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	165161	A. BUILDING _____ B. WING _____	C 07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	**1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date: 7/28/2022 The following deficiencies relate to the investigation of complaints #104776-C, #105842-C, and facility reported incident #105499-M conducted on July 20, 2022 to July 27, 2022. Complaint #104776-C was not substantiated. Complaint # 105842-C was not substantiated. Findings for facility reported incident #105499-M will be sent to the facility at a later date under a separate cover. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	PLAN OF CORRECTION Touchstone Healthcare Community denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.	7/28/2022
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 600	1. In continuing compliance with F 600 Free From Abuse and Neglect, Touchstone Healthcare Community corrected the deficiency by the DON suspending the alleged staff member on 7/12/2022. Staff A, Staff D, the DON, and the SSD were educated by the Administrator on 7/12/2022 on the process for reporting abuse, including their obligation as mandatory reporters. The facility ensured resident #1, #2, and all like residents were free from abuse and neglect until the facility closed on 7/21/2022. 2. To correct the deficiency and to ensure the problem does not recur, an all-staff education was initiated by the Administrator on 7/12/2022 on the process for reporting any suspected or witnessed resident abuse. The facility closed on 7/21/2022. 3. This deficiency was mitigated when the facility closed on 7/21/2022.	7/21/2022

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

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F 600	Continued From page 1 Based on clinical record review, policy and procedure review along with staff interviews, the facility staff failed to ensure 2 of 5 residents reviewed remained free from physical restraints that were imposed for purposes of discipline or convenience for which could potential be a form of abuse (Resident #1 and Resident #2). The facility reported a census of 11 residents. Findings included: 1. Resident #1's Minimum Data Set (MDS) assessment dated 6/27/22, documented a Brief Interview for Mental Status (BIMS) score of 0, indicating severe cognitive impairment. The MDS identified Resident #1 had delusions, verbal behaviors for four to six days, but less than daily, and other behavior symptoms not directed toward others for one to three days in the lookback period. The MDS identified that Resident #1 required staff assistance for all activities of daily living, he did not walk, he had impaired functional limitation of range of motion on upper, and lower extremities on both sides. Resident #1's diagnoses included traumatic brain injury, anxiety, and depression. The MDS documented that Resident #1 didn't use restraints. 2. Resident #2's MDS assessment dated 7/5/22, documented a BIMS score of 0. The MDS revealed Resident #2 required staff assistance for all activities of daily living, did not walk, and had impaired functional limitation of range of motion on upper, and lower extremities on both sides. Resident #2's diagnoses included a seizure disorder and unspecified intellectual disabilities. The MDS documented that Resident #2 didn't use restraints.	F 600		

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The Facility Incident documentation dated 7/12/22 at approximately 11:45 a.m. the Social Service Director notified the Admissions and Credentialing Director of three previously notified situations of potential abuse that got reported to management. The Social Service Director felt that nothing happened about them and still felt that they should have been reported to the Iowa Department of Inspections and Appeals (DIA).

On 7/20/22 at 5:00 p.m. the SSD reported that the first she learned of the situation regarding Resident #1 on 6/22/22, at approximately 5:52 p.m.. Staff D, CNA, messaged the SSD via a text message that she needed to talk with Staff A, regarding a staff member that kept tying up residents. The SSD reported that statement to the Director of Nursing (DON), on 6/23/22. The DON and the Administrator at that time told the SSD that they would take care of it. The SSD said she didn't hear anything more about that incident and she thought the situation was taken care of. On 7/7/22 at approximately 3:28 p.m. Staff D texted the SSD again stating that a coworker needed to stop, because she could hurt somebody. Staff D reported that she saw a gown tied in a knot again around Resident #1's knees. Staff D felt that she needed to tell someone else. Staff D said to the SSD that the knot was tied so tight that Resident #1 could not move his legs and Staff D could not get the knot out. The SSD reported that information in a stand up meeting to the Healthcare Group and the Regional Nurse for the Healthcare Group said that they would look into it. The SSD said that she went down to Resident #1s room to check on him and that the Healthcare Group's Regional Nurse entered the room right after her. They found Resident #1 wet with incontinence and the Regional Nurse untied

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F 600	Continued From page 3	F 600		

the knot in the gown. They didn't observe any skin areas at that time. The SSD said that it also got reported to her on 7/9/22, but she didn't know the time. The SSD got a text message from Staff C, CNA, about when she did morning rounds on Resident #1, that he wore two briefs. When Staff C turned Resident #1 onto his back she noticed the gown tied around his upper right arm and with it secured in the back of his body. The SSD received reports that this happened for months with a hospital gown being used to tie up Resident #1 and Resident #2.

