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	165324	A. BUILDING ______ B. WING ______	C **09/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF PLEASANTVILLE, LLC	**909 NORTH STATE STREET** **PLEASANTVILLE, IA 50225**

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F 000 ✓ ok/CP	INITIAL COMMENTS Correction date: 10/21/2024 The following deficiencies resulted from investigation of Complaints #121849-C, #122777-C, #122850-C, #123321-C, #123536-C, and Facility Reported Incidents #122714-I, and #123375-I conducted on September 22, 2024 to September 30, 2024. All Complaints and Facility Reported Incidents were substantiated. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F 000	Accura Healthcare of Pleasantville 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.	
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550	1. In continuing compliance with F 550 Residents Rights/Exercise of Rights, Accura Healthcare of Pleasantville corrected the deficiency by educating and terminating employment with both Staff B and G on resident rights, break policy, and abuse policy on 10/1/2024 for residents # 4,10, and 22 and all like residents. Staff C and H were educated by 9/30/2024 on standards of care. If a resident is incontinent, they should be checked, changed, and repositioned for resident #20 and all like residents. 2. To correct the deficiency and to ensure the problem does not recur, all staff were educated by 10/21/2024 by the Executive Director of the break policy, resident right policy, grievance policy, abuse policy and behavioral interventions. All Dietary staff were educated on 9/25/2024 by Regional Director of Operations on when paper products were to be used. The Executive Director and/or designee will audit for compliance three times weekly for four weeks, two times weekly for four weeks then one time weekly for four weeks and then as needed to ensure continued compliance. 3. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	10/21/2024

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

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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F 550	Continued From page 1	F 550		

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 observations, clinical record review, resident interviews, staff interviews, Resident Bill of Rights, and policy review the facility failed to provide personal care to a resident that was incontinent, provide medication when a resident requested, allow a resident to make his own decision, and properly serve residents on appropriate flatware. Concerns were found for 4 of 6 residents reviewed for dignity (Resident #4, 10, 20, and 22). The facility reported a census of 45 residents.

Finding include:

1. The Quarterly Minimum Data Set (MDS) dated 7/9/24 documented Resident #10 had a Brief Interview for Mental Status (BIMS) of 15, which indicated no cognitive impairment.

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F 550	Continued From page 2 On 9/23/24 at 3:48 PM Resident #10 stated Staff G, Licensed Practical Nurse (LPN) was the nurse 9/20/24 overnight to 9/21/24. Resident #10 stated Staff G brought her in medications on that overnight around 2:30 AM Resident #10 stated there were 2 pills in the medication cup and she asked Staff G if Tylenol was in the medication cup. Resident #10 stated when she takes Tramadol and Tylenol together in the middle of the night at times it keeps her awake. Resident #10 stated she told Staff G that she did not want both the Tramadol and Tylenol that is why she asks for them separately. Resident #10 stated Staff G told her that she was going to take both now or she was not going to get anything. Resident #10 said she said she did not f**king want them together and that Staff G told her f**k it now you're not getting any. Resident #10 stated Staff G then left her room. Resident #10 stated Staff I, Registered Nurse (RN) gave her just the Tramadol that she had requested around 3:00 AM about 30 minutes later. Resident #10 stated it made her very offended and upset. Resident #10 stated she was paralyzed but still feels pain in her back. Resident #10 stated she did not try to abuse her medication. Resident #10 stated that Staff G stated that she did not have time to come back later and give her Tylenol. Resident #10 stated that Staff G stated that she was orienting a new nurse that night and did not have time to mess with her all night. Resident #10 acknowledged that she told Staff G not getting her medications the way she wanted was a f**king big deal. Resident #10 stated she kept ringing her call light until Staff I came into the room. Resident #10 stated the call light was on for half an hour or more. Resident #10 stated she heard Staff G state that she could stop	F 550		

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ringing the call light (door bell). Resident #10 stated she could read the clock on the wall. Resident #10 stated she spoke with the Director of Nursing (DON) about it but stated she did not know what the agenda was for Staff G that evening.

Review of document titled, Daily Staff Schedule Sheet dated 9/20/24 for shift 10:00 PM - 6:00 AM revealed Staff G as the front of the house nurse orienting Staff I.

On 9/24/24 at 11:40 AM the DON stated Resident #10 told her on the overnight 9/20/24 - 9/21/24 that Staff G brought Resident #10 Tylenol and Tramadol together and that she did not want Tylenol. The DON stated she did not fill out a grievance form for Resident #10. The DON stated she went to the Administrator about it. The DON stated Staff G called and spoke to Administrator about the situation and did not know what happened after that. The DON acknowledged that Staff G she was rough with her words, and reported that Staff G told Resident#10 to take the medication now or she was not coming back.

On 9/25/24 at 1:00 PM Staff G, Licensed Practical Nurse (LPN) / Assistant Director of Nursing (ADON) / Infection Preventionist (IP) stated she was orienting Staff I to the overnight shift. Staff G stated she was familiar with Resident #10 and had administered her medication before. Staff G stated she did have interaction with Resident #10 about medications. Staff G stated the interaction was after midnight on the morning of 21st about 2:30 AM. Staff G stated Resident #10 rang her call light (doorbell) and a Certified Nursing Assistant (CNA)

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F 550	Continued From page 4 answered the call. Staff G stated the CNA reported Resident #10 wanted Tramadol. Staff G stated Resident #10 normally wants Tylenol and Tramadol. Staff G stated she took the medication to Resident #10 and when entered the room Resident #10 requested to see the medication. Staff G stated at that time Resident #10 stated are you trying to overdose me. Staff G stated she told Resident #10 that usually she wanted both the Tramadol and the Tylenol together. Staff G stated Resident #10 continued to cuss and carry on. Staff G stated she told Resident #10 that when she calmed down she would bring the medication back to her. Staff G stated Resident #10 then screamed F**king B**ch when she exited the room. Staff G stated she returned to the nurses station and asked Staff I, RN to take the medication to Resident #10. Staff G stated Staff I had given her the HS medications that evening. Staff G stated the medication was not taken to Resident #10 immediately but at the very most 10 minutes later. Staff G stated at 8 pm that night she wanted both of the medications together. Staff G stated she only asks for Tramadol at night. Staff G stated she would usually offer both medications that are As Needed (PRN) at the same time for pain complaints. Staff G stated she did not ask Resident #10 what medications she wanted prior to taking the medications down to her room. Staff G stated she did not cuss back at Resident #10. Staff G stated she did not take the Tylenol out at the time because Resident #10 was screaming and cussing. Staff G stated Resident #10 had behavior charting in her care plan related to the outbursts. Staff G stated she did not have a chance to utilize any interventions on the care plan related to Resident #10's behaviors. Staff G stated she asked Resident #10 what her pain	F 550		

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F 550	Continued From page 5 level was when she entered the room. Staff G stated Resident #10's pain level was an 8 at the time. Staff G acknowledged 8 was a high pain level. Staff G stated she did not know if giving Resident #10 times to calm down and return was one of the interventions for behaviors. Staff G stated after the incident Resident #10 did not ring her door bell at all prior to Staff I entering the room. Staff G stated there are certain CNA that cuss all the time and Staff C was recently written up for it. Staff G stated Staff E and Staff J cuss at the nursing station. On 9/25/24 at 3:25 PM Staff I, RN stated she was familiar with Resident #10. Staff I stated she was oriented on the front of the house by Staff G on the overnight of 9/20/24 - 9/21/24 Staff I stated Resident #10 and Staff G must have gotten into it. Staff I stated she did not hear or witness any of the conversation. Staff I stated Staff G told her that the Resident #10 cussed at her. Staff I stated Staff G ended up not giving Resident #10 the PRN medication. Staff I stated she did return to the resident and administered the Tramadol alone. Staff I stated she returned to give Resident #10 the Tramadol by itself. Staff I stated she did not believe it was a long length of time, probably longer than 10 minutes but not an hour. Stated when she returned to the she did not recall if Resident #10 was awake or not. Staff stated she did not remember if she signed off the medication when it was administered but if she gave it she should have. Staff I stated last weekend Resident #10 asked for both PRN pain medications Tramadol and Tylenol. Staff I stated she did not remember if she actually administered the medication or if the resident was using her call light (doorbell) between Staff G leaving the room. Staff I stated she did not	F 550		

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remember that night at all. Staff I stated she did not remember if she had given the medication or not.

