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F 000 ✓ ok/CP	INITIAL COMMENTS Correction date: 11-25-23 The following deficiencies resulted from investigation of Complaints #115046-C, #115126-C, #115136-C, #115207-C, #115464-C, #115419-C, #115604-C, #115741-C, #116003-C, #116085-C, #116241-C, #116342-C, and Facility Reported Incidents #115890-I and #116079-I, #115827-I, #116442-I conducted on October 9, 2023 to October 25, 2023. Complaints #115046-C, #115126-C, #115136-C, #115207-C, #115464-C, #115419-C, #115604-C, #115741-C, #116003-C, #116085-C, #116241-C, and #116342-C were substantiated. Facility Reported Incident #115890-I, #116079-I, #115827-I, and #116442-I, were 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.	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: D Chapman, LNHA | TITLE: Administrator | (X6) DATE: 11/26/23

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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§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

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

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

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, policy and procedure review and staff interviews the facility failed to treat a resident with respect and dignity in a manner that promotes maintenance or enhancement of his or her quality of life for 1 out of 5 resident reviewed. (Resident #11). The facility identified a census of 73 residents.

Findings include:

1. The Significant Change in Status Minimum Data Set (MDS) for Resident #11, with an

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assessment reference dated 9/25/2023, documented diagnosis for which included Cancer, Osteoporosis, Malnutrition, Depression, Anxiety, Bipolar Disorder, and restlessness and agitation. The MDS revealed the resident with short and long term memory problems, severely impaired for decision making abilities, verbal and other behavioral symptoms directed towards others, and required total assist of two staff members for all aspects of daily living.

The Care Plan with a initiated date 4/23/2022, stated the resident has impaired cognitive function and/or impaired though processes as evidenced by short/long term memory deficit, impaired decisions making and/or impaired ability to understand others related to diagnosis of intellectual disability. Interventions include:
*Ask yes/no questions as indicated in order to determine the residents needs.
* Cue, reorient and supervise as needed.
*Monitor document/ report as necessary any changes in cognitive function, specifically changes in the following: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status.
*Use terms, gestures that resident can understand. Anticipate any non-verbal needs
* Provide support and allow resident to express feelings, fears and concerns

An Incident Summary Report Dated 9/11/2023, at 5:20 p.m. documented the following; with an incident occurred dated 9/10/2023 at 8:00 a.m., report that this writer received a statement from Staff J, Assistant Director of Nursing (ADON) at approximately 2:45 p.m., in regards to an allegation of abuse made by employee Staff M,

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Certified Nursing Assistant (CNA) against employee Staff N, CNA. The employee indicated she was in the dining room at breakfast and saw Resident #11 slumped over the side of her chair with her face resting on the arm rest and her arm hanging over the left side of her chair. Staff indicated she attempted to reposition and indicated she did not know this resident as the employee was new to the community. Employee waited for Staff N to come and assist her. Staff M, indicated that when Staff N, came to assist the resident that Staff N "jerked patients head" and the residents top half moved to the right in the chair. The resident is extremely contracture and has jerky movements. Resident can be difficult to reposition due to her rigidity.

The Progress Notes dated 9/11/2023 at 3:58 p.m., documented, Incident Note, Late Entry: Staff M reported that on 9/11/2023, while in dining room waiting on a room tray noted that Resident #11 was leaned over in her wheelchair with her head resting on the arm rest. Staff M attempted to reposition her and asked another Staff N, to assist her as she was still leaning over. She stated that Staff N, put her hand on Resident #11 top of head. Then "jerked" her when trying to reposition her. Staff M could not say for sure that this action was done with the intent of "Harming the resident". She was unable to give further details but felt as though it was "rougher" then was intended/needed. This nurse reviewed skin around head/forehead, no redness, bruises or abrasions were noted to the head. Resident did not appear to be in pain at this time. Resident is primarily non-verbal. She will at times look towards a voice or
person. She was resting in recliner per her norm at this time. Resident has very poor truck control

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and is regularly
in a contracted position. She prefers to lean or lay on her right side. She will at times kick her legs out or wiggle
herself but does not do this with purpose.

On 10/11/2023 at 2:30 p.m., Staff N, said that when she was coming down the 200 hall way, Staff M, was in the dining room and asked if Staff N could help with repositioning Resident #11. Staff N said that she went over to the residents wheelchair and place Staff N hands behind the residents shoulders and attempted to reposition the resident with her shoulders. Staff N did confirm and verify that they did grab the residents shoulders and pull the resident back in the wheelchair. Staff N did also confirm and verify that there was a sling underneath the resident and the sling needed to be used to reposition the resident and not the resident shoulders.

Interview on 10/11/2023 at 2:30 p.m., Staff O, Certified Occupation Therapy Assistant (COTA), confirmed and verified that the sling needed to be used to position Resident #11, and not to pull, jerk or attempt to position the by using the resident neck.

On 10/12/2023 at 2:30 p.m., Staff J, ADON, confirmed and verified that the sling needed to be used to position Resident #11 when they are leaning in their wheelchair.

On 10/13/2023 at 10:15 a.m., the facility Administrator confirmed and verified that the sling needed to be used to position the resident and it is the expectation of staff to treat all resident with dignity and respect.

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F 550	Continued From page 5 The Promoting/Maintaining Resident Dignity Policy dated 1/2023, it is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment that maintains or enhances residents quality of life by recognizing each residents individuality. 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. 5. When interacting with a resident, pay attention to the resident as an individual. 10. Speak respectfully to residents, avoid discussions about resident that may be over heard. 14. Each resident will be provided equal access to quality care regardless of diagnosis, severity of condition or payment source.	F 550		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to	F 580		

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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 clinical record, and staff interview, the facility failed to notify the facility physician of a urinary analysis that was not collected in a timely manner for 1 of 4 residents reviewed (Resident #5). The facility reported a census of 73 residents.

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Findings include:

1. The Admission Minimum Data Set (MDS) dated 7/31/2023, for Resident #5 revealed a Brief Interview for Mental Status (BIMS) score of 13 for which indicated no impaired cognition. The MDS documented the resident with verbal behavioral symptoms towards others, and required supervision of set-up assistance for transfers, locomotion on and off the unit, toilet use and personal hygiene and was frequently incontinent of bladder. The MDS revealed the resident had diagnoses which included muscle weakness and personal history of urinary tract infections and was on an antibiotic in the last 7 days.

The Encounter Note dated 7/31/2023 at 3:54 p.m., documented New admission to the facility. History includes urinary incontinence. Past Medical History for urinary tract infection, anxiety, weakness and repeated falls.

The Nursing Communications form dated 8/17/2023 at 9:01 p.m., documented that resident states that she has burning sensation and discomfort when trying to go to the bathroom. May we have an order for a urine analysis (UA) and culture and sensitivity (C&S). Response from physician on 8/23/2023 gave orders for UA, and C&S if indicated.

The Progress notes dated 8/17/2023 at 9:01 p.m., COMMUNICATION - with Physician
Situation: UA C&S
Background/Data: Resident states that she has a burning sensation and discomfort when trying to void. May
we have an order for a UA C&S??

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The Progress notes dated 8/23/2023 at 12:50 p.m., documented,Order Note Text: New order obtained at this
time for UA with C&S if indicated. Staff aware to obtain UA.

The Progress notes dated 8/24/2023 at 3:39 p.m., documented Note Text: UA, C&S sample was collected and sent to laboratory.

The Bacteriology Routine testing with a documented urine collected dated on 8/24/2023 at 1:36 p.m., and verified dated of 8/27/2023 at 9:32 a.m., and order dated 8/28/2023 by the Advanced Registered Nurse Practitioner (ARNP), to start antibiotic for 7 days.

The Progress notes dated 8/25/2023 at 7:11 p.m., documented Note Text: Received returned fax from Primary Care Physician (PCP) regarding UA result. Awaiting final culture and sensitivity.

The Progress notes dated 8/27/2023 at 8:16 p.m., documented Health Status Note Text: Received susceptible list for UTI, call placed to on call spoke with physician received new order for Bactrim DS (antibiotic) 1 capsule by mouth twice a day for 5 days for UTI.

The Progress notes dated 8/28/2023 at 9:04 p.m., documented Health Status Note Text: Received returned fax from
PCP regarding susceptibility results. New Order to discontinue Bactrim and start Cipro (antibiotic) 250 mg tab by mouth twice a day for 7 days.

The Encounter Note dated 9/07/2023 at 11:19 a.m., documented, Routine 30 day visit with

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history of urinary incontinence. Recently completed antibiotic for treatment of urinary tract infection. Past Medical History with urinary tract infections, weakness and repeated falls.

The Encounter Note dated 10/02/2023 at 1:11 p.m., documented Routine 60 days visit with history of urinary incontinence. Resident does complain of dysuria and frequency of urine. Will obtain a UA. Past Medical History of urinary tract infections, weakness and repeated falls. Orders to obtain a UA.

The Progress notes dated 10/3/2023 at 1:06 a.m., documented Nursing Note Text: Encounter form received with new orders for labs and UA.

A Urine Testing with a collection dated 10/3/2023 at 7:33 a.m., documented to await final culture and sensitivity by the ARNP.

A Bacteriology Routine testing with collection dated of 10/3/2023 at 7:33 a.m., documented by the ARNP to await final report and If signs/symptoms persist please send catheter urine specimen for UA/C&S if indicated. OK to straight catheter to obtain, signed and dated by ARNP on 10/05/2023.

The Progress notes dated 10/3/2023 at 10:18 a.m., documented Nursing Note Text: UA obtained and sent to lab.

The Progress notes dated 10/4/2023 at 12:49 p.m., documented Nursing Note Text: Resident culture results came back from lab for U/A. Resident found to have e-coli 10,000-50,000 susceptibility to follow. Will await susceptibility. Results faxed to MD. Fluids

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encouraged. Resident remains afebrile. No further concerns.

The Progress notes dated 10/4/2023 at 5:56 p.m., documented Nursing Note Text: UA received with no new orders. Await C&S.

The Progress notes dated 10/5/2023 at 1:24 p.m., documented Nursing Note Text: Lab fax received back from PCP stating "Await final culture and sensitivity."

The Progress notes dated 10/9/2023 at 5:28 p.m., documented Nursing Note Text: This writer spoke with Lab
regarding residents UA and they informed of that the UA was contaminated will recollect.

The Progress notes dated 10/9/2023 at 5:57 p.m., Nursing Note Text: Straight catheter UA attempted this shift
with little to no urine return. Brief was noted to be wet at the time pericare was completed by this nurse indicating bladder was likely empty. Will pass on instructions to attempt collection to later shift.

The Progress notes dated 10/12/2023 at 11:28 a.m., documented Nursing Note Text: UA obtained via clean catch and sent to lab.

A Bacteriology Routine testing with collection dated 10/12/2023 at 11:15 a.m., documented upon further incubation, three or more bacterial species isolated from urine indicating superficial or fecal contamination. Orders signed and dated by the ARNP to please obtain new UA with C&S if indicated.

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The Progress notes dated 10/13/2023 at 12:27 p.m., documented Nursing Note Text: Resident U/A results received and culture was indicated and found to have 10,000 to 50,000 cfu/ml of Escherichia coli and susceptibility to follow.

With clinical record review the facility failed to notify the facility physician of a urinary the analysis that was not collected in a timely manner, due to contamination.