During an interview on 7/20/22 at 3:45 p.m., the facility Director of Nursing (DON) verified that she knew about the incident involving Resident #1 with the hospital gown being tied around the resident, and did a written education documentation on the staff that allegedly applied the hospital gown around the resident bottom and tied the corners together on 6/23/22. The facility DON confirmed and verified that the staff member continued to work at the facility after the allegation on 6/23/22 and the staff member continued to work with the two residents that were involved.

Review of the Time Detail Reporting, documented the alleged staff member continued to work from 6/23/22 - 7/11/22, when another allegation was alleged with the same two residents.

During an interview 7/20/22 1:10 p.m., the Interim Administrator verified he expected all staff to report any allegation of potential abuse and that staff needed to follow up with investigating and reporting to the proper authorities.

During an interview on 7/21/22 at 8:00 a.m., the

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F 600	Continued From page 4 facility Business Office Manager (BOM) stated that the prior management company failed to provide the facility with an Abuse Policy/Procedure on how to identify, report, and investigate any types of abuse. The Resident Rights policy/procedure dated 12/17, documented that a mechanism is in place to ensure that the rights of the resident will be recognized and respected by the facility as well as the medical staff. The policy further directed: a. Expect reasonable responses to requests for services within our capacity, our stated mission and applicable law and regulation b. Considerate and respectful care, including consideration of psychosocial, spiritual, cultural, and safety needs.	F 600		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 604	1. In continuing compliance with F 604 Right to be Free from Physical Restraints, Touchstone Healthcare Community corrected the deficiency by the DON suspending the alleged staff member on 7/12/2022. Staff A, Staff B, and the DON, were educated by the Administrator on 7/12/2022 on the process for reporting any suspected or witness abuse to include the use of physical restraints. The facility ensured restraints were not utilized on resident #1, #2, and all like residents until the facility closed on 7/21/2022. 2. To correct the deficiency and to ensure the problem does not recur, an all-staff education was initiated by the Administrator on 7/12/2022 on the right for all resident to be free from use of restraints. The facility closed on 7/21/2022. 3. This deficiency was mitigated when the facility closed on 7/21/2022.	7/21/2022

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F 604	Continued From page 5 §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff interviews, policy and procedure review the facility failed to indicate medical symptoms that indicated the need for a restraint; failed to complete consent forms for the resident's responsible parties that provide education of the risks and benefits; failed to document dates and times of restraint usage for 2 of 5 residents reviewed. The facility reported a census of 11. (Residents # 1, and Resident #2). Findings include: 1. Resident #1's Minimum Data Set (MDS) assessment dated 6/27/22, documented a Brief Interview for Mental Status (BIMS) score of 0, indicating severe cognitive impairment. The MDS identified Resident #1 had delusions, verbal behaviors for four to six days, but less than daily, and other behavior symptoms not directed toward others for one to three days in the lookback period. The MDS identified that Resident #1 required staff assistance for all activities of daily living, he did not walk, he had impaired functional limitation of range of motion on upper, and lower extremities on both sides. Resident #1's	F 604		

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F 604	Continued From page 6	F 604		

diagnoses included traumatic brain injury, anxiety, and depression. The MDS documented that Resident #1 did not use restraints.

The Medication Review Report signed on 6/14/22, documented to monitor for behaviors such as: itching, picking at skin, restlessness (agitation), hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, psychosis, aggression, and refusing care.