On 9/25/24 at 2:15 PM the Director of Nursing (DON) stated it was not her or the facility's expectation that 2 PRN pain medication would not be administered without request from the resident. The DON stated if Resident #10 did not take the medication at that time. The DON acknowledged Resident #10 was reproached by Staff I. The DON acknowledged that Staff I should have signed the Tramadol off on the medication administration record (MAR) when it was given. The DON stated the MAR should be signed off after the medication was administered.

On 9/24/24 at 12:40 PM the Administrator stated Staff G had said something to her about Resident #10 yelling at her about not wanting her Tylenol and Tramadol at the same time. The Administrator stated Staff G reported she just stepped out for a little bit and was going to reproach Resident #10 later. The Administrator stated when Resident #10 rang her call light a little later the Staff I brought the Tramadol only down to the resident. The Administrator stated Staff G said that Resident #10 was screaming at her so she just had to step away. The Administrator reported Staff G said that Resident #10 was yelling and screaming. Staff G reported she did not say anything inappropriate, and just stepped out. The Administration reported she would be okay with the nurse stepping out. The Administrator stated she did not know how long it took Staff I to return to Resident #10's room with the medication. The Administrator stated she did not investigate this incident at all once Staff G brought it to her attention. The Administrator

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F 550	Continued From page 7 stated she did not discuss this incident with the DON. On 9/25/24 at 2:15 PM the DON stated it was not her or the facility's expectation that 2 PRN pain medications would be administered without request from the resident. The DON stated if Resident #10 did not take the medication at that time to reproach with Staff I and have Staff I sign administration of medication when it was given. The DON stated after the medication is administered to the resident that is when the staff was supposed to sign the MAR. On 9/27/24 at 11:22 AM the Administrator stated after survey team had talked to the administration developed a grievance for Resident #10 related to an incident with Staff G. The Administrator stated the administration is working on education or discipline being given to Staff G right now and waiting for HR to approve. The Administrator acknowledged that the investigation of that incident should have occurred earlier. The administrator stated she thought Staff G was reporting Resident #10 was having a behavior and it did not occur to her about the issue with pain medication administration. The Administrator stated there was always nursing staff on the floor. The Administrator stated she never saw the staff all go out to smoke together. The Administrator stated she just did education with staff that only one person can be out smoking at a time on 9/25/24. The Administrator stated a resident's family called and filed a grievance about staff smoking outside and no nursing staff being on the floor. 2. Review of Resident #20's Entry MDS dated	F 550		

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9/16/24 revealed an admission date of 9/16/24 from another nursing home.

Review of Resident #20's Care Plan with a revision date of 9/17/24 revealed that Resident #20 was at risk for skin breakdown related to incontinence.

During continuous observation 9/24/24 from 12:10 PM to 2:53 PM Resident #20 was getting up from the lunch table and was observed to have a large wet area to the back of the Residents pants. Staff H, Certified Nurses Aide (CNA) was observed to have her hand on the wet spot on Resident #20's back when the transfer occurred. Resident #20 was transferred with assist of one with a gait belt by Staff H CNA to the living room couch to lay down. Staff H then hand sanitized and left Resident #20 on the couch laid down with a wet spot on his back.

Interview 9/24/24 at 2:53 PM Staff H, CNA revealed residents should be changed, and repositioned every hour or so, and at most every two hours. At this time it was observed that the wet spot on Resident #20's back was now dry and that there was a large wet area on Resident #20's left side.

Interview 9/24/24 at 4:00 PM with the Director of Nursing (DON) revealed that her expectation would be for residents to be checked, changed, and repositioned at minimum every 2 hours and encouraged to try to do this hourly. The DON further revealed she would expect Residents to not lay in urine, and be treated with dignity.

Review of a personnel file for Staff C, CNA revealed a document titled Employee corrective

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F 550	Continued From page 9 action form dated 9/16/24 documented a Resident reported that Staff C was talking about the facility negatively while completing cares on this Resident. The document further revealed that this behavior goes against the facility's values, especially regarding integrity which means doing the right thing always, and kindness which considers the feelings of others always. 3. A Admission MDS assessment form dated 8.26.24 indicated Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. During an interview 9.24.24 at 10:24 a.m. the resident indicated a nurse who wore orange on this day yelled at him and refused to allow him to make his own decisions. An observation at the same time revealed Staff B as the nurse who wore orange. The resident also denied having felt safe at the facility but refused provision of specifics. During an interview 9.24.24 at 4 p.m. the resident confirmed the nurse who yelled at him, as he pointed to her, as Staff B, Licensed Practical Nurse (LPN). Review of the Time Card for Staff B revealed she worked 9.24.24 from 5:54 a.m. until 6:06 p.m. 4. A Discharge Return Anticipated MDS assessment dated 7.25.24 indicated Resident #22 with a BIMS score of 14, which indicated cognition intact. A Grievance Form dated 9.1.24 indicated the	F 550		

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Resident verbalized the following concern related to Staff B, LPN:

The nurse had always been hateful and mean to her. The staff member came into her room and asked what she needed and then told her she had over 40 residents to get up and slammed the door when she left. The Resident also heard the staff member said hurtful things about her and she took care of the Resident at another facility and had not liked her as the resident cried during this discussion.

5. During an interview 9.25.24 at approximately 2 p.m. the Clinical Nurse Supervisor indicated the COVID-19 outbreak began 8.26.24.

During an interview 9.25.24 at 1:50 p.m. the Executive Director confirmed the facility as out of outbreak status on 9.19.24.

During a interview 9.22.24 at 12:40 p.m. the Minimum Data Set (MDS) Coordinator indicated the facility as out of COVID-19 outbreak status as they only had one (1) resident currently with COVID-19.

An observation 9.23.24 at 11:25 a.m. revealed two (2) dietary staff as they brought the steam table and an four (4) wheeled cart which contained various drink containers such as milk and juices to CCDI (chronic confusion or dementing illness) unit. The Dining Services Manager served the resident meal on Styrofoam plates and plastic silverware.

