the night, within a half hour of leaving the facility for an outing, and at other times deemed necessary.

Park View Rehabilitation Center

601 Park Avenue • Sac City, IA 50583 • Ph: (712) 662-3818

Plan of Correction related to complaint survey completed October 25, 2023 -November 1, 2023

Preparation and implementation of the plan of correction should not be construed as an admission of the deficiencies cited. This plan of correction is prepared solely because it is required under federal or state law.

F000 Correction date for F550, F689, F690: 12/1/23

F 550 Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)

1. The social worker followed up with resident #6 on 11/3/23 to investigate their grievances and provide follow up resolution to the concerns. The social worker or designee will meet weekly x 2 months with Resident #6 to provide emotional support and to encourage the resident to voice any concerns. An individualized toileting schedule was implemented on 11/17/23 for resident #5. Care plan updated to provide staff with alternative interventions to maintain resident's dignity when he refuses staff to assist him with toileting.
2. A Nurse meeting was held on 11/14/23 and a CNA (Certified Nursing Assistant) meeting was held on 11/15/23. Topics included reeducation on promptly reporting resident/family grievances per the Grievance policy.
3. DON or designee will conduct random incontinence care audits weekly x 3 months. The social worker or designee will conduct random audits monthly x 3 months of residents and staff to ensure knowledge of grievance procedures. Through the facility's quality assurance process the continued frequency of audits will be determined based on outcomes.

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

1. When a resident's care plan is updated staff receive the information through alerts posted on the electronic health record dashboard as well as verbal reports at the beginning of their shift.
2. Staff were reeducated regarding reviewing and following resident's plan of care during the morning huddle meeting on 11/8/23. Information from morning huddle meeting is posted for all staff to review daily that were not able to attend morning huddle. A staff Nurse meeting was held on 11/14/23 and a CNA (Certified Nursing Assistant) meeting was held on 11/15/23. Topics included care plan review process and ensuring residents are transferred according to their care plan.
3. DON or designee will audit staff transfers with residents weekly x 3 months. Through the facility's quality assurance process the continued frequency of audits will be determined based on outcomes.

F 690 Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)

1. An individualized toileting schedule was implemented on 11/17/23 for resident #5. Care plan updated to provide staff with alternative interventions to maintain resident's dignity when he refuses staff to assist him with toileting.

2. Reeducation on incontinence care was provided to staff at CNA meeting 11/15/23.
3. DON or designee will conduct incontinence care audits weekly x 3 months on resident #5. Through the facility's quality assurance process the continued frequency of audits will be determined based on outcomes.