The cancelled Care Plan dated 7/19/22, documented included the following interventions:
a. Resident #1 sometimes puts a blanket over his head. He likes to do that as it makes him feel safe and secure.
b. Please offer Resident #1 coffee if he becomes disruptive, this helps calm him down.
c. Staff to observe for symptoms of confusion
d. Resident #1 enjoys listening to the radio in his room, sometimes he uses his television for music.
e. Resident #1 enjoys visiting with the staff on a daily basis, during care, or when he is in the common area.
f. Resident #1 has contractures to his upper and lower extremities.
g. Please provide Resident #1 with reassurance and support when he becomes upset, impatient, and demanding. Meet Resident #1's needs in a timely manner.

Resident #1's Care Plan lacked information related to the use of a restraint.

Resident #1's clinical record failed to reveal a consent form signed by the resident's responsible party for the use of a restraint that described the

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benefits and risks had been completed.

Resident #1's clinical record lacked a physician's order for use of a restraint.

2. Resident #2's MDS assessment dated 7/5/22, documented a BIMS score of 0. The MDS revealed Resident #2 required staff assistance for all activities of daily living, did not walk, and had impaired functional limitation of range of motion on upper, and lower extremities on both sides. Resident #2's diagnoses included a seizure disorder and unspecified intellectual disabilities. The MDS documented that Resident #2 didn't use restraints.

The cancelled Care Plan dated 7/20/22, included the following interventions:
a. Resident #2 is incontinent of bladder and bowel. Check and change approximately every two hours and as needed. Staff to provide incontinent cares.
b. If you see Resident #2 having behaviors such as masturbating, please provide privacy, and lay him down.
c. Please provide pericares and handwashing as needed after masturbating.

Resident #2's Care Plan lacked information related to the use of a restraint.

Resident #2's clinical record failed to reveal a consent form signed by the resident's responsible party for the use of a restraint that described the benefits and risks had been completed.

Resident #2's clinical record lacked a physician's order for use of a restraint.

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F 604	Continued From page 8 The Restraints, Physical, General Guidelines policy dated 12/17: The purpose of these physical restraint guidelines is to ensure each resident attains and maintains his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits physical restraint usage to circumstances in which the resident has medical symptoms that warrant the use of restraints. Practices that meet the definition of a restraint include, but are not limited to: *tucking in or using Velcro to hold a sheet, fabric, or clothing tightly so that a residents movement is restricted *Physical restraints shall not be used to limit resident mobility for the convenience of staff During an interview on 7/20/22 at 1:15 p.m., Staff A, Certified Nurse Aide (CNA), confirmed and verified that a hospital gown tied in a knot behind each of the residents' knees was considered a restraint and limited the residents movement in bed. During an interview on 7/21/22 at 9:30 a.m., the Director of Nursing confirmed and verified that the hospital gown tied behind the residents' knees would be considered a physical restraint due to the fact that it would limit the resident ability to move and reposition themselves independently. During an interview on 7/26/22 at 3:12 p.m., Staff B, CNA, confirmed and verified that a hospital gown tied in a knot around each of the residents' knees restricted the movement of them and would be considered a restraint.	F 604		
F 607	Develop/Implement Abuse/Neglect Policies	F 607		

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F 607 SS=D	Continued From page 9 CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview and the review of resident rights policy/procedure the facility failed to ensure the nursing/long term care facility had an abuse prevention policy that directly related to long term care regulations and included all key components related to abuse prevention. The facility reported a census of 11. Findings include: During an interview on 7/21/22 at 8:00 a.m., the facility Business Office Manager, confirmed and verified that the prior management group failed to provide the facility with an Abuse policy/procedure for prevention, identification and investigation and reporting the different types of abuse. The Resident Rights policy/procedure dated 12/17, documented that a mechanism is in place to ensure that the rights of the resident will be recognized and respected by the facility as well as the medical staff: The policy further directed: a. Expect reasonable responses to requests for	F 607	1. In continuing compliance with F 607 Develop/Implement Abuse/Neglect Policies, Touchstone Healthcare Community corrected the deficiency by the Administrator initiating an all staff education on 7/12/2022. 2. To correct the deficiency and to ensure the problem does not recur, an all-staff education was initiated by the Administrator on 7/12/2022 on what the expectation for identifying and reporting any suspected or witnessed abuse would be from 7/12/2022 until the facility closes. The facility closed on 7/21/2022. 3. This deficiency was mitigated when the facility closed on 7/21/2022.	7/21/2022