An observation 9.23.24 at 11:45 a.m. revealed the dietary staff served the residents meal in the

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F 550	Continued From page 11 main dining room on Styrofoam plates and plastic silverware. During an interview 9.23.24 at 11:32 a.m. the Dietary Services Manager confirmed she served resident meals on Styrofoam plates since the beginning of the last COVID-19 outbreak and had not been directed otherwise. During an interview 9.23.24 at 11:35 a.m. Staff D, Licensed Practical Nurse (LPN) indicated there had been no COVID-19 positive residents in the CCDI unit since 8.31.24 and dietary staff served all meals on Styrofoam plates with plastic silverware since the beginning of the outbreak to present. During an interview 9.23.24 at 1:35 p.m. Staff C, Certified Nursing Assistant (CNA) confirmed dietary staff served resident meals on Styrofoam plates with plastic silverware since the beginning of the COVID-19 outbreak and the facility currently had not been in outbreak status. Review of policy titled, Residents Bill of Rights dated 11/16 documented the 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.	F 550		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced	F 641		

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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 641	Continued From page 12 by: Based on clinical record review, staff email and policy review the facility failed to represent an accurate picture of the resident's status during the observation period of the Minimum Data Set (MDS) by not completing an accurate assessment of resident behaviors for 1 of 3 residents reviewed. (Resident #1) The facility also failed to properly code their 802 Matrix related to restraints for 6 of 6 residents reviewed. The facility reported a census of 45 residents. Findings include: 1. An Incident Report form dated 8.13.24 at 9:45 p.m. included the following documentation: The MDS Coordinator and Director of Nursing (DON) heard yelling down the hall and responded. They found Resident #1 had shoved Resident #2 up against the wall which resulted in a fall. A Minimum Data Set Assessment dated 8.18.23 indicated Resident #1 had no signs of delirium, mood or physical, verbal behavioral symptoms directed towards others or other verbal symptoms not directed towards others. 2. Review of a Resident Matrix form printed 9.22.24 by the facility staff identified 6 of 45 residents with restraints. An email from the Clinical Nurse Specialist 9.25.24 at 4:50ppm. indicated no residents utilized restraints in the facility.	F 641	1. In continuing compliance with F 641 Accuracy of Assessments the facility corrected the deficiency by staff education to ensure that no restraints are reported for resident #2, and like residents. MDS was corrected for resident #1. 2. To correct the deficiency and to ensure the problem does not recur, regional nurse specialist educated the MDS Coordinator on 9/27/2024 on accurately maintaining the 802 assessment. The DON and/or designee will audit for compliance of the 802 assessment 1x weekly for twelve weeks and then as needed to ensure continued compliance. 3. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	10/16/2024
F 656 SS=D	Develop/Implement Comprehensive Care Plan	F 656		

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	165324	A. BUILDING ______ B. WING ______	C 09/30/2024

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F 656	Continued From page 13 CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 656	1. In continuing compliance with F 656 Development/Implement Comprehensive Care Plans the facility corrected the deficiency by educating the Shower Aide on completing showers and accurately documenting showers in PCC. The facility will ensure compliance in showers for residents #2, 4 and 5, and like residents. 2. To correct the deficiency and to ensure the problem does not recur all CNA staff were educated on 10/1/2024 by DON on completing showers and accurately documenting showers in PCC. Preferences have been clarified and care plans amended to reflect the preference of all applicable residents by 10/18/2024. The DON and/or designee will audit for compliance three times weekly for four weeks, two times weekly for four weeks then one time weekly for four weeks and then as needed to ensure continued compliance. 3. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	10/18/2024

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(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview and policy review the facility failed to implement Care Plans (CP) for 3 of 3 residents (Resident #2, #4 and #5) reviewed. The facility reported a census of 45 residents.

Findings include:

1. A Quarterly Minimum Data Set Assessment (MDS) form dated 9.12.24 indicated Resident #2 had a Brief Interview for Mental Status (BIMS) score of 4 out of 15 (severely cognitively impaired), with no delirium, behaviors or rejection of cares and required partial to moderate assistance of staff with bathing.

A Care Plan indicated the resident with a Focus area of an activities of daily living (ADL's) self-care performance deficit related to (r/t) confusion and incontinence, with revision date 2/20/24. The Interventions/Tasks included the following:

a. Bathing/showering with assistance of one (1) staff member two(2) times a week and as needed (PRN). (revised 2.20.24)

According to the facilities Shower form (not dated) identified the resident's bath days as

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Monday and Thursday.

According to the resident's Shower Skin Check Report forms the resident refused baths/showers on the following dates with no identified reproaches and/or other interventions such as bed baths or change in times or dates:

a. 9.2.24, 9.5 where he wanted to wait until later, 9.19 and 9.23 where he refused times (x) 2 attempts.

2. A MDS assessment form dated 8.26.24 indicated Resident #4 had a BIMS score of 15 (cognitively intact) with no delirium, behaviors or rejection of cares and required supervision or touching with baths/showers.

A Care plan indicated the resident with a Focus area of ADL self care performance deficit r/t Hemiplegia (initiated 9.19.24). The Interventions/Tasks included the following:

a. Bathing/showering with assistance of 1 staff member 2 times a week and PRN (revised 9.19.24)

According the the facilities Shower form (not dated) identified the resident's bath days as Wednesdays and Saturdays.

According to the resident's Shower Skin Check Report forms the resident received baths/showers on the following dates:

a. 9.4.24, 9.11 and 9.21 with no refusals documented.

3. A MDS assessment form dated 7.4.24

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indicated Resident #5 had a BIMS score of 6 (severely impaired cognition with no delirium, with verbal behaviors directed towards others, verbal behaviors not directed towards others, no refusal of cares and required substantial/maximal assistance of staff with baths/showers.

A BIMS Evaluation form dated 9.26.24 at 12:42 p.m. indicated the resident had a score of 12 (moderately impaired cognitive skills)

A Care plan indicated the resident with a Focus area of ADL self care performance deficit r/t Hemiplegia and a Stroke (initiated 4.20.24). The Interventions/Tasks included the following:

a. Bathing/showering with assistance of 1 staff member 2 times a week and PRN. (revised 4.20.24)
b. Provision of a sponge bath when a full bath or shower had not been tolerated. (created 4.20.24)

According the the facilities Shower form (not dated) identified the resident's bath days as Mondays and Thursdays.

According to the resident's Shower Skin Check Report forms the resident received baths/showers on the following dates:

a. 9.2.24, 9.4, 9.12, 9.19 and 9.23 with no refusals documented.

F 658 SS=D Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) F 658

§483.21(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility,

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F 658	Continued From page 17 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 and staff interview the facility staff failed to properly set up and administer medications in accordance with Professional Standards of Practice for 3 residents reviewed. (Resident #10, #1 and #21). The facility identified a census of 45 residents. Findings include: 1. During an observation 9.24.24 at 12:10 p.m. as the medication carts had been assessed with the Clinical Nurse Specialist, Staff B, Licensed Practical Nurse (LPN) approached the medication cart, opened the top drawer and removed two (2) clear plastic medication cups, one that contained a clear red liquid identified by Staff B as liquid protein and the other plastic med cup stacked under the previous said med cup contained Baclofen and Gabapentin non of which were labeled as to the resident's name and actual medication present. Staff B indicated Resident #10 refused to take her medications before she ate lunch so she placed them in the top drawer which had been the norm for the resident. The Clinical Nurse Specialist confirmed this observation. During an interview 9.23.24 at 2:06 p.m. Staff E, CNA confirmed the nursing staff left resident medications unattended on the dining room tables and the resident's bedside stands/tables. 2. A Physician's Progress Notes form dated 8.14.24 at 4:32 p.m. included the following	F 658	1. In continuing compliance with F 658 Services Provided Meet Professional Standards the facility corrected the deficiency by educating Staff B on 9/25/2024 and terminating employment with Staff B on 10/1/2024 and educating the DON on the 6 rights of medication on 9/25/2024. The facility will ensure correct medication administration for residents #1, 10, and 21, and like residents. 2. To correct the deficiency and to ensure the problem does not recur all nursing and CMA staff were educated in medication administration by DON on 10/1/2024. The DON and/or designee will audit for compliance three times weekly for four weeks, two times weekly for four weeks then one time weekly for four weeks and then as needed to ensure continued compliance. 3. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	10/1/2024

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documentation for Resident #1:

Upon room inspection, staff found medication under the residents bed which suggested he failed to take his doses as prescribed.

During an interview 9.24.24 at 12:44 p.m. the Environmental Services Supervisor confirmed she cleaned the entire building and found a pill on the foot end of the bed for Resident #1 and reported her findings to the charge nurse. The staff member also confirmed she observed a nurse leave medications in an unknown resident's room and she randomly found pills throughout the building and immediately reports the situation to the nurse.