The Progress notes dated 10/15/2023 at 5:55 p.m., documented Nursing Note Text: urine collected for sample was contaminated per lab. urine will need to be obtained on 10/16 via straight catheter. family was very upset that their has been a time delaying in obtaining urine and results.

A Facsimile dated and signed by the ARNP on 10/16/2023 at 9:55 a.m. documented to obtain UA with C&S if indicated per straight catheter. Please call office once sample obtained so we can start antibiotics while awaiting results.

A Progress note dated 10/16/2023 at 11:00 a.m., documented, facsimile faxed over that we got a urine sample from resident so we could get her started on something.

A Facsimile dated and signed by the ARNP on 10/16/2023 at 1:46 p.m., with orders to start Nitrofuarntoin (antibiotic) 100 milligrams times 7 days. Please follow up and notify office when culture results are back.

The Progress notes dated 10/16/2023 at 1:55 p.m., documented Social Service Note Text: Spoke with resident this am with nurse regarding

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F 580	Continued From page 12 collecting a urine sample, after nurse went over process resident was willing to allow her to proceed with the process. The Progress notes dated 10/16/2023 at 9:49 p.m., documented Nursing Note Text: Nurse reported Straight catheter UA successful this am. Lab report indicated need for C&S. New order received to Start Nitrofurntoin 100 mg PO BID x 7 days and notify when there are culture results for reassessment of order. Interview on 10/19/23 at 12:00 p.m., Staff H, Licensed Practical Nurse (LPN) explained that a clean catch ua would be attempted three times and after the third attempt with no success than an order would be obtained by the physician to do a straight catheter ua. Interview on 10/19/23 at 12:15 p.m., Staff H, Registered Nurse (RN) explained that the facility has no policy/procedure for the collection of an urine analysis, and it is the expectation of the nursing staff to attempt a clean catch urine analysis three times and after the third failed attempt to notify the physician that a straight catheter urine analysis is needed.	F 580		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property,	F 609		

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are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in 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 interview and review of policy and procedures, the facility failed to ensure all alleged violations involving mistreatment, neglect, or abuse of a resident and/or residents are reported immediately to management staff per facility policy and to the Iowa Department of Inspection and Appeals within two hours. (Resident #11). The facility reported a census of 73 residents.

Findings include:

1. The Significant Change in Status Minimum Data Set (MDS) for Resident #11, with an assessment reference dated 9/25/2023, documented diagnoses including Cancer, Osteoporosis, Malnutrition, Depression, Anxiety,

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Bipolar Disorder, and restlessness and agitation. The MDS revealed the resident with short and long term memory problems, severely impaired for decision making abilities, verbal and other behavioral symptoms directed towards others, and required total assist of two staff members for all aspects of daily living.

The Care Plan with a initiated date 4/23/2022, stated the resident has impaired cognitive function and/or impaired though processes as evidenced by short/long term memory deficit, impaired decisions making and/or impaired ability to understand others related to diagnosis of intellectual disability. Interventions include:
*Ask yes/no questions as indicated in order to determine the residents needs.
* Cue, reorient and supervise as needed.
*Monitor document/ report as necessary any changes in cognitive function, specifically changes in the following: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status.
*Use terms, gestures that resident can understand. Anticipate any non-verbal needs
* Provide support and allow resident to express feelings, fears and concerns

An Incident Summary Report Dated 9/11/2023, at 5:20 p.m., with an incident occurred dated 9/10/2023 at 8:00 a.m., report that this writer received a statement from Staff J Assistant Director of Nursing (ADON) at approximately 2:45 p.m., in regards to an allegation of abuse made by employee Staff M, Certified Nurses Aide CNA against employee Staff N, CNA. The employee indicated she was in the dining room at breakfast and saw Resident #11 slumped over the side of

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her chair with her face resting on the arm rest and her arm hanging over the left side of her chair. Staff indicated she attempted to reposition and indicated she did not know his resident as the employee was new to the community. Employee waited for Staff N to come and assist her. Staff M, indicated that when Staff N, came to assist the resident that Staff N "jerked patients head" and the resident top half moved to the right in the chair. The resident is extremely contracture and has jerky movements. Resident can be difficult to reposition due to her rigidity.

The Progress Notes dated 9/11/2023 at 3:58 p.m., documented, Incident Note, Late Entry: Staff M reported that on 9/11/2023, while in dining room waiting on a room tray noted that Resident #11 was leaned over in her wheelchair with her head resting on the arm rest. Staff M attempted to reposition her and asked another Staff N, to assist her as she was still leaning over. She stated that Staff N, put her hand on Resident #11 top of head. Then "jerked" her when trying to reposition her. Staff M could not say for sure that this action was done with the intent of "Harming the resident". She was unable to give further details but felt as though it was "rougher" then was intended/needed. This nurse reviewed skin around head/forehead, no redness, bruises or abrasions were noted to the head. Resident did not appear to be in pain at this time. Resident is primarily non-verbal. She will at times look towards a voice or
person. She was resting in recliner per her norm at this time. Resident has very poor truck control and is regularly
in a contracted position. She prefers to lean or lay on her right side. She will at times kick her legs out or wiggle

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herself but does not do this with purpose.

On 10/10/2023 at 10:12 a.m., Staff M, CNA confirmed and verified that the facility was aware of the allegation of abuse on 9/10/2023 right after breakfast.

On 10/11/2023 at 11:00 a.m., Staff L, Licensed Practical Nurse (LPN) confirmed and verified that Staff M, CNA, reported the allegation of abuse to the facility nurses on 09/10/2023, sometime after the breakfast meal. Staff L, confirmed and verified that Staff N continued to work their entire shift with all residents in the facility.

On 10/11/2023 at 2:30 p.m., Staff N, CNA, confirmed and verified that they continued to work their entire shift on 9/10/2023 and also their entire shift on 9/11/2023 with all the residents in the facility.

On 10/17/2023 at 9:22 a.m., the facility Administrator confirmed and verified that they failed to report the incident with in the two hour time frame that the facility policy and procedure stated and that Staff N worked the entire shift on 9/10/2023 and 9/11/2023.

The Employee Timecard Report with a period dated 09/10/2023 to 09/23/2023, revealed Staff N, CNA, punched in on:
*9/10/2023 at 5:51 a.m., and punched out at 2:07 p.m.
*9/11/2023 at 5:52 a.m., and punched out at 2:05 p.m.

The Abuse, Neglect and Exploitation policy with a date of 07/2023, documented that it is the policy of this facility to provide protections for the health,

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F 609	Continued From page 17 welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriations of residents property. Reporting/Response *Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies with in specific timeframe's: *Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury or *Not later than 24 hours if the events that cause the allegation do not involve abuse and do no result in serious bodily injury.	F 609		
F 610 SS=J	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 610		

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This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review, staff interview and facility policy review the facility failed to thoroughly investigate a major injury (Resident #1) and separate an alleged abuser from the victim (Resident #11), for 2 of 5 residents reviewed. On 09/10/2023, Staff N, Certified Nurses Aide (CNA) was reported as being rough with Resident #11 during repositioning by "jerking and pulling" on Resident #11's neck and then Staff N continued to work the rest of the shift on 09/10/2023 and also the entire shift on 09/11/2023, caring for Resident #11 and other vulnerable residents. This failure resulted in Immediate Jeopardy to the health, safety, and security of the resident. On 8/19/23 at approximated 6:00 a.m., Staff A, Certified Nursing Assistant (CNA) assisted Resident #1 to transfer. During transfer the resident became anxious, was waiving her arms, Staff A heard a loud sound and lowered the resident to the floor. Resident #1 sustained a right arm fracture and required hospitalization and surgery. The facility investigation failed to identify that Staff A, CNA had failed to use a gait belt during the transfer. The facility reported a census of 73 residents.

The facility was notified of the Immediate Jeopardy (IJ) on October 23, 2023 at 3:40 p.m. The IJ was removed on October 25, 2023. The Facility Staff removed the Immediate Jeopardy through the following education:
Compliance with Reporting Allegations of Abuse/Neglect/Exploitation:
It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property

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are reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations.
*Compliance Guidelines: The facility will develop and operational policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property. The purpose is to assure that the facility is doing all that is written its control to prevent occurrences.
1. Screening
2. Training
3. Prevention
4. Identification
5. Alleged violation
6. Investigation
7. Protection
8. Reporting/Response

The scope and severity was lowered from an "J" to and "G" at the time of the survey after ensuring the plan of correction was put in place and implemented.

Finding include:

1. The Significant Change in Status Minimum Data Set (MDS) for Resident #11, with an assessment reference dated 9/25/2023, documented diagnoses including Cancer, Osteoporosis, Malnutrition, Depression, Anxiety, Bipolar Disorder, and restlessness and agitation. The MDS revealed the resident with short and long term memory problems, severely impaired for decision making abilities, verbal and other behavioral symptoms directed towards others,

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does not resist cares, and required total assist of two staff for all aspects of daily living. The MDS revealed no functional limitations in range of motion to upper or lower extremities and the wheelchair as primary mode of transportation.

The Care Plan with a initiated date of 11/10/2021 revealed resident has self care deficit as evidenced by requiring assistance with activity of daily living (ADL's), impaired balance during transitions requiring assistance and/or walking, incontinence Dx: intellectual disability, abnormal posture, muscle weakness, bipolar, history of cancer, glaucoma, rheumatic valve disease. Interventions include:
*TOILETING: 1 Assist. Provide peri-care with every incontinent episode and PRN
*TRANSFER: 2 people assist. with mechanical hoyer lift
*Use full body slings for hoyer transfer.
*EATING: Assist x 1- Dependent on staff
*Ask yes/no questions as indicated in order to determine needs.

An Incident Summary Report Dated 9/11/2023, at 5:20 p.m. documented as follows; with an incident occurred dated 9/10/2023 at 8:00 a.m., report that this writer received a statement from Staff J, Assistant Director of Nursing (ADON) at approximately 2:45 p.m., in regards to an allegation of abuse made by employee Staff M, CNA, against employee Staff N, CNA. The employee indicated she was in the dining room at breakfast and saw Resident #11 slumped over the side of her chair with her face resting on the arm rest and her arm hanging over the left side of her chair. Staff reported that she attempted to reposition and indicated she did not know this resident as the employee was new to the

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community. Employee waited for Staff N to come and assist her. Staff M, indicated that when Staff N, came to assist the resident that Staff N "jerked patients head" and the resident's top half moved to the right in the chair. The resident is extremely contracture and had jerky movements. Resident can be difficult to reposition due to her rigidity.

The Progress Notes dated 9/11/2023 at 3:58 p.m., documented as follows; Incident Note, Late Entry: Staff M reported that on 9/10/2023, while in dining room waiting on a room tray noted that Resident #11 was leaned over in her wheelchair with her head resting on the arm rest. Staff M attempted to reposition her and asked Staff N, to assist. Staff M, stated that Staff N, put her hand on Resident #11 top of head. Then "jerked" on Resident #11 neck when trying to reposition her. Staff M could not say for sure that this action was done with the intent of "Harming the resident". She was unable to give further details but felt as though it was "rougher" then was intended/needed. This nurse reviewed skin around head/forehead, no redness, bruises or abrasions were noted to the head. Resident did not appear to be in pain at this time. Resident is primarily non-verbal. She will at times look towards a voice or person. She was resting in recliner per her norm at this time. Resident has very poor truck control and is regularly in a contracted position. She prefers to lean or lay on her right side. She will at times kick her legs out or wiggle herself but does not do this with purpose.