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F 607	Continued From page 10 services within our capacity, our stated mission and applicable law and regulation b. Considerate and respectful care, including consideration of psychosocial, spiritual, cultural, and safety needs. The State Operations Manual section 483.12(b)(1-4) revised 11/22/17 instructed that the regulation was written to provide protections for the health, welfare and rights of each resident residing in the facility. In order to provide these protections, the facility must develop written policies and procedures to prohibit and prevent abuse, neglect, exploitation of residents, and misappropriation of resident property. These written policies must include, but are not limited to, the following components: · Screening; · Training; · Prevention; · Identification; · Investigation; · Protection; and · Reporting/response.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(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, 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	F 609	1. In continuing compliance with F 609 Reporting of Alleged Violations, Touchstone Healthcare Community corrected the deficiency by the Administrator initiating an all staff education on 7/12/2022 to ensure alleged abuse violations are reported for Resident #1, #2, and all like residents. 2. To correct the deficiency and to ensure the problem does not recur, an all-staff education was initiated by the Administrator on 7/12/2022 on what the expectation for reporting any suspected or witnessed abuse would be from 7/12/2022 until the facility closes. The facility closed on 7/21/2022. 3. This deficiency was mitigated when the facility closed on 7/21/2022.	7/21/2022

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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 record review, staff interview, the facility failed to report an allegation of abuse to the Department of Inspections and Appeals. (Resident #1 and Resident #2) The facility reported a census of 11 residents.

Findings include:

1. A Quarterly Minimum Data Set (MDS) assessment tool, dated 6/27/22, documented resident #1 with a Brief Interview for Mental Status (BIMS) score of 0. A score of 0 to 7 indicates severely impaired cognition with inattention, disorganized thinking and altered level of consciousness. The MDS also documented the resident with delusion, verbal behaviors and other behaviors symptoms not directed toward others. The MDS revealed the resident required staff assistance for all activities of daily living and had not walked and impaired

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 12	F 609		

functional limitation of range of motion on upper and lower extremity on both sides. The MDS revealed the resident's diagnoses included Traumatic Brain Injury, anxiety and depression and no restraints used.

2. A Quarterly Minimum Data Set (MDS) assessment tool, dated 7/5/22, documented resident #2 with a BIMS score of 0. A score of 0 to 7 indicates severely impaired cognition with inattention, long term memory impairment, severely impaired for decision making abilities, inattention and altered level of consciousness. The MDS revealed the resident required staff assistance for all activities of daily living and had not walked and impaired functional limitation of range of motion on upper and lower extremity on both sides. The MDS revealed the resident's diagnoses included Seizure Disorder, and unspecified Intellectual Disabilities and no restraints used.

Review of facility incident on 7/12/22 documented at approximately 11:45 a.m., Social Service Director notified the Admissions and Credentialing Director of 3 situations of potential abuse that had been reported to management in the past and now feels that nothing has been done about them and still feels that they should have been reported to DIA.

During an interview 7/20/22 1:10 p.m., the Interim Administrator verified he expected all staff to report any allegation of potential abuse and that staff needed to follow up with investigating and reporting to the proper authorities.

During an interview on 7/21/22 at 8:00 a.m., the facility Business Office Manager (BOM) stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 07/27/2022

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TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

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F 609	Continued From page 13 that the prior management company failed to provide the facility with an Abuse Policy/Procedure on how to identify, report, and investigate any types of abuse. During an interview on 7/21/22 at 9:10 a.m., the facility DON confirmed that DIA was not notified of the allegation on 6/23/22 and also 7/7/22 and 7/9/22 allegations.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff interviews, resident rights policy and procedure, the facility failed to investigate an allegation of potential abuse and prevent further potential abuse for 2 of 5 residents reviewed (Resident #1 and Resident #2). The facility reported a census of 11	F 610	1. In continuing compliance with F 610 Investigate/Prevent/Correct Alleged Violation, Touchstone Healthcare Community corrected the deficiency by the Administrator initiating an all-staff education on 7/12/2022 to ensure alleged abuse violations are investigated for Resident #1, #2, and all like residents. 2. To correct the deficiency and to ensure the problem does not recur, an all-staff education was initiated by the Administrator on 7/12/2022 on what the expectation for investigating any suspected or witnessed abuse would be from 7/12/2022 until the facility closes. The facility closed on 7/21/2022. 3. This deficiency was mitigated when the facility closed on 7/21/2022.	7/21/2022

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residents.