3. A Admission Minimum Data Set dated 7.25.24 indicated Resident #21 had diagnosis that included Amyotrophic Lateral Sclerosis (Lou Gehrig's disease), chronic pain and Arthritis. The Assessment indicated the resident with a Brief Interview for Mental Status (BIMS) score of 15 out of 15 (cognitively intact), in occasional pain with the highest rated at a 8 out of 10 but ton scheduled and as needed pain medication.

A Medication Administration Record (MAR) dated 7.1.24 thru 7.31.24 indicated the resident received the following physician orders as dated:

a. Tramadol 50 milligrams (mgs) every 24 hours as needed (PRN) for pain from 7.15.24 thru 7.19.24.
b. Tramadol 50 mg every 6 hours PRN for pain started 7.19.24.
c. Gabapentin 400 mg one (1) capsule three times a day (TID) for nerve pain started 7.15.24.

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F 658	Continued From page 19 Review of a Grievance Form dated 7.30.24 indicated Resident #21 verbalized a concern with the Assistant Director of Nursing (ADON) who placed her medications on the bedside table and left the room and failed to assure the medications and water had been in reach of the resident. During an interview 9.27.24 at 9:40 a.m. the resident indicated she discussed the issue with the ADON and it had been resolved however, the unknown night in question her pain pill fell in her bed and the ADON refused to give her another one which left her in pain and the next morning the staff found the pill in her bed.	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 observation, clinical record review, resident interview, staff interview and facility policy review the facility failed to bath 3 of 4 residents according to their individual schedules and bathing requests. (Resident #2, #4 and #5) The facility also failed to provide appropriate perineal cares for 1 of 3 residents reviewed. (Res #10) Findings include: 1. A Minimum Data Set Assessment (MDS) form dated 9.12.24 indicated Resident #2 had a Brief Interview for Mental Status (BIMS) score of 4 out of 15 (severely cognitively impaired), with no	F 677	1. In continuing compliance with F 677 ADL Care Provided for Dependent Residents the facility corrected the deficiency by educating the Shower Aide on completing showers and accurately documenting showers in PCC. The facility will ensure compliance in showers for residents #2, 4 and 5, and like residents. 2. To correct the deficiency and to ensure the problem does not recur all CNA staff were educated on completing showers and accurately documenting showers in PCC on 10/1/2024 by DON. Preferences have been clarified and care plans amended to reflect the preference of all applicable residents by 10/18/2024. All CNA staff were educated on 10/1/2024 by DON including perineal care. The DON and/or designee will audit for compliance three times weekly for four weeks, two times weekly for four weeks then one time weekly for four weeks and then as needed to ensure continued compliance. 3. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	10/18/2024

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F 677	Continued From page 20	F 677		

delirium, behaviors or rejection of cares and required partial to moderate assistance of staff with bathing.

A Care Plan indicated the resident with a Focus are of an activities of daily living (ADL's) self-care performance deficit related to (r/t) confusion and incontinence. The Interventions/Tasks included the following:

a. Bathing/showering with assistance of one (1) staff member two(2) times a week and as needed (PRN). (revised 2.20.24)

According to the facilities Shower form (not dated) identified the resident's bath days as Monday and Thursday.

According to the resident's Shower Skin Check Report forms the resident refused baths/showers on the following dates with no identified reproaches and/or other interventions such as bed baths or change in times or dates:

a. 9.2.24, 9.5 where he wanted to wait until later, 9.19 and 9.23 where he refused times (x) 2 attempts.

2. A MDS assessment form dated 8.26.24 indicated Resident #4 had a BIMS score of 15 (cognitively intact) with no delirium, behaviors or rejection of cares and required supervision or touching with baths/showers.

A Care plan indicated the resident with a Focus area of ADL self care performance deficit r/t Hemiplegia (initiated 9.19.24). The Interventions/Tasks included the following:

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F 677	Continued From page 21	F 677		

a. Bathing/showering with assistance of 1 staff member 2 times a week and PRN (revised 9.19.24)

According the the facilities Shower form (not dated) identified the resident's bath days as Wednesdays and Saturdays.

According to the resident's Shower Skin Check Report forms the resident received baths/showers on the following dates:

a. 9.4.24, 9.11 and 9.21 with no refusals documented.

During an interview 9.24.24 at 10:24 a.m. the resident indicated he preferred a bath 2 times a week. An observation at the same time revealed the resident's hair as oily which indicated a lack of cleanliness.

3. A MDS assessment form dated 7.4.24 indicated Resident #5 had a BIMS score of 6 (severely impaired cognition with no delirium, with verbal behaviors directed towards others, verbal behaviors not directed towards others, no refusal of cares and required substantial/maximal assistance of staff with baths/showers.

A BIMS Evaluation form dated 9.26.24 at 12:42 p.m. indicated the resident had a score of 12 (moderately impaired cognitive skills)

A Care plan indicated the resident with a Focus area of ADL self care performance deficit r/t Hemiplegia and a Stroke (initiated 4.20.24). The Interventions/Tasks included the following:

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a. Bathing/showering with assistance of 1 staff member 2 times a week and PRN. (revised 4.20.24)
b. Provision of a sponge bath when a full bath or shower had not been tolerated. (created 4.20.24)

According the the facilities Shower form (not dated) identified the resident's bath days as Mondays and Thursdays.

According to the resident's Shower Skin Check Report forms the resident received baths/showers on the following dates:

a. 9.2.24, 9.4, 9.12, 9.19 and 9.23 with no refusals documented.

During an interview 9.24.24 at 10:24 a.m. the resident indicated he preferred a bath/shower 2 times a week.

During an interview 9.24.24 (time unknown) Staff F, Certified Nursing Assistant (CNA) confirmed she provided baths to the residents scheduled two (2) times a week however there had been times she had been pulled to work the floor as a CNA with provision of direct cares. The staff member indicated 15-16 resident baths/showers had been scheduled every day for an eight (8) hour shift. When scheduled to provide baths her other responsibilities included assistance with meals and laying residents down after meals which took a total of 2-3 hours out of her 8 hour day. The staff member indicated she knew staff failed to provide showers on Saturdays due to staffing.

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During an interview 9.23.24 at 1:35 p.m. Staff C, CNA confirmed the facility failed to provide baths/showers according to the resident's individual schedules and/or requests.

During an interview 9.23.24 at 2:06 p.m. Staff E, CNA confirmed the facility staff failed to provide baths/showers according to the residents individual schedules and/or requests due to staffing issues.

The facilities Standards of Personal Care (Minimum) policy (not dated) included the following:

a. Each resident received 2 baths per week unless otherwise care planned. Resident's hair should have been shampooed with each bath, unless done at the beauty shop or otherwise care planned.

4. A MDS dated 7.9.24 indicated Resident #10 had diagnosis that included Traumatic Spinal Cord Dysfunction and Quadriplegia. The assessment indicated the resident had a BIMS score of 15 out of 15 (cognitively intact), toileting hygiene and transfer had not been attempted due to medical condition or safety concerns, required partial/moderate assistance of staff with toileting hygiene, urinary continence not rated due to a catheter and always incontinent of bowels.

Review of Resident Council minutes dated 4.10.24 at 1 p.m. revealed Resident #10, verbalized a concern that the night CNA's failed to properly cleanse her perineal/gluteal region which caused irritation and itching.