On 10/10/2023 at 10:12 a.m., Staff M, CNA confirmed and verified that the facility was aware of the allegation of abuse on 9/10/2023 right after breakfast.

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On 10/11/2023 at 11:00 a.m., Staff L, Licensed Practical Nurse (LPN) confirmed and verified that Staff M, CNA, reported the allegation of abuse to the facility nurses on 09/10/2023, sometime after the breakfast meal.

Interview on 10/11/2023 at 2:30 p.m., Staff N, CNA, confirmed and verified that they continued to work their entire shift on 9/10/2023 and also their entire shift on 9/11/2023 with all the residents in the facility.

Interview on 10/17/2023 at 9:22 a.m., the facility Administrator confirmed and verified that Staff N, CNA, continued to work their entire shift on 9/10/2023 and 9/11/2023 and that the facility failed to separate the alleged abuser from the victim.

The Employee Timecard Report with a period dated 09/10/2023 to 09/23/2023, revealed Staff N, CNA, punched in on:
*9/10/2023 at 5:51 a.m., and punched out at 2:07 p.m.
*9/11/2023 at 5:52 a.m., and punched out at 2:05 p.m.

The Abuse, Neglect and Exploitation policy with a date of 07/2023, stated that it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriations of residents property.
*Procedure for Response and Reporting Allegations of Abuse/Neglect/Exploitation:
When suspicion of abuse/neglect/exploitation or

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reports of abuse/neglect/exploitation occur, the following procedure will be initiate.
1. The Licensed Nurse will:
*Respond to the needs of the resident and protect him/her from further incident/
*Remove the accuse employee from resident care areas.
*Notify the Director of Nursing or designee
*Notify the Administrator or designee
*Notify the attending physician, residents family/legal representative
*Document actions taken in the medical record
*Complete an incident report is indicated

2. The Quarterly MDS assessment with a reference date of 6/28/23 for Resident #1 documented a score of 10 of 15 on Brief Interview for Mental Status (BIMS) test which indicated moderate cognitive impairment. The resident had diagnoses that included dementia, osteoporosis, muscle weakness, and anxiety and required extensive assistance of one staff for bed mobility, transfer, ambulation, dressing, toilet use, and personal hygiene. The resident had no falls since reentry.

A Nursing Care Plan dated as initiated on 8/1/22 identified a focus area: Activities of Daily Living (ADL) self-care deficit, with a goal of maintaining current level of function, and directed the following interventions: Transfers and ambulates with the assistance of 1 staff member and four wheeled walker (FWW), and one person assist for toileting. The Care Plan further identified resident has had falls related to impaired balance, poor safety awareness, neuromuscular/functional impairment and/or the use of medications that may increase fall risk, with a goal that resident will

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have no serious injury from falls, and directed the following interventions: Ensure resident is wearing proper footwear, follow all facility protocol related to falls which included: report, investigate, and immediate intervention and long-term interventions.

A Fall Risk Assessment dated 5/10/23 documented a score of 18 which indicated a high risk of falls.

Observation on 10/18/23 at 2:15 p.m. Resident #1 was observed to transfer. Resident appeared anxious, and was noted to shakily and unpredictably move her arms, and yell out in a high-pitched tone.

A Progress Note written by Staff C, Registered Nurse (RN) at 6:29 a.m. 8/19/23 documented that Staff C was alerted by the CNA that the resident had been lowered to the floor on 8/19/23 at 6:03 a.m. in the resident's restroom. Staff C assessed and suspected a right shoulder injury. The resident was placed in a wheelchair and a call to the on-call was placed to obtain permission to send to the local hospital.

On 10/16/23 at 4:05 p.m., Staff C, RN recalled he had been called to Resident #1's room by Staff A, CNA who had reported the resident was on the floor. Staff C reported that he responded immediately and found the resident on the floor near the toilet in her room. Confirmed Staff A had been the only staff person in the room at the time of the fall, and had reported the resident had lost balance during the transfer, was flailing around, and hurt the arm while being lowered to the ground. Staff C stated that he had documented in a progress note but thought someone else had

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filled out the incident report. Staff C confirmed that an incident report or risk assessment should be filled out with all falls.

During an interview on 10/16/23 at 2:52 p.m., Staff D, Licensed Practical Nurse (LPN) confirmed that she had responded to the room to assess Resident #1 who was on the floor and yelling in pain. Staff D recalled that the resident had complained of right arm pain. Staff D reported that after an assessment was completed staff assisted the resident from the floor with a gait belt. Staff D stated that she would expect staff to use a gait belt for all staff assisted transfers. Staff D responded that Staff A had reported trying to get resident over to the toilet, the resident was flailing around and she lowered her to the floor. Staff D responded she had not filled out an incident report, that would have been the responsibility of Staff C, RN. Staff D reported that she had assumed that he had filled out the incident report due to the fact that there was a fall, and the process would be to do a fall-risk management assessment to fully investigate the circumstances of the fall.

In an interview on 10/16/23 at 2:59 p.m., Staff A, CNA recalled on 8/18/23, at approximately 6:00 a.m. she had gone in to provide care to Resident#1. The Resident requested to use the bathroom, so she assisted the resident to walk to the bathroom with her walker. Once in the bathroom, the resident started to turn, and Staff A reported to assist with removal of the residents clothing. Staff A reported the resident became hysterical without warning and started flailing her arms. Staff A reported she had heard a sound like clothes ripping, and noticed the resident's arm was limp and lowered the resident to the

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floor. Staff A denied that she had seen resident strike arm on anything. Staff A responded that she had not used a gait belt to ambulate and transfer the resident. Staff A, clarified that she had not anticipated that she would need a gait belt, no gait belt was available in the room and she was not wearing one. Staff A stated she knew that she should have used a gait belt, but would have had to go get one and didn't. Further interview on 10/17/23 at 5:18, Staff A clarified that she had eased the resident to the floor by grasping the waist of the resident's pants. Staff A denied that she had grasped the resident by the arm at any time.

In an interview on 10/16/23 at 2:45 p.m. the Administrator stated that she had referred the investigation to the previous DON. The Administrator reported she would have expected that a Interdisciplinary report and investigation would have been completed, however she was unable to provide it. The Administrator stated that she wasn't as involved at the time as she reported now being.

In an interview on 10/16/23 at 6:15 p.m. the previous DON confirmed she had completed the investigation but could not recall the specifics. The previous DON stated there should have been a risk assessment completed.

In an interview on 10/17/23 at 5:00 p.m. the Administrator and Interim Director of Nursing (IDON) stated that they had questioned how Staff A had transferred the resident and had received a text message that she had transferred by grasping at the waist of the resident. The IDON had questioned the previous DON if a gait belt had been used, but the DON had resigned

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without answering her question.

An Investigation Self-Report Amendment submitted to the Department by the facility included the following; Resident#1 had a fall with injury on 8/19/23. The resident was in the restroom and staff were assisting to the resident to the bathroom. The resident grabbed the grab bar for assistance. Staff A, CNA while assisting heard a "pop" in the resident's right arm. Staff A lowered the resident to the floor and notified the nurse. Resident#1 assessed and sent to the local Emergency Room (ER) for evaluation. Resident#1 sustained a fracture of the right humerus. The Resident was admitted to hospital and surgery was performed.

A Hospital Operative Report dated 8/21/23 documented a preoperative diagnosis of closed right displaced, comminuted (broken in numerous pieces) humerus (upper arm bone) fracture. History documented resident sustained a fall resulting in the injury. Decision was made to operatively repair the fracture.

Review of a facility policy titled, Use of Gait Belt, dated 4/2/22 directed to use gait belts with residents that cannot independently ambulate or transfer for the purpose of safety. The policy included the following guidelines: Responsibility of each employee to ensure they have a gait belt available for use at all times when at work. Failure to use gait belt properly may result in termination.

Review of a facility policy dated as reviewed on 7/2023 included: Investigation of alleged abuse, neglect, and exploitation. An immediate investigation is warranted when suspicion of

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F 610	Continued From page 28 abuse, neglect, or exploitation, or reports of abuse, neglect or exploitation occur. Identifying and interviewing all involved persons, focusing the investigation on determining if abuse, neglect, exploitation and/or mistreatment has occurred, the extent, and the cause. Providing complete and thorough documentation of the investigation.	F 610		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, resident, and staff interviews, the facility failed to provide care and services according to accepted standards of clinical practice for 2 of 3 residents reviewed (Resident #2 and #12) and failed to give medications as directed per the physicians orders during the medication pass for (Resident #15 and Resident #16). The facility failed to assure Resident #2 attended follow up cardiac appointment as ordered following a May hospitalization. Resident's appointment was canceled on 6/1/23 for lack of transportation and 6/7/23 due to lack of communication. Resident was again hospitalized and on 8/14/23 the resident was seen for a follow up cardiac appointment, however no record of her medications was sent to the clinic despite their request. Resident #12 had an appointment with the wound clinic on 9/8/2023, Resident #12 was late for the appointment and was not able to be seen. The facility reported a census of 73	F 658		

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residents.

Findings include:

1. According to the Quarterly Minimum Data Set (MDS) assessment dated 8/15/23 Resident #2 had a Brief Interview for Mental Status (BIMs) score of 9, indicating moderately impaired cognition. The MDS identified Resident #2 required extensive assistance for bed mobility, transfer, dressing and toilet use.

The progress notes lacked documentation of canceled appointments.

Review of Hospital discharge orders dated 5/16/23 at 12:45 p.m. directed follow up appointment on 6/1/23 at 2:50 p.m. with cardiac specialist.

Review of facility appointment calendar for June 1, 2023 documented appointment for Resident #2 at 2:50 p.m. with a local cardiology appointment with a notation that read: appointment canceled by the contract transportation service. See new appointment 6/7/23 at 3:20 p.m.

Interview on 10/24/23 at 3:00 p.m., Staff H, Registered Nurse (RN) revealed that she had reviewed the appointment book for 6/7/23 and found no notation regarding a rescheduled appointment for Resident #2. Staff H stated she would have expected the rescheduled appointment to be placed on the appointment calendar as part of their process to assure resident's attend appointments as scheduled, would also expect paperwork, which would include a list of current medications to accompany the resident as requested.

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Review of a Cardiology Recheck report dated 8/14/23 documented Resident #2 seen for follow-up after hospitalization in May. Unfortunately, we have no records of her medications from the facility despite reaching out to them. The report additionally noted that the resident had not followed up with Cardiology since the hospitalization and had been re-hospitalized on 8/7-8/11/23.

The facility reported no policy regarding scheduling of appointments.

2. According to the Quarterly MDS assessment dated 7/30/2023, Resident #12 had a BIMS score of 15, which indicated no impaired decision making abilities. The MDS identified Resident #12 required limited assistance with bed mobility, personal hygiene and locomotion on and off the unit, and activity did not occur with ambulation. The MDS documented that the resident required dressing changes and applications of ointments/medications to the skin.

The Progress notes dated 9/1/2023 at 12:36 p.m., documented, call placed to wound clinic to follow up on information that was sent for referral. Appointment scheduled at this time for Friday (9/8/23) at 7:30 a.m. Awaiting call back from transport to set up transportation.

The progress notes lacked any documentation of the resident not being seen on 9/8/2023 at the wound clinic.