Findings included:

1. Resident #1's Minimum Data Set (MDS) assessment dated 6/27/22, documented a Brief Interview for Mental Status (BIMS) score of 0, indicating severe cognitive impairment. The MDS identified Resident #1 had delusions, verbal behaviors for four to six days, but less than daily, and other behavior symptoms not directed toward others for one to three days in the lookback period. The MDS identified that Resident #1 required staff assistance for all activities of daily living, he did not walk, he had impaired functional limitation of range of motion on upper, and lower extremities on both sides. Resident #1's diagnoses included traumatic brain injury, anxiety, and depression. The MDS documented that Resident #1 didn't use restraints.

2. Resident #2's MDS assessment dated 7/5/22, documented a BIMS score of 0. The MDS revealed Resident #2 required staff assistance for all activities of daily living, did not walk, and had impaired functional limitation of range of motion on upper, and lower extremities on both sides. Resident #2's diagnoses included a seizure disorder and unspecified intellectual disabilities. The MDS documented that Resident #2 didn't use restraints.

The Facility Incident documentation dated 7/12/22 at approximately 11:45 a.m. the Social Service Director notified the Admissions and Credentialing Director of three previously notified situations of potential abuse that got reported to management. The Social Service Director felt that nothing happened about them and still felt

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that they should have been reported to the Iowa Department of Inspections and Appeals (DIA).

On 7/20/22 at 5:00 p.m. the SSD reported that the first she learned of the situation regarding Resident #1 on 6/22/22, at approximately 5:52 p.m.. Staff D, CNA, messaged the SSD via a text message that she needed to talk with Staff A, regarding a staff member that kept tying up residents. The SSD reported that statement to the Director of Nursing (DON), on 6/23/22. The DON and the Administrator at that time told the SSD that they would take care of it. The SSD said she didn't hear anything more about that incident and she thought the situation was taken care of. On 7/7/22 at approximately 3:28 p.m. Staff D texted the SSD again stating that a co-worker needed to stop, because she could hurt somebody. Staff D reported that she saw a gown tied in a knot again around Resident #1's knees. Staff D felt that she needed to tell someone else. Staff D said to the SSD that the knot was tied so tight that Resident #1 could not move his legs and Staff D could not get the knot out. The SSD reported that information in a stand up meeting to the Healthcare Group and the Regional Nurse for the Healthcare Group said that they would look into it. The SSD said that she went down to Resident #1s room to check on him and that the Healthcare Group's Regional Nurse entered the room right after her. They found Resident #1 wet with incontinence and the Regional Nurse untied the knot in the gown. They didn't observe any skin areas at that time. The SSD said that it also got reported to her on 7/9/22, but she didn't know the time. The SSD got a text message from Staff C, CNA, about when she did morning rounds on Resident #1, that he wore two briefs. When Staff C turned Resident #1 onto his back she noticed

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the gown tied around his upper right arm and with it secured in the back of his body. The SSD received reports that this happened for months with a hospital gown being used to tie up Resident #1 and Resident #2.

During an interview on 7/21/22 at 9:10 a.m., the Director of Nursing (DON) confirmed and verified that facility did not complete incident reports or investigations related to the allegations of potential abuse.

During an interview on 7/21/22 at 8:00 a.m., the facility Business Office Manager (BOM) stated that the prior management company failed to provide the facility with an Abuse Policy/Procedure on how to identify, report, and investigate any types of abuse.

The Resident Rights policy/procedure dated 12/17, documented:
A mechanism is in place to ensure that the rights of the resident will be recognized and respected by the facility as well as the medical staff. The policy further directed:
a. Expect reasonable responses to requests for services within our capacity, our stated mission and applicable law and regulation
b. Considerate and respectful care, including consideration of psychosocial, spiritual, cultural, and safety needs.