A Grievance Form dated 4.10.24 indicated

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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 677	Continued From page 24 Resident #10 reported the night CNA's failed to properly cleanse her. During an interview 9.24.24 at 2 p.m. the resident indicated when staff provided perineal cares on the night shift they failed to cleanse her appropriately which left her gluteal region irritated and itchy.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview and facility policy review the facility failed to follow physician orders for 1 of 3 residents reviewed. (Resident #18) The facility identified a census of 45 residents. Findings include: Review of the Medication Administration Record (MAR) form dated 9/1/24 to 9/30/24 for Resident #18 indicated the resident's medication list included the following medications documented as administered on 9.1.24: a. Memantine HCL (hydrochloric acid) 10 mg.	F 684	1. In continuing compliance with F 684 Quality of Care the facility corrected the deficiency by educating Staff B on 9/25/2024 and terminating employment with Staff B on 10/1/2024 and educating the DON on the 6 rights of medication on 9/25/2024. The facility will ensure correct medication administration for residents #18 and like residents. 2. To correct the deficiency and to ensure the problem does not recur all nursing and CMA staff were educated in medication administration on DON on 10/1/2024. The DON and/or designee will audit for compliance three times weekly for four weeks, two times weekly for four weeks then one time weekly for four weeks and then as needed to ensure continued compliance. 3. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	10/1/2024

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F 684	Continued From page 25 (for Alzheimer's disease) b. Mirtazapine 7.5 mg. (Depression) During an observation of the front medication carts on 9.24.24 at 12:10 p.m. with the Clinical Nurse Specialist cards Memantine HCL 10 mg and Mirtazapine 7.5 mg had been present in the medication card for Resident #18 scheduled 9.1.24. The other medication scheduled at the same time Olanzapine 7.5 mg had been absent. During an interview at the same time, the Clinical Nurse Specialist confirmed staff documented all 3 medications as administered and she agreed with the observation. An observation 9.24.24 at 11:55 a.m. revealed Staff B, Licensed Practical Nurse (LPN) as she attempted to administer crushed medications in a clear plastic medication cup with applesauce to Resident #17 however the resident refused as noted by the failure to open her mouth as Staff C, Certified Nursing Assistant (CNA) observed same observation. The staff member then took the meds and brought the Clinical Nurse Specialist to the medication cart and noted them both document in the narcotic book. Record review at the same time revealed the staff member signed out administration of the medications on the MAR. During an interview 9.26.24 at 8:33 a.m. Staff C, CNA confirmed the resident refused her noon medications 9.24.24 at 11:55 a.m. During an interview 9.25.24 at 5 p.m. Staff B indicated the resident refused her morning medications but she failed to correct the MAR after she originally signed them out. An observation at the same time revealed the staff	F 684		

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F 684	Continued From page 26 member change the MAR which revealed proper documentation. During an interview 9.25.24 at 5:05 p.m. related to the observation dated 9.24.24 Staff B stated , yes she did take her medications at noon, it took me along time but I finally got them in her but she failed to take her morning meds which I changed on the MAR.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview the facility failed to provide restorative services to the residents as a means to maintain their highest level of functioning. (Resident #5) The facility identified a census of 45 residents.	F 688	1. In continuing compliance with F 688 Increase/Prevent Decrease in ROM/Mobility the facility corrected the deficiency by educating MDS Coordinator and DON on 10/16/2024 on implementing and ensuring restorative programs are current and accurate in PCC. The facility will ensure restorative therapy if offered for resident #5 and like residents. 2. To correct the deficiency and to ensure the problem does not recur all CNA staff were educated on properly documentation of restorative therapy services on 10/1/2024 by DON. The DON updated all applicable restorative programs in PCC on 10/14/2024. The DON and/or designee will audit for compliance three times weekly for four weeks, two times weekly for four weeks then one time weekly for four weeks and then as needed to ensure continued compliance. 3. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	10/16/2024

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F 688	Continued From page 27 Findings include: The Quarterly Minimum Data (MDS) dated 7/04/24 documented that Resident#5 had required moderate assistance with toileting hygiene, and upper body dressing. During an interview 9.24.24 at 2:25 p.m. Resident #5 indicated staff failed to perform range of motion (ROM) exercises and she preferred to exercise as her goal had been to return home. During an interview 9.23.24 at 1:35 p.m. Staff C, Certified Nursing Assistant (CNA) confirmed the facility failed to provide restorative services for the residents. During an interview 9.23.24 at 2:06 p.m. Staff E, CNA confirmed the facility failed to provide restorative services for the residents. According to an email 9.26.24 at 1:28 p.m. the Clinical Nurse Specialist indicated the facility lacked a restorative policy or procedure. During an interview 9.26.24 at 2:30 p.m. the Clinical Nurse Specialist and Director of Nursing agreed the facilities restorative program required a restructure and appropriate follow through which is part of the plan of correction at this time.	F 688		
F 689 SS=F	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	F 689		

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F 689	Continued From page 28 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility staff failed to maintain a locked and secured treatment cart for one of two med carts reviewed. The facility identified a census of 45 residents. Findings include An observation 9.22.24 at 12:47 p.m. revealed a treatment cart positioned along the wall in the nurse's station area beside the resident's paper chart rack unlocked and unattended accessible to all residents in the front of the building. During an interview 9.25.24 at 1:20 p.m. the Administrator indicated the facility referred to areas of the building as the front and the back with the back also known as the Chronic Confusion Dementing Illness (CCDI) unit. Additionally, she confirmed 30 residents resided in the front portion of the building. During an interview 9.23.24 at 1:35 p.m. Staff C, Certified Nursing Assistant (CNA) confirmed she observed unlocked, unattended med carts with the drawers left open including the narcotic drawer for any staff, visitors or residents to access. During an interview 9.23.24 at 2:06 p.m. Staff E, CNA confirmed she frequently observed unlocked and unattended medication carts.	F 689	1. In continuing compliance with F 689 Free of Accident Hazards/Supervision/Devices the facility corrected the deficiency by educating Staff B on 9/25/2024 and terminating employment with Staff B on 10/1/2024 and educating the DON on the 6 rights of medication and of locking all carts at all times on 10/1/2024. The facility will ensure correct medication administration for all residents. 2. To correct the deficiency and to ensure the problem does not recur all nursing and CMA staff were educated in medication administration and locking all carts at all times on 10/1/2024 by DON. The DON and/or designee will audit for compliance three times weekly for four weeks, two times weekly for four weeks then one time weekly for four weeks and then as needed to ensure continued compliance. 3. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	10/1/2024

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F 725	Continued From page 29	F 725		
F 725 SS=G	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 §483.71. §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 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 electronic health records (EHR), resident interview, staff interviews, and policy review the facility failed to provide nursing staff to assure residents safety by not completing visual observations, providing cares, or offering assistance to a resident that required assistance for 1 of 6 residents reviewed (Resident #9). The	F 725	1. In continuing compliance with F 725 Sufficient Nursing Staff the facility corrected the deficiency by educating and terminating employment with Staff B on resident rights, break policy, standards of care and abuse policy on 10/1/2024 for residents # 4 and 9 and all like residents. Staff C, E, L, M were educated by 10/1/2024 on resident rights, break policy, standards of care and abuse policy for resident #4 and 9 and all like residents. 2. To correct the deficiency and to ensure the problem does not recur, all staff were educated by 10/1/2024 by the Executive Director/DON of the resident rights, break policy, standards of care, call lights and abuse policy. The CNA staff were educated on 10/21/24 by the Executive Director of doing walking rounds at shift change and every two hours. The Executive Director and/or designee will audit for compliance three times weekly for four weeks, two times weekly for four weeks then one time weekly for four weeks and then as needed to ensure continued compliance. 3. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	10/21/2024

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facility reported a census of 45 residents.

Findings include:

1. The Minimum Data Set (MDS) dated 9/14/24 documented Resident #9 had a Brief Interview for Mental Status (BIMS) of 9 which indicated moderate cognitive impairment. MDS also documented maximal assistance with dressing and moderate assistance with toileting.