Review of facility appointment calendar for September 8, 2023 documented appointment for Resident #12 to wound clinic, to be picked up at

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7:30 a.m.

Interview on 10/17/2023 at 3:10 p.m., Staff J, LPN, confirmed and verified that the facility needed to follow up on the wound clinic appointment for which the resident did not get seen due to being late.

3. The Quarterly MDS assessment dated 9/23/2023, documented Resident #15 with diagnosis for which included anxiety, depression, and respiratory failure. The resident had a BIMS score of 11 for which indicated no impaired cognition and required total to extensive assistance of two for bed mobility, transfers, personal hygiene and toilet use.

The Clinical Physicians Orders on the Point Click Care Program dated 10/17/2023, instructed to take one capsule of Omeprazole (Prilosec) (medication to treat heartburn) 20 milligrams by mouth daily *take 60 minutes before meals, do not chew/crush. The Physicians Order for Prilosec documented that the resident was to take the medication related to Gastro-Esophageal Reflux Disease (when stomach acid repeatedly flows back into the tube connecting your mouth and stomach).

Observation on 10/17/2023 at 8:25 a.m., Staff L, Licensed Practical Nurse (LPN), proceeded to give Resident #15 morning medications at the dining room table which included Prilosec 20 milligrams (mg) (1) before meals. Resident #15 was in the process of eating an omelet, and two slices of toast.

Interview on 10/17/2023 at 8:35 a.m., Resident #15, confirmed and verified that they get all their

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medications at the same time, and also explained they get up around 6:00 a.m., every day and that they get heartburn after eating. Resident #15 explained that they would like their Prilosec given 60 minutes prior to their breakfast meal.

Interview on 10/17/2023 at 11:15 a.m., Staff L LPN, confirmed and verified that the Prilosec needed to be given 60 minutes prior to meals and that the Prilosec was given with breakfast and the physicians orders were not followed.

4. The Quarterly MDS assessment dated 9/22/2023, documented Resident #16 with diagnoses for which included anemia, heart failure, depression, restlessness and agitation The resident had a BIMS score of 7 for which indicated moderately impaired cognition and required extensive assistance with bed mobility, transfers, personal hygiene and toilet use.

The Clinical Physicians Orders on the Point Click Care Program dated 10/17/2023, instructed to take Omeprazole (Prilosec)(medication to treat heartburn) 20 mg, by mouth daily *take 60 minutes before meals, do not crush/chew.

The Residents Clinical Record documented a listing of Medical Diagnoses which included Gastro-Essophageal Reflux Disease (disease which caused heartburn).

Observation on 10/17/2023 at 8:44 a.m., Staff Q, Registered Nurse (RN) proceeded to give Resident #16 morning medications at the dining room table which included Prilosec 20 mg (1) before meals. Resident #16 was in the process of eating a bowl of oatmeal with dried cranberries.

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F 658	Continued From page 33 Interview on 10/17/2023 at 9:30 a.m., Resident #16, confirmed and verified that they get up in the morning around 7:00 a.m., and that they get all their medications at the dining room table and that they would prefer to have their Prilosec before the meals and as the physician ordered. Interview on 10/17/2023 at 11:45 a.m., Interim DON (corporate nurse), confirmed and verified that the nurses need to follow the physicians orders for giving the Prilosec as directed 60 minutes prior to meals.	F 658		
F 677 SS=E	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 clinical record review and staff and resident interview, the facility failed to provide two baths a week as directed for 4 out of 5 residents reviewed (#6, #7, #8 and #13). The facility reported a census of 73 residents. Findings include: 1. The Annual Minimum Data Set (MDS) assessment dated 8/14/2023, revealed Resident #6 had diagnoses for which included heart failure, hypertension, anxiety, depression and morbid obesity. The MDS documented the resident scored a 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident to be cognitively intact. The MDS assessment documented the resident with no rejection of	F 677		

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cares, and the bathing activity itself did not occur and the entire 7-day look back period with this assessment.

Review of electronic documentation of task completion for Resident #6 revealed the facility failed to provide baths in September on 9/27/2023 and for the dates October on 10/4/2023, and 10/7/0223.

In an interview on 10/17/2023 at 3:50 p.m., Resident #6 stated that they did not receive their bath/showers on the above dates and would like to have their bath/shower two times per week.

2. The Quarterly MDS assessment dated 8/21/2023, revealed Resident #7 had diagnoses that included heart failure, hypertension, renal insufficiency, quadriplegia and depression. The MDS documented the resident scored a 7 on the BIMS which indicated moderate impaired cognition. The MDS documented that the resident did not resist cares. The MDS assessment documented the resident with a catheter. The MDS documented that the resident required extensive assistance of two staff for bathing.

Review of the electronic documentation of task completion for Resident #7 revealed the facility failed to provide baths in September on 9/26/2023 and in October on 10/3/2023 and 10/5/2023.

In an interview on 10/18/2023 at 3:00 p.m., Resident #7 confirmed and verified that they do not receive two bath/shower per week and would like to have two a week.

3. The Annual MDS assessment dated 7/2/2023,

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revealed Resident #8 had diagnoses that included benign prostatic hyperplasia, renal insufficiency, arthritis, depression and severe obesity. The MDS documented the resident scored a 9 on the BIMS. A score of 9 indicates moderately impaired cognition and no resisting of cares. The MDS documented the resident with total dependence of two staff for bathing activity.

Review of the electronic documentation of task completion for Resident #8 revealed the facility failed to provide baths in September on 9/20/2023 and 9/30/2023 and in October on 10/4/2023.

In an interview on 10/11/2023 at 2:30 p.m., Staff N, Certified Nursing Assistant (CNA) confirmed and verified that the baths are not getting complete two times a week.

In an interview on 10/18/2023 at 4:00 p.m., Staff P, CNA/CMA, confirmed that the baths/showers are not getting completed two times per week and that the residents are lucky to get one bath/shower a week.

4. The Quarterly MDS assessment dated 9/3/23, revealed Resident #13 had diagnoses that included a history of acute and chronic respiratory failure, severe obesity, and muscle weakness. The MDS documented the resident scored 15 on the Brief Interview for Mental Status (BIMS). A score of 15 identified cognitively intact. The MDS assessment documented the resident frequently incontinent of bladder, occasionally incontinent of bowel and dependent on physical help of two staff for part of bathing.

Review of electronic documentation of task

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F 677	Continued From page 36 completion for Resident #13 revealed the facility failed to provide baths in August 2023 on 8/7/23 and 8/10/23, in September 9/23 and 9/30/23, and in October 10/7/23, In an interview on 10/10/23 at 4:00 p.m. Resident #13 stated that she often had not received two showers per week.. In an interview on 10/10/23 at 3:00 p.m. Staff K, Certified Medication Aide (CMA) responded that baths were not being completed, and Administration is aware.	F 677		
F 684 SS=J	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 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, hospital records, resident, staff and advanced registered nurse practicitioner interview along with the facility protocol/policy, at the time of the investigation, the facility failed to provide ongoing assessment and intervention for a resident who demonstrated an unstageable wound to the right lateral plantar foot that was covered with eschar. The facility was not able to provide any wound documentation, and failed to follow through with wound clinic referral for which resulted in the	F 684		

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resident being admitted to the hospital with septic shock (blood poisoning, for which can lead to organ failure, and death) related to osteomyelitis (infection in the bone for which travels in the bloodstream) and gangrene (tissues death) to the residents right foot for which resulted in the resident having a guillotine (emergency surgical amputation to prevent the spread of infection) amputation (removal of the limb) on 9/12/23 and a below the knee amputation on 9/20/23 for 1 of 6 residents reviewed. (Resident #12). This failure resulted in Immediate Jeopardy to the health, safety, and security of the resident. The facility identified a census of 73 residents.

The facility was notified of the Immediate Jeopardy (IJ) on October 17, 2023 at 5:16 p.m. The IJ was removed on October 19, 2023. The Facility Staff removed the Immediate Jeopardy through the following actions:
1. To accurately asses each residents skin status
2. On 10/6/2023 skin evaluation orders were updated and the process for skin assessment was updated to be
completed in the Assessment tab in PCC.
3. On 10/6/2023 skin evaluation orders were updated and the process for skin assessment was updated to be
completed in the Assessment tab of PCC with a stand-alone assessment to be completed every 7 days by
a licensed nurse.
4. On 10/3/2023 and ongoing all licensed and Certified staff have been educated on wound care, Skin
assessment, Timely intervention, Wound intervention, prevention, and healing. Verification of an
understanding of this material was done through

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a Nurse and/or Nurse aide Competency Test.
5. A complete house sweep was conducted to identify any new areas of concern, following the audit
systems results, on 10/17/2023.
6. Director of Nursing (DON) or designee will monitor documentation of treatments (5) Resident records per week for (1) month then (10) records every (1) month for (2) months. Discrepancies will be promptly reported to the
Administrator and Nurse Consultant for immediate corrective action.
7. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time
consistent substantial compliance has been met.

The scope and severity was lowered from an "IJ" to and "G" at the time of the survey after ensuring the plan of correction was put in place and implemented.

Findings include:

1. A Quarterly Minimum Data Set (MDS) assessment form dated 7/30/2023, documented Resident #12 had diagnosis that included orthostatic hypotension, renal insufficiency, renal failure, diabetes mellitus, need for assistance with personal care, varicose veins of bilateral lower extremities with pain and abnormalities of gait and mobility . The assessment documented the resident with a Brief Interview for Mental Status (BIMS) score of 15, for which indicated intact cognition and had the ability to make needs known, needing limited assistance of two (2) staff members with bed mobility, extensive assistance of (2) for transfers, dressing, toilet use and bathing. The assessment also documented the

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resident with being at risk for developing pressure ulcers/injuries with no use of pressure reducing device for bed, chair and no turning/repositioning program.

A Care Plan with a initiated date of 7/31/2023 and revision date of 8/03/2023, documented the resident had a Stage 5 pressure ulcer on resident right foot related to immobility. Interventions include the following:
*Administer treatments as ordered and monitor for effectiveness.
*Educate the resident/family/caregivers as to causes of skin break down, including: transfer/positioning requirements, importance of taking care during ambulating/mobility/, good nutrition and frequent repositioning.
*Follow facility policies/protocols for the prevention/treatment of skin breakdown.
*heel protectors on at all times, float heels while in bed, monitor and report if area deteriorates.
*Inform the resident/family/caregivers of any new area of skin breakdown.
*Weekly treatment documentation to include measurement of each area of skin breakdowns width, length, depth, type of tissue and exudate.

The Progress Notes dated 7/31/2023 at 11:10 a.m., documented communication - with Physician Situation: Noted to have a 1.0 cm x 0.5 cm x 0.2 cm open area to foot. Area appears to be pressure related at this time. Area had small amount of drainage. No odor. Resident reports pain when pressure is applied.

The Progress Notes dated 7/31/2023 at 8:04 p.m., documented Text: new orders: heel protection treatment and protection all times.

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An Occupational Therapy Evaluation an Plan of Treatment dated 8/01/2023-8/11/2023, documented patient training initiated with positioning in wheelchair as patient displays skin breakdown on ball of right foot and awaiting appointment with wound doctor outside of the facility.