Progress Note dated 9/7/24 at 9:06AM for Resident#9 documented as follows by Staff B, Licensed Practical Nurse (LPN); Resident #9 was found on the floor with bloody tissues laid all around her, Resident #9 had a large purple bruise to the right side of the face (eye and eyebrow area). Resident #9 was dressed in blue jeans, blouse, shoes, and socks. Resident #9 was continent of bowel and bladder, resident indicated right hip pain when emergency medical transport staff tried to move Resident #9. The resident was able to move other extremities without pain.

Review of facility investigation dated 9/7/24 documented Resident #9 was last seen at 3:30 AM and was found at 8:30 AM on the floor. Resident #9 was admitted to the hospital for pain but no fracture was found. At approximately 8:36 AM Resident #9 was observed in her bedroom by Staff B on her floor. Resident #9 had blood on her forehead. Resident #9 was immediately sent to the hospital where the hospital performed diagnostic testing. The hospital ruled out any new or acute fractures or injuries, however, the hospital did admit Resident #9 for acute pain. On 9/7/24, at approximately 8:36 AM the Administrator was notified by Staff B, LPN, that

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Resident #9 was observed in the sitting position in her bedroom on her floor with blood on her forehead. The hospital notified Staff B, that Resident #9 was admitted as
inpatient for uncontrolled pain secondary to unwitnessed fall. At approximately 8:30 AM Staff B went into Resident #9's room to administer medications and ask her if she would like breakfast. Upon entry to Staff B observed Resident #9 sitting on the floor on her bottom with bloody tissues around her and a bruise on the right side of her face. Resident #9 stated to Staff B she had gone to turn off her lamp at her bedside table in the night and she fell and was unable to get up. Resident #9 was last observed by Staff K, Certified Nursing Assistant (CNA) at 3:30am on 9/7/24 resting quietly with eyes closed in bed. At approximately 8:40 AM Resident #9 was transported via ambulance to the hospital for treatment due to initial assessment indicated acute, new onset pain to right knee and right hip and limited range of motion to right knee and right hip. The hospital performed diagnostic testing including x-rays and a CT of head and spine. Results of completed x-rays and CT scans did not indicate any new or acute fracture or injury. Due to acute increase in reports of pain secondary to incident, Resident #9 was admitted to the hospital with a diagnosis of acute pain.

Review of document titled, Discharge Summary dated 9/10/24 for Resident #9 documented on 9/7/24 Resident #9 was evaluated in the emergency room after a fall at the long term care facility. Resident #9 reported getting up to shut off a lamp right before going to bed. Resident #9 reported the floor was recently waxed and was slippery. Resident #9 reported falling to her knees on the way back to bed and did hit her

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head. Resident #9 stated she yelled for help all night and nobody checked on her until the morning. Wound on the forehead was sutured in the emergency room on 9/7/24.

On 9/24/24 at 7:20 AM Resident #9 stated she had fallen at night when she had the injury to her head and was on the floor yelling for help for a long time before anyone came into the room. Resident #9 stated that she could not reach her call light. Resident #9 stated she received stitches as a result of the accident. Resident #9 stated she tried to clean up the blood but kept on bleeding. Resident #9 stated they did not check on her until she was found on the floor by Staff B in the morning.

On 9/24/24 at 7:50 AM Staff B, LPN stated she was the nurse that found Resident #9 on the floor. Staff B stated she came in at 6am on 9/7/24. Staff B stated she did not think the CNA's working that day did walking rounds and now CNA's have to sign off rounds were completed. Staff B stated she was taking am medications to Resident #9 was sitting next to her bed and had bloody tissues all around her. Staff B stated she was fully dressed in blue jeans. Staff B stated Resident #9 stated she was lying on the floor a good portion of the night. Staff B stated the blood on the tissues were still wet. Staff B stated Resident #9 stated she tried to go to the bathroom and then she fell. Staff B stated Resident #9 stated she yelled for quite some time but her voice is soft. Staff B stated the door was closed. Staff B stated there was a laceration on the left side of Resident #9's head. Staff B stated she immediately ran down and called 911. Staff B stated Resident #9 did have stitches for the

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laceration. Staff B stated the weekends are very short.

On 9/23/24 at 2:25 PM Staff L, Certified Nursing Assistant (CNA) stated she was working the 9/7/24 that Resident #9 was found on the floor. Staff L stated Staff B, LPN and Staff M, CNA were the staff that attended the fall. Staff L stated Staff M and her had gotten a majority of the residents up that morning. Staff L stated Staff B yelled down the hallway their names. Staff L stated when she entered the room she saw Resident #9 on the floor. Staff L stated there was a big pile of dried up bloody tissues by Resident #9. Staff L stated Resident #9 was located by her bed. Staff L stated Resident #9 was awake and alert. Staff L stated the call light was lying on top of the bed. Staff L stated she had not completed rounds, maybe Staff K, CNA completed rounds. Staff L stated Resident #9 was found about 8 am. Staff L stated rounds were supposed to be completed about 6 am when they entered the facility. Staff L stated she went out for a smoke break at 7am. Staff L stated at times all of the nursing staff was out smoking together. Staff L stated Saff M helped Resident #9 off the floor and at that time Resident #9 was complaining about leg, hip, or both pain. Staff L stated she asked Resident #9 if her head hurts and she said yes. Staff L stated Staff B called 911 and the ambulance took Resident #9 to the hospital.

On 9/24/24 at 1:53 PM Staff M, CNA stated she was familiar with Resident #9. Staff M stated she worked with Resident #9 the morning of 9/7/24. Staff M stated she walked into Resident #9's room with Staff B, LPN and found Resident #9 on the floor. Staff M stated there was blood on her

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head but was not bleeding very bad at all at that time. Staff M stated some of the blood was dry and some of the blood was wet and appeared with all the tissues that Resident #9 attempted to clean herself up. Staff M stated the call light was on her bed. Staff M stated she did not round on rooms that morning. Staff M stated she had not opened Resident #9's door or entered her room that day at all. Staff M stated Resident #9 was alert and not confused at all. Staff M stated Resident #9 stated she had been on the floor bleeding for a while. Staff M stated Resident #9 stated she fell at night and she had been yelling for help since. Staff M stated she did not hear Resident #9 yelling for help when she entered the room either. Staff M stated the facility was very short staffed and she works every Saturday and it is not enough staff with showers and the behaviors with most of the residents. Staff M stated the residents are not being properly cared for. Staff M stated some baths are completed in the afternoon.

On 9/24/24 at 11:40 AM the Director of Nursing (DON) stated a CNA had not entered Resident #9's room from 3:30 AM till 8:30 AM when the resident was found. The DON stated she did the fall scene investigation. The DON stated she expected rounds would have been completed around 4:30 AM and at shift change at 6:00 AM. Stated change of shift rounds were being completed starting after the fall but was because of a lot of things. The DON stated what the facility would like is hourly rounding. Stated the facility's expectation would be rounding every 2 hours. The DON stated she would like to staff at least one more CNA on dayshift. The DON stated she had seen all of the nursing staff go out for cigarette breaks together. The DON stated

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the Administrator was aware of the nursing staff all taking breaks together.

On 9/24/24 at 12:40 PM the Administrator stated she was familiar with the Resident #9. The Administrator stated there was no checks on Resident #9 between 3:30 AM and 8:30 AM the morning of the fall. The Administrator stated she would have absolutely expected an observation of the resident in-between these times. The Administrator stated the facility had implemented walking rounds to be completed with oncoming shifts. The Administrator stated she did not know how long Resident #9 had been on the floor in her room. The Administrator stated the blood was not dry. The Administrator stated she felt there was enough staff to provide appropriate care to the residents. The Administrator stated it had never been brought to her attention that all nursing staff is smoking at the same time.