The Progress Notes dated 8/03/2023 at 8:28 a.m., documented, Order Note: New order obtained at this time to discontinue current treatment for heel. Start Cleanse with wound cleanser of choice, apply betadine moistened gauze, cover with abdominal pad and wrap with gauze, change daily and PRN (as needed). Refer to wound clinic. Prevalon boot at all times as tolerated. Will set up appointment for wound clinic.

The Care Plan lacked documentation of the Prevalon boot at all times as tolerated order dated 8/3/23 at 8:28 a.m. from the Progress Note.

The Progress Notes dated 8/04/2023 at 4:39 p.m., documented, Skin/Wound Text: Wound area to right foot
(heel). Additional amino acid supplement to promote wound healing.

A Weekly Pressure Wound Assessment tool dated 8/10/2023 at 2:37 p.m., documented acquired pressure area to right foot as healed.

The Progress Notes dated 8/10/2023 at 5:56 p.m., documented, Order Note: Encounter note received from ARNP (Advanced Registered Nurse Practitioner) with new orders to discontinue wound treatment to heel. Continue heel protection and notify office if redness, bogginess

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or open wound recurs.

A Weekly Skin Review Form dated 8/13/2023 at 3:39 p.m., documented resident presents with dry skin to the lower shins. Charting reflects resident frequently refuse preventive treatments.
Post-podiatry visit resident has areas of concern noted to her right foot. Areas included:
*right lower leg (front) dry patch measuring 6 centimeters (cm) by 2 cm with scabs throughout.
*right toe(s), 3rd toe nail was trimmed by podiatry, nail was cut short and open area formed. Scant blood drainage noted on sock. Band-Aid removed. Wound cleaned and new Band-Aid applied. 1 cm by 1 cm open spot at the first knuckle of the same toe. No drainage or sign/symptoms of infection noted.
*right toe(s), right 4th and 5th metatarsal-contains a callous that has been shaved leaving a open spot in the interior measuring 6 millimeters by 5 millimeters with a 3 millimeter depth. Skin is hard and dry around the edges with a soft dark red interior wound bed. No signs/symptoms of infection at this time.

The Progress Notes dated 8/13/2023 at 4:19 p.m.,documented, Note Text: Skin assessment completed on right foot this afternoon after concerned noted post podiatry visit.
-3rd toe nail was trimmed by podiatry nail was cut short and open area formed. 4 mm x 1 mm. Scant blood drainage noted on sock. Band-Aid removed. Wound cleaned and new Band-Aid applied. 1x1 mm open spot at the first knuckle of the same toe. No drainage or s/s of infection noted.
-Right 4th and 5th Metatarsal area contains a callous that has been shaved leaving a open spot in the interior measuring 6 mm x 5 mm with a 3

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mm depth. Skin is hard and dry around the edges with a soft dark red interior wound bed. No signs/symptoms of infection at this time.

The Progress Notes dated 8/14/2023 at 9:00 a.m., documented, Nursing Note Text: Fax received to apply triple antibiotic ointment to open areas and cover with non-adherent dressing once daily. Monitor for improvement and report if not improving or patient has signs/symptoms of infection.

A Metro Geriatric Service Encounter note dated 8/28/2023 at 2:42 p.m., revealed resident chief complaint-right foot wound.
*This patient is seen for routine encounter.
*Right lower extremity wound. Unable to be seen by wound nurse practitioner due to hemodialysis schedule. Right lateral plantar foot with eschar. Unstageable pressure wound. Will discontinue triple antibiotic ointment and start betadine and refer to wound clinic.
*Orders and Requisitions:
*Refer to wound clinic
*Please use Prevalon boots as ordered.
*Plan Notes:
*Continue current level of care.
*Dressing changes as above.
*Refer to wound clinic.

The Progress Notes dated 9/01/2023 at 12:36 p.m. documented, Health Status, Note Text: Call placed to Wound Clinic to follow up on information that was sent for referral. Appointment scheduled at this time for Friday at 7:30 a.m.. Awaiting call back from transport to set up transportation.

The Progress Notes dated 9/12/23 at 6:15 a.m.,

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documented Health Status Note Text: During 5:00 a.m., medication pass resident was not responding to nurse, resident would open her eyes then shut them, when checking mental status she would state her name but didn't know place month or year. Resident was twitching and jerking. Blood pressure attempted to get via manual cuff. Resident unable to swallow sips of water to take medication. Call placed to receive orders to send to Emergency Room. Call placed to family, left message on cell phone of resident being transferred to emergency room.

The Progress Notes dated 9/12/2023 at 11:02 p.m., documented, Note Text: Call placed to Hospital to check in on resident admitted to Critical Care Unit (CCU) Admitting Diagnosis: Sepsis

The Pre-Arrival Summary dated 9/12/2023 at 7:14 a.m., documented, patient was brought into the emergency department due to confusion and twitching this morning at 5:00 a.m.

The Emergency Room notes dated 9/12/2023 at 7:15 a.m., documented, this patient present with weakness and lethargy. The onset was just prior to arrival. The character of symptoms is generalized. Patient was ok last night when went to bed at 11:00 p.m., but when they woke her up at 5:00 a.m., patient was less alert and "twitching" per facility On emergency medical service arrival patient was more alert and oriented but had borderline low blood pressure. Patient appears fatigued on arrival but arousable to voice and denies any complaints. Chronic right foot ulceration. skin appears to be warm, dry with large necrotic ulceration to right foot with surrounding erythema and warmth. Antibiotic

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ordered due to suspected right foot as source of sepsis. Diagnosis=septic shock, soft tissue infection of right foot. Condition=critical

The Hospital Progress notes dated 9/12/2023 at 11:19 a.m., documented, 70-year-old female with a history of end stage renal disease, chronic hypotension who presents with septic shock suspected secondary to soft tissue infection on the right foot. Will obtain MRI of the right lower extremity to rule out osteomyelitis. Reviewing with the patient, a large colonic chronic foot wound measuring 4 cm by 4 cm appearing somewhat deep. Patient with large 4 cm by 4 cm necrotic wound on the distal lateral plantar aspect of the right foot.

The Pharmacy Antibiotic Kinetic Consult dated 9/12/2023 at 1:36 p.m., documented patient brought into the emergency department due to confusion and twitching this morning at 5:00 a.m. Blood pressure that time was noted to be 70/59. Patient has large colonic chronic foot wound measuring 4 cm by 4 cm appearing somewhat deep. Facility nurse reports they have been dealing with this foot wound for the last 3 to 4 weeks, and have had wound care consulted, with regular wound care occurring.

The Vascular Consult dated 9/12/2023 at 6:09 p.m., documented, patient with bilateral Charcot foot deformity, chronic right foot wound.
*Right foot x-ray, numerous gas bubbles overlying the distal fifth metatarsal and abnormal appearance of the distal fifth metatarsal suspicious for osteomyelitis
*Sepsis
Today's Plan= consulted with podiatry for poor prognosis of right lower extremity limb salvage,

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discussed at length risks and benefits of proceeding with guillotine amputation versus keeping the patient comfortable, patient agreed to proceed with amputation this evening. will perform right above ankle guillotine amputation.

The Podiatrist Surgery Progress Note dated 9/12/2023 at 6:21 p.m., documented, resident with plantar left forefoot ulcer, necrotic right forefoot ulcer/cellulite/developing abscess with probable osteomyelitis, poor prognosis for right lower extremity limb salvage, will consult vascular surgery.

The Vascular Amputation Operative Note dated 9/12/2023 at 9:21 p.m., documented, preoperative diagnosis= septic right deep space diabetic foot infection, with hypotension. Procedure= Guillotine right foot amputation. Podiatry had evaluated the patients septic right diabetic foot, and deemed it unsalvageable. The patient was evaluated, and noted to have deep space tenderness, and foul gangrenous tissue in the lateral foot. The right foot is chronically inverted, due to Charcot diabetic foot.

The History and Physical Consultation dated 9/13/2023 at 2:48 p.m., documented on arrival to the emergency department on 9/12/2023, patient reports that she got confused. Reviewing with the patient she has a large right colonic chronic foot wound measuring 4 cm by 4 cm appearing somewhat deep. Patient was evaluated at the bedside. Right foot x-ray personally reviewed and was significant for gas bubbles overlying the distal fifth metatarsal and abnormal appearance of the distal fifth metatarsal suspect osteomyelitis. Guillotine amputation of right lower extremity covered in surgical bandages with swelling and

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erythema appreciated proximal to bandaging.

The Vascular Operative Notes dated 9/20/2023 at 2:40 p.m., documented pre-operative diagnosis= sepsis/right foot osteomyelitis/status post urgent right ankle guillotine amputation. Procedure=right below knee amputation

The History and Physical Consultation report dated 9/21/2023 at 9:41 p.m., documented patient presented to the emergency department on 9/12/2023 in the early morning by the emergency medical service as an emergent transfer from a local nursing home. Reportedly she was confused and has a chronic foot wound measuring 4 cm by 4 cm for the last 3-4 weeks, her normal self yesterday, however at about 5:00 a.m., this morning she was no longer objectively alert and oriented to person, place and time which is her baseline. Patient was lethargic, arousable but only alert to persons, place, or time or situation. She was found to be in septic shock and transferred to the Intensive Care Unit for pressor support. Septic Shock was secondary to osteomyelitis of her right foot and positive culture for proteus (acquired infection), vascular was consulted and status/post guillotine amputation on 09/12/2023 and later status/post below knee amputation on 9/20/2023.
Assessment/Plan
*Acute Right foot osteomyelitis secondary to right foot gangrene.
*Chronic Diabetic right foot wound with bilateral Charcot foot deformity status/post below knee amputation
*9/12/2023, right foot x-ray, numerous gas bubbles overlying the distal fifth metatarsal, abnormal appearance of the distal fifth metatarsal suspect osteomyelitis.

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*9/15/2023, pathology= right foot, above ankle amputation, ulcer with gangrenous necrosis and acute osteomyelitis, margins grossly viable.

The Hospital Progress notes dated 10/10/2023 at 3:42 p.m., documented the hospital course, patient initially presented to the emergency department from local nursing home on 9/12/2023, due to weakness/lethargy, right foot wound and hypotension. Patient was found to be in septic shock with right foot osteomyelitis. Patient was admitted to Intensive Care Unit for pressor support and was started on broad spectrum antibiotics. Vascular surgery was consulted and patient underwent right ankle amputation on 9/12/2023 and then on returned to the operating room on 9/20/2023 for right below the knee amputation. Pathology showed nonviable subcutaneous tissue involving stump, focal calcifications tibia arteries, and excision margin with grossly viable tissues.

Interview on 10/9/23 at 3:30 p.m., Resident #12, confirmed and verified that the hospital did an emergency guillotine amputation on 9/12/2023 and a below the knee amputation on 9/202023 and that they were not aware of the area on their right foot was necrotic and had gangrene. Resident #12, felt that if the facility would of done the twice weekly bathing and did weekly skin assessment as required the amputation could of been prevented.

Interview on 10/16/23 at 4:45 p.m., Staff I, LPN (licensed practical nurse)(mds coordinator), confirmed and verified that the clinical record lacked documentation of the weekly skin sheets being completed on Resident #12 after 8/13/2023. Staff I also confirmed and verified that

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the expectation of the nursing staff are to do weekly skin assessments and complete baths as scheduled two times per week.

Interview on 10/16/2023 at 5:00 p.m., the facility administrator, confirmed and verified that the clinical record lacked documentation of Resident #12 skin sheets being completed weekly after 8/13/2023, and it is the expectation of the nursing staff to do them weekly and the facility will take responsibility to make sure the resident receives the cares that they deserve.