On 9/25/24 at 9:04 AM the Administrator stated staffing levels are determined by acuity and budget. The Administrator stated she never feels like there is not enough in the budget for the acuity level at the facility. The Administrator stated the acuity level is determined by the level of assistance the resident requires and treatments the residents need. The Administrator stated she felt the facility does have enough staff to care for the residents appropriately. The Administrator stated she would like some more but it's really hard to find nurses or CNA's. The Administrator stated the facility has ads to try to get more staff at the facility. The Administrator stated there are not a lot of people applying. The Administrator stated the facility is in a rural area and makes it difficult. The Administrator stated the facility does not use agency. The

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Administrator stated the facility has enough staff so has not been an issue that had to be brought to the corporate level.

The Administrator acknowledged the facility had no policy that covered expectations on bed checks or rounds on residents.

Review of document titled, Residents Bill of Rights with review date of 11/16 documented The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and support for daily living safely.

Review of document titled, Employee Resource Guide revised 8/24 documented smoking by employees should be limited to designated break times and is allowed only in designated areas and never in the corridors, living rooms, residents ' /patients ' rooms, nurse's stations, kitchen, and storage areas or near any room where oxygen is stored or is being administered. This policy also extends to all tobacco products, e-cigarettes and vaping.

Review of undated document titled, Standards of personal Care documented overnight cares include routine rounds to assure safety; meet individual needs for those unable to sleep.

2. During an interview 9.24.24 at 10:24 a.m. Resident #4 indicated he timed his call light on for up to 30 minutes as he used the clock on the wall in his room. After he waited for a lengthy period of time he went to find staff for assistance. The resident felt the facility failed to provide adequate staffing to meet his individual needs.

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During an interview 9.23.24 at 1:35 p.m. Staff C, Certified Nurse Aide (CNA) confirmed she had not been able to answer resident call lights within 15 minutes when she dealt with an emergent situation.

During an interview 9.23.24 at 2:06 p.m. Staff E, CNA confirmed staff failed to answer resident call lights in a timely manner due to staffing issues.

During an interview 9.24.24 (time unknown) Staff F, Certified Nursing Assistant (CNA) confirmed she provided baths to the residents scheduled two (2) times a week however there had been times she had been pulled to work the floor as a CNA with provision of direct cares. The staff member indicated 15-16 resident baths/showers had been scheduled every day for an eight (8) hour shift. When scheduled to provide baths her other responsibilities included assistance with meals and laying residents down after meals which took a total of 2-3 hours out of her 8 hour day. The staff member indicated she knew staff failed to provide showers on Saturdays due to staffing.

During an interview 9.24.24 (time unknown) Staff F, CNA indicated the facility staffed two (2) CNA's to care for the residents who resided in the front of the building and half (1/2) of those residents required 2 staff assistance so that left the other residents unattended.

The facilities Standards of Personal Care (Minimum) policy (not dated) included the following:

a. Call lights placed within reach of the

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F 725	Continued From page 38 resident when n their rooms and answered promptly by staff.	F 725		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident interviews, and staff interviews the facility failed to be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility reported a census of 45 residents. Finding include: 1. The Minimum Data Set (MDS) dated 9/14/24 documented Resident #9 had a Brief Interview for Mental Status (BIMS) of 9 which indicated moderate cognitive impairment. MDS also documented maximal assistance with dressing and moderate assistance with toileting. On 9/24/24 at 7:20 AM Resident #9 stated she had fallen at night when she had the injury to her head and was on the floor yelling for help for a long time before anyone came into the room. Resident #9 stated that she could not reach her call light. Resident #9 stated she received stitches as a result of the accident. Resident #9 stated she tried to clean up the blood but kept on	F 835	1. In continuing compliance with F 835 Administration the facility corrected the deficiency by terminating employment with Staff B and G on 10/1/2024 for residents # 9 and 10 and all like residents. Executive Director was educated on 9/25/2024 on Nursing Facility Abuse Prevention, Identification, Investigation, and reporting policy by Regional Director of Operations for resident #9 and 10 and all like residents. 2. To correct the deficiency and to ensure the problem does not recur, all Administration staff were educated by 10/1/2024 by the Executive Director on maintain a professional and collaborative approach as to not interfere with the quality of care provided to residents. All staff were educated on 9/24/2024 of proper use of PPE/EBP by DON. All staff were educated on the grievance policy on 10/21/2024 by the Executive Director. The Executive Director and/or designee will audit for compliance three times weekly for four weeks, two times weekly for four weeks then one time weekly for four weeks and then as needed to ensure continued compliance. 3. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	10/21/2024

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F 835	Continued From page 39 bleeding. Resident #9 stated they did not check on her until she was found on the floor by Staff B in the morning. Review of Resident #9's EHR documented under the progress notes section documented by Staff B Resident #9 was found on the floor with bloody tissues laid all around her, Resident #9 had a large purple bruise to the right side of the face (eye and eyebrow area). Resident #9 was dressed in blue jeans, blouse, shoes, and socks. Resident #9 was continent of bowel and bladder, resident indicated right hip pain when emergency medical transport staff tried to move Resident #9 was able to move other extremities without pain. Review of facility investigation dated 9/7/24 documented Resident #9 was last seen at 3:30 AM and was found at 8:30 AM on the floor. Resident #9 was admitted to the hospital for pain but no fracture was found. At approximately 8:36 AM Resident #9 was observed in her bedroom by Staff B on her floor. Resident #9 had blood on her forehead. Resident #9 was immediately sent to the hospital where the hospital performed diagnostic testing. The hospital ruled out any new or acute fractures or injuries, however, the hospital did admit Resident #9 for acute pain. On 9/7/24, at approximately 8:36 AM the Administrator was notified by Staff B, Licensed Practical Nurse (LPN), that Resident #9 was observed in the sitting position in her bedroom on her floor with blood on her forehead. The hospital notified Staff B, that Resident #9 was admitted as inpatient for uncontrolled pain secondary to unwitnessed fall. At approximately 8:30 AM Staff B went into Resident #9's room to administer medications and ask her if she would like breakfast. Upon entry to Staff B observed	F 835		

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F 835	Continued From page 40 Resident #9 sitting on the floor on her bottom with bloody tissues around her and a bruise on the right side of her face. Resident #9 stated to Staff B she had gone to turn off her lamp at her bedside table in the night and she fell and was unable to get up. Resident #9 was last observed by Staff K, Certified Nursing Assistant (CNA) at 3:30 am on 9/7/24 resting quietly with eyes closed in bed. At approximately 8:40 AM Resident #9 was transported via ambulance to the hospital for treatment due to initial assessment indicated acute, new onset pain to right knee and right hip and limited range of motion to right knee and right hip. The hospital performed diagnostic testing including x-rays and a CT of head and spine. Results of completed x-rays and CT scans did not indicate any new or acute fracture or injury. Due to acute increase in reports of pain secondary to incident, Resident #9 was admitted to the hospital with a diagnosis of acute pain. On 9/23/24 at 2:25 PM Staff L, Certified Nursing Assistant (CNA) stated she was working the 9/7/24 that Resident #9 was found on the floor. Staff L stated Staff B and Staff M were the staff that attended the fall. Staff L stated she had not completed rounds, maybe Staff M completed rounds. Staff L stated Resident #9 was found about 8:00 am. Staff L stated rounds were supposed to be completed about 6 am when they entered the facility. Staff L stated she went out for a smoke break at 7 am. Staff L stated at times all of the nursing staff was out smoking together. On 9/24/24 at 1:53 PM Staff M, CNA stated there was never proper PPE available. Staff M stated there were gloves and N95 but no gowns or eye protection. Staff M stated she had been bringing	F 835		