Interview on 10/17/23 at 3:10 p.m., Staff J, LPN, confirmed and verified that Resident #12 clinical record lacked any documentation of weekly skin sheets being completed after 8/13/2023 and that it is expected that nursing staff complete the skin sheets weekly.

Interview on 10/18/23 at 9:45 a.m., the facility Advanced Registered Nurse Practitioner (ARNP) was aware of the necrotic area on Resident #12's right lateral plantar foot with eschar from a visit on 8/28/2023 and explained that an order was given to have the resident seen at the wound clinic and if the facility would of informed the ARNP that Resident #12 was not seen at the wound clinic an order to send Resident #12 to the Emergency room would of been given due to the area being necrotic and would of expected the facility to notify and inform of any changes.

Completing an Accurate Assessment Regarding Pressure Injuries, Facility Policy and Practice with no date, revealed that the assessment must accurately assess the residents status and to assure that each resident receives an accurate assessment reflective of the residents status at

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F 684	Continued From page 49 the time of the assessment by staff that are qualified to assess relevant care areas and knowledge about the resident status, needs, strengths, and areas of decline. Why Its Done- to accurately assess each residents skin status. First things First-Read the instructions in the RAI manual How You Do It- 1. Following the instructions in the RAI manual (utilization guidelines), complete the MDS section M and Care Area Assessment using: a. Staff member interviews (if appropriate) b. Observations/wound assessments c. Medical Record review Complete the Electronic Medication Administration Record (EMAR), skin assessment in EMAR Go to assessments, open up weekly skin review. Complete for date scheduled. If new area, measure and document in assessment. If new areas identified, open risk management. Notify Medical Doctor and Power of Attorney Obtain treatment order Document in progress notes Notify wound nurse	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		

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This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review, staff interviews, and facility policy review, the facility failed to ensure two (2) of five (5) residents actively reviewed (#1 & #4), received adequate supervision to protect against hazards in the environment. Review revealed Resident #1 required assistance of one staff with a gait belt for transfer. On 8/19/23 at approximated 6:00 a.m., Staff A, Certified Nursing Assistant (CNA) assisted Resident #1 to transfer without a gait belt. During transfer the resident became anxious, was waiving her arms, Staff A heard a loud sound and lowered the resident to the floor. Resident #1 sustained a right arm fracture and required hospitalization and surgery. Additionally, the facility failed to provide 1:1 supervision as assigned for Resident #4 identified with agitation, aggression, exit seeking and trespassing behaviors. On 9/27/23 Staff B, CNA left Resident #4 unsupervised to go on break. Resident #4 exited the building without authorization. The facility reported a census of 73 residents.

Findings include:

1. The Quarterly Minimum Data Set (MDS) assessment with a reference date of 6/28/23 for Resident #1 documented a score of 10 of 15 on Brief Interview for Mental Status (BIMS) test which indicated moderate cognitive impairment. The resident had diagnoses that included dementia, osteoporosis, muscle weakness, and anxiety and required extensive assistance of one staff for bed mobility, transfer, ambulation, dressing, toilet use, and personal hygiene. The resident had no falls since reentry.

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A Nursing Care Plan dated as initiated on 8/1/22 identified a focus area: ADL (Activities of Daily Living) self-care deficit, with a goal of maintaining current level of function, and directed the following interventions: Transfers and ambulates with the assistance of 1 staff member and FWW (four wheeled walker), and one person assist for toileting. The care plan further identified resident has had falls related to impaired balance, poor safety awareness, neuromuscular/functional impairment and/or the use of medications that may increase fall risk, with a goal that resident will have no serious injury from falls, and directed the following interventions: Ensure resident is wearing proper footwear, follow all facility protocol related to falls which included: report, investigate, and immediate intervention and long-term interventions.

A Fall Risk Assessment dated 5/10/23 documented a score of 18 which indicated a high risk of falls.

Observation on 10/18/23 at 2:15 p.m. Resident #1 was observed to transfer. Resident appeared anxious, and was noted to shakily and unpredictably mover her arms, and yell out in a high-pitched tone.

A Progress Note dated at written by Staff C, Registered Nurse (RN) at 6:29 a.m. 8/19/23 documented that Staff C was alerted by the CNA that the resident had been lowered to the floor on 8/19/23 at 6:03 a.m. in the resident's restroom. Staff C assessed and suspected a right shoulder injury for the resident. The resident was placed in a wheelchair and a call to the on-call was placed to obtain permission to send to the local hospital.

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In an interview on 10/16/23 at 4:05 p.m., Staff C, RN recalled he had been called to Resident #1's room by Staff A, CNA who had alerted resident was on the floor. Staff C stated responded immediately and found resident on the floor near the toilet in her room. Confirmed Staff A had been the only staff person in the room at the time of the fall, and had reported resident had lost balance during transfer, was flailing around, and hurt the arm while being lowered to the ground.

In an interview on 10/16/23 at 2:52 p.m., Staff D, Licensed Practical Nurse (LPN) confirmed that she had responded to the room to assess Resident #1 who was on the floor and yelling in pain. Staff D, recalled that the resident had complained of right arm pain. Staff D stated after the assessment the staff had assisted the resident from the floor with a gait belt. Staff D stated that she would expect staff to use a gait belt for all staff assisted transfers. Staff D stated that Staff A had reported trying to get the resident over to the toilet and, the resident was flailing around and Staff A, CNA lowered the resident to the floor.

In an interview on 10/16/23 at 2:59 p.m., Staff A, CNA recalled on 8/18/23, at approximately 6:00 a.m. she had gone in to provide care to Resident#1. The resident requested to use the bathroom, so Staff A assisted the resident to walk to the bathroom with her walker. Once in the bathroom, Staff A started to turn and assist the resident with her clothing. Staff A reported the resident became hysterical without warning and started flailing her arms. Staff A reported she had heard a sound like clothes ripping, and noticed the resident's arm was limp and lowered resident to the floor. Staff A denied that she had seen

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resident strike arm on anything. Staff A responded that she had not used a gait belt to ambulate and transfer resident. Staff A clarified that she had not anticipated that she would need a gait belt, no gait belt was available in the room and she was not wearing one. Staff A stated she knew that she should have used a gait belt, but would have had to go get one and didn't. Further interview on 10/17/23 at 5:18, Staff A clarified that she had eased to the floor by grasping the waist of the resident's pants. Staff A denied that she had grasped the resident by the arm at any time.

In an interview on 10/17/23 at 5:00 p.m. the Administrator and Interim Director of Nursing (IDON) stated that they had questioned how Staff A had transferred the resident and had received a text message that she had transferred by grasping at the resident at the waist. The IDON had questioned the previous DON if a gait belt had been used, but the previous DON had resigned without answering her question.

An investigation self-report amendment submitted to the Department by the facility included the following; Resident had a fall with injury on 8/19/23. The resident was in the restroom and staff were assisting the resident to the bathroom. The resident grabbed the grab bar for assistance. Staff member assisting heard a "pop" in the resident's right arm. Staff member lowered resident to the floor and notified the nurse. Resident assessed and sent to the local Emergency Room (ER) for evaluation. Resident reported to have a fracture of the right humerus. Resident admitted to hospital and surgery performed.

A Hospital Operative Report dated 8/21/23

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documented a preoperative diagnosis of closed right displaced, comminuted (broken in numerous pieces) humerus (upper arm bone) fracture. History documented resident sustained a fall resulting in the injury. Decision was made to operatively repair the fracture.

Review of a facility policy titled, Use of Gait Belt, dated 4/2/22 directed to use gait belts with residents that cannot independently ambulate or transfer for the purpose of safety. The policy included the following guidelines: Responsibility of each employee to ensure they have a gait belt available for use at all times when at work. Failure to use gait belt properly may result in termination.

2. The Quarterly MDS assessment with a reference date of 9/3/23 for Resident #4 documented a score of 9 of 15 on Brief Interview for Mental Status (BIMS) test which indicated moderate cognitive impairment. The resident had diagnoses that included a stroke, anxiety, dementia and independent bed mobility, transfer, ambulation, dressing, toilet use, and personal hygiene. The MDS documented that verbal behavioral symptoms directed towards others and wandering occurred 1-3 days.

A Nursing Care Plan dated as initiated on 2/20/23 identified a focus area as follows; Resident has episodes of behaviors as evidenced by being combative, negative verbalizations, refusal of medications/cares. The Care Plan included the following directives: Administer medications as ordered, intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner, divert attention, remove from situation and take to alternate location. Minimize

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the potential for the resident's disruptive behaviors by offering tasks which divert attention. Observe for early warning signs of oncoming behaviors. Call by name. Remove from unwanted stimuli. Utilize the language line for communication.

The Nursing Care Plan further identified a focus area: Resident an elopement risk/wanderer related to history of attempts to leave facility unattended, impaired safety awareness dated as initiated on 4/18/23, with a goal that resident will not leave the facility unattended and included the following directives:

8/7/23 Resident attempted to leave the facility: monitor hours of sleep, stop sign place on skilled door to remind, continue wander guard in place and redirect as appropriate.

9/23/25 Resident attempted to leave facility, due to extreme behaviors sent to hospital for evaluation

9/25/23 Resident attempted to leave the facility, 1:1, wander guard in place

Disguise exits: cover door knobs, handles and tape floor

Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book

Identify pattern of wandering, and intervene as appropriate

Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes.

Wander alert device, verify device is working every night and replace if it is not functioning appropriately.

When resident wants to go outside assist the resident to exit. If the resident refuses to re-enter the facility call family to assist per request.

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An Interdisciplinary Team Progress Note dated 9/26/23 at 9:57 a.m. documented that alarms triggered staff to the activity room door where resident was noted to be outside. Resident discharging home on Friday with daughter. Immediate interventions: 1 on 1, wander guard in place, continue with medication management.

A Nursing Progress note dated 9/28/23 at 2:53 a.m., Staff E, Licensed Practical Nurse (LPN) documented on 9/27/23 at 9:50 p.m. she was at the nurse's desk when the door alarm goes off. Alarm board alerted the door at the bottom of the 200 hall was sounding. Staff E ran to the door and exited and found resident in the parking lot sitting in wheelchair self-propelling to the bottom of the hill, another staff person also responded. Approached resident who was waving fists, and throwing rocks. Police were summoned for assistance, resident was returned inside facility buildings. Assisted to his room and given snacks and fluids. One on one assigned to resident for the night shift with new staff member. One on one supervision will continue through the shift.

In an interview on 10/11/23 at 4:20 p.m., Staff F, LPN stated on 9/27/23 on the evening shift Staff B, CNA had been assigned to provided 1 on 1 supervision for Resident #4 due to behaviors and elopement risk. Staff F stated that he had observed Staff B on a hand-held electronic device during the shift so he reminded Staff B that she was supposed to be watching the resident. The nurse stated that he felt Staff B was not being attentive to the resident so he helped out by redirecting and anticipating the resident's needs. Staff F stated when he left work at approximately 9:45 p.m. Staff B was sitting at the front desk with

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the resident and he had assured that staff knew that he was leaving. Staff F, LPN responded that a one on one for a resident with dementia and behaviors is required to have all their attention focused on the resident so you can quickly identify changes in behavior and intervene. Staff F reported that he would not leave a one on one resident unattended unless he had been assured that someone else was assigned the responsibility and able to provide 1 on 1 supervision.

In an interview on 10/16/23 at 12:42 p.m., Staff E LPN stated that she worked the night shift starting 9/27/23, when she arrived at work she passed Staff F, who was leaving work. Staff E reported that she was aware that a 1 on 1 had been initiated for the resident based on his behaviors and that the resident had gotten outside, with supervision previously. Staff E recalled when she arrived Staff B CNA was at the front desk, and was assigned the 1 on 1, however Resident #4 was not in sight. Staff E questioned Staff B who was with the resident and Staff B shrugged her shoulders and stated that she needed a break, Staff B then denied that she had assured responsibility for 1 on 1 had been assigned to another staff person to take break. At that same time the 200 hall exit alarm sounded and Staff E responded. Staff Ee exited the facility and noted that the resident was outside but with two oncoming staff. Staff E confirmed staff stayed with the resident until the resident returned inside the facility and 1 on 1 supervision reinstated. Staff E, LPN stated she would expect a staff person assigned to 1 on 1 supervision to be with that resident at all times, to anticipate needs, redirect, diffuse behaviors, and keep safe. Staff E responded that she would never expect staff to

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leave resident unattended and the staff person assigned to the 1 on 1 would be responsible to ask for help, have someone else assigned to resident before leaving their responsibility as the 1 on 1 staff member.

In an interview on 10/12/23 at 12:30 p.m. Staff B, CNA confirmed that she had been assigned the 1 on 1 supervision for Resident #4. Staff B responded that she understood her responsibility was to be with the resident at all times, and stated that she should not have left the resident to go into the breakroom unless a peer had assumed responsibility for Resident #4. Staff B further responded under no circumstances would you leave a resident who required 1 on 1 supervision unattended.

An Interdisciplinary Team Note dated 9/28/23 at 9:51 a.m., initiated by the DON documented that a complete skin assessment of the resident was completed with no skin issues. Continue 1 on 1, wander guard in place.

Review of an Employee Disciplinary Form dated 9/27/23 documented that Staff B, CNA was issued a suspension for an occurrence that was described as: Staff B was assigned to resident #4 as a 1 to 1 for resident that eloped on 9/27/23.

Review of a facility Staff In-Service Training attendance sign in sheet dated 9/27/23 documented staff were educated that for a 1 to 1, keep resident in eyesight at all times.

Observation on 10/11/23 at 3:00 p.m. the 200-door exit was alarmed but not a wander guard exit. Observation revealed an interior exit door, a foyer and an exterior alarmed exit.

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F 689	Continued From page 59 Beyond the exterior door there is a cemented area that leads to the front parking lot. The DON provided a screenshot from her cell phone that was sent to staff on 9/25/23 at 11:00 p.m. that directed Resident #4 required 1 to 1 supervision. The facility was unable to provide a facility policy that addressed the responsibility of a 1 to 1 situation.	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under	F 725		

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paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, resident and staff interview the facility failed to complete bathing/showers as required for 4 of 5 residents reviewed. (#6, #7, #8 and #13) The facility census was 73 residents.

Findings include:

1. The Annual Minimum Data Set (MDS) assessment dated 8/14/2023, revealed Resident #6 had diagnoses which included heart failure, hypertension, anxiety, depression and morbid obesity. The MDS documented the resident scored a 15 on the Brief Interview for Mental Status (BIMS). A score of 15 identified cognitively intact. The MDS assessment documented the resident with no rejection of cares, and the bathing activity itself did not occur and the entire 7-day look back period.

Review of electronic documentation of task completion for Resident #6 revealed the facility failed to provide baths in September on 9/27/2023 and in October on 10/4/2023, and 10/7/0223.

In an interview on 10/17/2023 at 3:50 p.m., Resident #6 stated that they did not receive their bath/showers on the above dates and would like to have their bath/shower two times per week and due to not enough staff, showers/baths are not being completed.

2. The Quarterly MDS assessment dated

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8/21/2023, revealed Resident #7 had diagnosis that included heart failure, hypertension, renal insufficiency, quadriplegia and depression. The MDS documented the resident scored a 7 on the BIMS. A score of 7 identified moderate impaired cognition and no resisting of cares. The MDS assessment documented the resident with a catheter, and extensive assistance of physical help of two staff for bathing.

Review of the electronic documentation of task completion for Resident #7 revealed the facility failed to provide baths in September on 9/26/2023 and in October on 10/3/2023 and 10/5/2023.

In an interview on 10/18/2023 at 3:00 p.m., Resident #7 confirmed and verified that they do not receive two bath/shower per week and would like to have two a week.

3. The Annual MDS assessment dated 7/2/2023, revealed Resident #8 had diagnoses that included benign prostatic hyperplasia, renal insufficiency, arthritis, depression and severe obesity. The MDS documented the resident scored a 9 on the BIMS. A score of 9 indicates moderately impaired cognition and no resisting of cares. The MDS documented the resident with total dependence of two staff for bathing activity.

Review of the electronic documentation of task completion for Resident #8 revealed the facility failed to provide baths in September on 9/20/2023 and 9/30/2023 and in October on 10/4/2023.

In an interview on 10/11/2023 at 2:30 p.m., Staff N, Certified Nursing Assistant (CNA) confirmed

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and verified that the baths are not getting complete two times a week due to not enough staff.

In an interview on 10/18/2023 at 4:00 p.m., Staff P, CNA/CMA, confirmed that the baths/showers are not getting completed two times per week and that the residents are lucky to get one bath/shower a week due to shortage of staff to have them completed.

4. The Quarterly MDS assessment dated 9/3/23, revealed Resident #13 had diagnoses that included a history of acute and chronic respiratory failure, sever obesity, and muscle weakness. The MDS documented the resident scored 15 on the Brief Interview for Mental Status (BIMS). A score of 15 identified cognitively intact. The MDS assessment documented the resident frequently incontinent of bladder, occasionally incontinent of bowel and dependent on physical help of two staff for part of bathing.

Review of electronic documentation of task completion for Resident #13 revealed the facility failed to provide baths in August 2023: on 8/7/23 and 8/10/23, in September 2023: on 9/23 and 9/30/23, and in October 2023: 10/7/23.

In an interview on 10/10/23 at 4:00 p.m. Resident #13 stated that she often had not gotten two showers per week, adding that she thinks they just don't have enough staff.

In an interview on 10/10/23 at 3:00 p.m. Staff K, Certified Medication Aide (CMA) responded that baths were not being completed, and Administration is aware. Staff K reported that they

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	165350	A. BUILDING _____ B. WING _____	C 10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE ACRES REHABILITATION AND CARE CENTER	1501 OFFICE PARK ROAD WEST DES MOINES, IA 50265

(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 725	Continued From page 63 are not fully staffed, and often are staffed with only 2 staff in the 200 hall, where there is just too many 2 person lifts and cares to have a person in the shower room.	F 725		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on personnel record review and staff interview, the facility failed to do an annual performance evaluation for 1 of 6 employee records reviewed. (Staff A). The facility identified a census of 73 residents. 1. Record Review on 10/23/2023 at 11:00 a.m., revealed Staff A, Certified Nursing Assistant (CNA) had a hire date of 5/03/2017. *A Performance Evaluation dated 3/26/2021, revealed an annual evaluation, signed and dated by Staff A on 5/28/2021. The Personnel record lacked any documentation of Annual Performance Evaluations completed for 2022 and 2023. Interview on 10/24/2023 at 10:00 a.m., the facility Interim DON (corporate nurse), confirmed and verified that the personnel record lacked annual performance evaluations for 2022/2023 and that the expectations are that the performance	F 730		

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F 730	Continued From page 64 evaluations to be completed yearly.	F 730		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, policy review and staff interview, the facility failed to ensure the medication cart was locked on 3 occasions when the Certified Medication Aide (CMA)/Nurse responsible for the cart was not in sight. The facility reported a census of 73 residents.	F 761		

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F 761	Continued From page 65	F 761		

Findings include:

1. Observation 10/25/23 at 10:50-10:57 a.m. revealed the medication cart was unlocked and unoccupied just outside room 111 in the 100 hallway. At 10:57 a.m., Staff G, Licensed Practical Nurse (LPN) approached the cart and acknowledged it had not been locked as expected. Staff G, LPN stated she was responsible for the medication cart and confirmed and demonstrated that the drawers to the cart were able to be opened when the cart not locked and the drawers contained medications.

2. Observation on 10/10/23 at 12:12 p.m., - 12:20 p.m., revealed the medication cart was unlocked and unattended/unoccupied in the 200 hallway. At 12:20 p.m., Staff J, LPN was approached by this surveyor and was informed that the medication cart was unlocked, Staff J proceeded down the hallway and locked the medication cart, Staff L, LPN, came down the hallway and confirmed and verified that the medication cart needed to be kept locked at all times.

3. Observation on 10/16/23 at 1:15 p.m., revealed the medication cart was unlocked and unattended down the 300 hallway and Staff F, LPN, was sitting behind the nurses station with the medication cart not in line of view. Interim DON (corporate nurse) came by and proceeded to lock the medication cart, confirmed and verified that the medication cart needed to be kept locked at all times when not in use and the drawers contained resident medications.

The Medication Administration Policy/Procedure dated 01/2023, directed faciltiy staff as follow; Medications are to be administered by a licensed

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F 761	Continued From page 66 nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines: *Keep medication cart clean, organized, locked and stocked with adequate supplies. *Cover and date fluids and food.	F 761		

PINE ACRES
REHABILITATION AND CARE CENTER

This serves as the credible allegation of compliance for Pine Acres Nursing and Rehabilitation. We assert that all correctives described on this plan of correction have been implemented. In regard to the specific deficiencies, we have outlined our corrective actions and continued interventions to assure compliance with regulations and our plan of actions. The staff of Pine Acres Nursing and Rehabilitation is committed to delivering high quality healthcare to its residents to obtain their highest level of physical, mental, and psychosocial functioning. We respectfully submit that Pine Acres Nursing and Rehabilitation is in substantial compliance as set forth below. We are confident that we will be found in substantial compliance upon resurvey. The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. Pine Acres Nursing and Rehabilitation has completed the following interventions due to the survey's findings exiting 10/25/2023. The facility will be in substantial compliance by **11/25/2023.**

Action Plan

F550 – Resident Rights

Corrective Action

1. Staff N was immediately suspended pending investigation upon notification on 9/11/2023.
2. PT/OT referral made for positioning on 9/11/2023.
3. Investigation conducted on 9/11/2023 regarding alleged incident.
4. Self-report submitted on 9/11/2023 within 2 hours of the management team being made aware of the incident.

Identification of Others

Facility conducted interviews of 10 random residents with a BIM's of 8 or higher to ensure that resident rights/dignity are maintained.

Systemic Changes to Prevent Future Occurrence

On or before 10/26/2023 the facility provided education to all staff regarding Resident rights/dignity.

Monitoring

The administrator, director of nursing (DON), or designee will interview 10 alert/oriented residents with a BIMS of 8 or higher monthly. Audit results and additional corrected action will be reported and discussed in QAPI and further corrections in the monthly meeting for 4 months or until sustained compliance is achieved.

Compliance Date: 11/25/2023

F580 – Notify of Changes

Corrective Action

1. On or before 10/08/2023 Education was provided for all staff to ensure timely notification to residents, RR, and MD.
2. The original order for the UA was received on 10/3/2023. On 10/04 Provider notified of prelim results. On 10/9 provider notified of contaminated UA New order received. On 10/12 provider notified straight cath unsuccessful after multiple attempts and clean catch was obtained. On 10/13 provider notified of preliminary. On 10/15 Provider notified of contamination new order obtained. On 10/16 UA obtained. On 10/18 provider notified of preliminary results upon receipt and Macrobid ordered. 10/20 Provider notified sample contaminated, order obtained for new UA. Resident refused and provider notified and order to DC as resident was on Macrobid.
3. A contract was obtained with Vikor for a secondary way to process UA results when contamination occurs.

Identification of Other

All residents have the potential to be affected.

Systemic Changes to Prevent Future Occurrence

On or before 10/08/2023 the facility provided education to all staff regarding appropriate notification of changes in condition for Resident, RR, and MD.

Monitoring

The administrator, director of nursing (DON), or designee will review changes in condition during morning clinical x5/week. Audits will be conducted weekly x 6 weeks then monthly x 1 month. Audit results and additional corrected action will be reported and discussed in QAPI and further corrections in the monthly meeting for 6 months or until sustained compliance is achieved.

Compliance Date: 11/25/2023

F609 – Reporting of Alleged Violations

Corrective Action

1. Staff M was immediately educated on 9/11/23 when management was notified of abuse allegations on proper reporting of potential abuse.
2. Staff N was immediately suspended on 9/11/2023 upon management notification on alleged abuse allegations.
3. On 9/11/23 upon management notification on alleged abuse allegations immediate investigation was started and self-report completed per policy.
4. On or before 10/08/2023 education was provided to leadership on abuse and concern reporting process.
5. On 10/26/2023 education was provided to staff regarding abuse reporting.
6. Resident council meeting minutes were reviewed and process appropriately.

Identification of Others

Facility conducted interviews of 10 random residents with a BIM's of 8 or higher to ensure that resident rights/dignity are maintained.

Systemic Changes to Prevent Future Occurrence

1. On or before 10/08/2023, the administrator, director of nursing (DON), or designee conducted education for all staff on concern process, timely resolution and appropriate follow up related to grievances, abuse, neglect, exploitation, reporting of abuse, and investigative process.
2. Resident Counsel will be conducted two times per month.
3. IDT meeting post resident council to ensure concern forms are appropriately initiated and follow through has been completed.

Monitoring

The administrator, director of nursing (DON), or designee will randomly audit a 10 resident sample to ensure that there are no concerns and/or allegations of abuse. Audit results and additional corrected action will be reported and discussed in QAPI and further corrections in the monthly meeting for 4 months or until sustained compliance is achieved.

Compliance Date: 11/25/2023

F610 – Investigate/Prevent/Correct/alleged violation.

Corrective Action

1. Staff N was suspended 09/11/23, immediately upon allegation of abuse by staff M.
2. Staff A had not worked in the building since 10/15/23, notification of suspended while on vacation.
3. On 10/20/23 self-report was completed on allegations of abuse for resident 1.
4. On 10/20/2023 The leadership team was immediately educated on abuse and neglect, and appropriate follow-up and investigation processes.
5. On 10/26/23 staff were educated on abuse and neglect.
6. Staff A was terminated following the investigation.

Identification of Others

The Administrator or designee immediately ensured the safety and well-being of the resident by removing the accused staff members(s) from the facility. Immediately upon notification of alleged abuse on 9/11/2023 the staff member suspended pending investigation.

Systemic Changes to Prevent Future Occurrence

1.) All Federal and State protocols were followed in investigating and reporting the abuse allegation(s)
2.) Abuse policies were reviewed, updates were not required.
3.) Abuse investigation procedure and documentation process were reviewed.
4.) DON and designees educated all staff on facility abuse policies.
5.) DON and designees educated all staff on abuse prevention and reporting.
6.) The DON or designee reviewed facility abuse policies and procedures with any agency staff prior to their shift.
7.) Staff members were not permitted to work a shift until education had been completed.
8.) The investigation Checklist was utilized to ensure all necessary steps were taken.
9.) The Social Services Director began discussing facility abuse policies with residents and families at the initial care plan conference (upon admission)

10.)The Administrator or designee will continue to interview 10 residents with BIMS scores of 8 or higher monthly to ensure they have not experienced abuse. The findings of these interviews will be presented to the QAA Committee as a PIP project.

Monitoring

The administrator, director of nursing (DON), or designee will randomly sample abuse and neglect allegation checklists to ensure all appropriate steps are taken. Audit results and additional corrected action will be reported and discussed in QAPI and further corrections in the monthly meeting for 4 months or until sustained compliance is achieved.

Compliance Date: 10/08/2023

F658- Services Provided Meet Professional Standards

Corrective Action

1.) Resident 2 was seen for a follow up Cardiac appointment on 8/14/23. No further missed appointments have occurred.
2.) Resident 12 no longer resides at Pine Acres.
3.) Medication administration times for resident 15 and 16 times were adjusted to be provided prior to meals.

Identification of Others

All residents have the potential to be affected. The facility identified all residents that take omeprazole and updated the scheduled time to 0600 to ensure it is given prior to the meal.

Systemic Changes to Prevent Future Occurrence

1.) New appointment scheduling process implemented.
2.) All Omeprazole scheduled times adjusted to be provided at 0600 prior to meals or at HS.

Monitoring

Scheduled appointments are reviewed 5 x weekly for 4 weeks in Morning stand up then monthly x 2. Random EMAR audit completed with 5 resident weekly x 4 weeks, then 10 residents monthly x 2. Audit results and additional corrected action will be reported and discussed in QAPI and further corrections in the monthly meeting for 4 months or until sustained compliance is achieved.

Compliance Date: 11/25/2023

F677 – ADL Care Provided for Dependent Residents

Corrective Action

1. Resident 6, 7, 8,and 13 received/offered showers on scheduled days.
2. Resident 6, 7, 8, and 13 have been interviewed and bathing preferences updated.
3. Staff reeducated on appropriate documentation regarding bathing task.

Identification of Others

The facility determined that all residents have the potential to be affected.

Systemic Changes to Prevent Future Occurrence

On or before 10/08/23 an in-service education program was conducted by the Nurse Consultant and the Administrator with all nursing staff addressing the importance of ADL care- including bathing and appropriate documentation. Upon admission residents will be assigned a bathing schedule to meet their preference.

Monitoring

The Director of Nursing Services, or designee, will conduct a random audit of 10 per month for 2 months. These residents medical records will be reviewed to ensure bathing is documented appropriately and corrective action is taken with any variances. Audit results and additional corrected action will be reported and discussed in QAPI and further corrections in the monthly meeting for 6 months or until sustained compliance is achieved.

Compliance Date: 11/25/2023

F684 – Quality of care

Corrective Action

1. Resident 12 no longer resides in the facility.
2. On 10/8/2023 Education was provided to all licensed staff regarding quality of care and change of condition including skin assessment.
3. On 10/6 skin evaluation orders were updated and skin assessment process updated to be completed in the assessment tab in PCC

Identification of Others

1. On 10/6/2023 skin evaluation orders were updated and the process for skin assessment was updated to be completed in the Assessment tab in PCC.
2. A complete house sweep was conducted to identify any new areas of concern.

Systemic Changes to Prevent Future Occurrence

1. On 10/6/2023 skin evaluation orders were updated and the process for skin assessment was updated to be completed in the Assessment tab of PCC with a stand-alone assessment to be completed every 7 days by a licensed nurse.
2. On 10/8/2023 and ongoing all licensed and Certified staff have been educated on wound care, Skin assessment, Timely intervention, Wound intervention, prevention, and healing. Verification of an understanding of this material was done through a Nurse and/or Nurse aide Competency Test.

Monitoring

DON or designee will monitor documentation of treatments (5) Resident records per week for (1) month then (10) records every (1) month for (2) months. Discrepancies will be promptly reported to the Administrator and Nurse Consultant for immediate corrective action.

This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.

Compliance Date: 10/08/2023

F689 – Accidents hazards/supervision/devices

Corrective Action

1.) All nursing staff were educated on 10/26/23 by therapy on the appropriate use of the gait belt.

2.) Staff A terminated, following the investigation.

3.) Staff B terminated following the investigation.

Identification of Others

The facility determined that all residents are at risk for falls, and elopement have the potential to be affected.

Systemic Changes to Prevent Future Occurrence

1.) Gait belt will be provide to all newly hired care staff.

2.) Gait belts will be available in community for staff use.

3.) Resident 1 care plan updated to reflect use of gait belt with transfers if appropriate (current transfer status is with a hoyer lift)

4.) Education was provided to all staff on 9/27/2023 in regard to 1 on 1 assignment.

Monitoring

The Director of Nursing Services, or designee, will conduct a random audit of 10 falls per month for 2 months. The Social Service Designee or Designee will randomly audit 5 residents who are at risk for elopement to ensure appropriate interventions are in place. The Director of Nursing Services, or designee, will conduct a random audit of 10 staff transfers per month for 2 months. These residents' medical records will be reviewed to ensure the care plan is updated in a timely manner and interventions are in place. Audit results and additional corrected action will be reported and discussed in QAPI and further corrections in the monthly meeting for 6 months or until sustained compliance is achieved.

Compliance Date: 11/25/2023

F725 – Sufficient Nursing staff

Corrective Action

1. Resident 6, 7, 8,and 13 received/offered showers on scheduled days.
2. Staff reeducated on appropriate documentation regarding bathing task.

Identification of Others

The facility determined that all residents have the potential to be affected.

Systemic Changes to Prevent Future Occurrence

On or before 10/08/23 an in-service education program was conducted by the Nurse Consultant and the Administrator with all nursing staff addressing the importance of ADL care - including bathing and appropriate documentation. Upon admission residents will be assigned a bathing schedule to meet their preference.

Monitoring

The Director of Nursing Services, or designee, will conduct a random audit of 10 per month for 2 months. These residents medical records will be reviewed to ensure bathing is documented appropriately and corrective action is taken with any variances. Audit results and additional corrected action will be reported and discussed in QAPI and further corrections in the monthly meeting for 6 months or until sustained compliance is achieved.

Compliance Date: 11/25/2023

F730- Nurse Aide Perform Review-12 hr/yr In-Service

Corrective Action

1.) Staff A has been terminated.

Identification of Others

All staff audit will be conducted on or before 11/17/2023 to ensure that annual reviews are done timely for current employees.

Systemic Changes to Prevent Future Occurrence

A new tracking system was implemented to track annual review dates.

Monitoring

Performance evaluations will be conducted on or new employees anniversary dates.

Compliance Date: 11/25/2023

F761 – Label/Store Drugs and Biologicals

Corrective Action

1. Staff G was provided written education.
2. Staff L was provided written education.
3. Staff F was provided written education.

Identification of Others

All residents had the potential to be affected.

Systemic Changes to Prevent Future Occurrence

Education of all certified medical staff who are responsible for medication administration were educated on safe storage of medications.

Monitoring

The Director of Nursing Services, Administrator, or designee will conduct a random audit of medications cart audits to ensure safe storage of medications to be completed 5 times per week for two (2) consecutive weeks. Then a random audit of 10 per month for 2 months. Audit results and additional

corrected action will be reported and discussed in QAPI and further corrections in the monthly meeting for 6 months or until sustained compliance is achieved.

Compliance Date: 11/25/2023