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F 835	Continued From page 41 Resident #9 up for meals when the resident was Covid positive. Staff M stated the nurse said Resident #9 had to come out for breakfast even when Covid positive. Staff M stated she is not familiar with Enhanced Barrier Precautions (EBP). Staff M stated Friday or Saturday she was in-serviced on EBP with catheters. Staff M stated prior to inservice nobody used gowns in the room with residents that had catheters. Staff M stated she worked with Resident #9 the morning of 9/7/24. Staff M stated she walked into Resident #9's room with Staff B and found Resident #9 on the floor. Staff M stated there was blood on her head but was not bleeding very bad at all at that time. Staff M stated some of the blood was dry and some of the blood was wet and appeared with all the tissues that Resident #9 attempted to clean herself up. Staff M stated the call light was on her bed. Staff M stated she did not round on rooms that morning. Staff M stated she had not opened Resident #9's door or entered her room that day at all. Staff M stated Resident #9 was alert and not confused at all. Staff M stated Resident #9 stated she had been on the floor bleeding for a while. Staff M stated Resident #9 stated she fell at night and she had been yelling for help since. Staff M stated she did not hear Resident #9 yelling for help when she entered the room either. Staff M stated the facility was very short staffed and she works every Saturday and it is not enough staff with showers and the behaviors with most of the residents. Staff M stated the residents are not being properly cared for. Staff M stated some baths are completed in the afternoon. On 9/24/24 at 11:40 AM the DON stated a CNA had not entered Resident #9's room from 3:30 AM till 8:30 AM when the resident was found.	F 835		

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F 835	Continued From page 42 The DON stated she did the fall scene investigation. The Director of Nursing (DON) stated she expected rounds would have been completed around 4:30 AM and at shift change at 6:00 AM. Stated change of shift rounds were being completed starting after the fall but was because of a lot of things. The DON stated what the facility would like is hourly rounding. Stated the facility's expectation would be rounding every 2 hours. The DON stated she would like to staff at least one more CNA on dayshift. The DON stated she had seen all of the nursing staff go out for cigarette breaks together. The DON stated the Administrator was aware of the nursing staff all taking breaks together. On 9/24/24 at 12:40 PM the Administrator stated she was familiar with the Resident #9. The Administrator stated there was no checks on Resident #9 between 3:30 AM and 8:30 AM the morning of the fall. The Administrator stated she would have absolutely expected an observation of the resident in-between these times. The Administrator stated the facility has implemented walking rounds to be completed with oncoming shifts. The Administrator stated she did not know how long Resident #9 had been on the floor in her room. The Administrator stated the blood was not dry. The Administrator stated she felt there was enough staff to provide appropriate care to the residents. The Administrator stated it had never been brought to her attention that all nursing staff is smoking at the same time. 2. The Minimum Data Set (MDS) dated 7/9/24 documented Resident #10 had a Brief Interview for Mental Status (BIMS) of 15 which indicated no cognitive impairment.	F 835		

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Review of Resident #10's medication administration records documented a physician's order for Tramadol 50 mg to give one tab by mouth as needed for pain.

On 9/23/24 at 3:48 PM Resident #10 stated Staff G was the nurse 9/20/24 overnight to 9/21/24. Resident #10 stated Staff G brought her in medications on that overnight around 2:30 AM Resident #10 stated there were 2 pills in the medication cup and she asked Staff G if Tylenol was in the medication cup. Resident #10 stated when she takes Tramadol and Tylenol together in the middle of the night at times it keeps her awake. Resident #10 stated she told Staff G that she did not want both the Tramadol and Tylenol that is why she asks for them separately. Resident #10 stated Staff G then left her room. Resident #10 stated Staff I, Registered Nurse (RN) gave her just the Tramadol that she had requested around 3:00 AM about 30 minutes later.

On 9/24/24 at 11:40 AM DON stated Resident #10 told her that Staff G brought Resident #10 Tylenol and Tramadol together and that she did not want Tylenol. The DON stated she did not fill out a grievance form for Resident #10. The DON stated she went to the Administrator about it. The DON stated Staff G called and spoke to the Administrator about the situation and did not know what happened after that. The DON stated Staff #10 acknowledged she was rough with her words and said Staff G said that she told her that she had to take them or she was not coming back.

On 9/24/24 at 12:40 PM the Administrator stated Staff G had said something to her about Resident

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F 835	Continued From page 44 #10 was yelling at her about not wanting her Tylenol and Tramadol at the same time. The Administrator stated Staff G stated she she just stepped out for a little bit and was going to reproach Resident #10 later. The Administrator stated when Resident #10 rang her call light a little later the Staff I brought the Tramadol only down. The Administrator stated Staff G said that Resident #10 was screaming at her so she just had to step away. The Administrator stated Staff G said that Resident #10 was yelling and screaming and so that Staff G did not say anything appropriate she would be okay with the nurse stepping out. The Administrator stated she did not know how long it took Staff I to return to Resident #10's room with the medication. The Administrator stated she did not investigate this incident at all once Staff G brought it to her attention. The Administrator stated she did not discuss this incident with the DON. The Administrator stated corporate staff made observations of the staff wearing surgical masks instead of N95s. The Administrator stated Staff C told her that she had COPD and was allowed to wear just surgical masks when caring for Covid positive residents. The Administrator stated she did not require physician documentation of COPD. The Administrator stated the facility was in crisis mode and positive staff were required to work the floor as long as they were symptom free positive for Covid. The Administrator stated there was a grievance brought to her about Staff C cursing and that staff member was disciplined. The Administrator stated it has never been brought to her attention that all nursing staff is smoking at the same time. The Administrator stated she looks at all the grievances and did not destroy any grievances brought to her.	F 835		

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F 835	Continued From page 45 On 9/25/24 at 1:00 PM Staff G, Licensed Practical Nurse (LPN) / Assistant Director of Nursing (ADON) / Infection Preventionist (IP) stated Staff J asked about the gowns being available and she was told there was gowns on the back of doors. Staff G stated she had seen staff working with residents that were positive with no gowns or eye protection. Staff G stated she reinserviced every time she observed staff not wearing gowns or eye protection. Staff G stated there were no disciplinary actions as a result of noncompliance of wearing PPE. Staff G stated all the disciplinary actions came from the Administrator. Staff G stated she had obtained her IP certificate and she had not been shown how to use the program that tracks the trends of antibiotic use and infections. Staff G stated she just obtained her IP certificate and has not completed any audits during her time as infection Preventionist. Staff G stated it has been brought to her attention that all of the nursing staff is going outside to smoke and the staff have been talked to about this numerous times. Staff G stated she had brought this to the Administrator's attention. Staff G stated no change was seen and the CNA's continue to do this because it is certain CNA's that the Administrator does not want to upset. Staff G stated her professional relationship with the DON is not good. Staff G stated she has known the DON for 25 years, started working in February, and it has not been fun. Staff G stated the Administrator was very aware and Human Resources(HR) was as well because she emailed them about the issue. Staff G stated to get back at her the Administrator would go after her daughter who worked there as a CNA. Staff G stated the facility does not have restorative. Staff G stated there were several residents that could benefit from restorative care	F 835		

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that do not receive it. Staff G stated there was not enough staff to have restorative at this time. Staff G stated most of the time there was enough staff to care for the residents appropriately. Staff G stated she had been required to work so many hours on night shift she does not feel like she can complete her infection prevention job appropriately. Staff G stated there are certain CNA's that cuss all the time and Staff C was recently written up for it. Staff G stated Staff E, CNA and Staff J CNA sit out and cuss at the nursing station and cuss while the residents were present.

On 9/27/24 at 11:22 AM the Administrator stated Staff G, LPN was the Infection Preventionist (IP), and she was logging the infections on a log. The Administrator stated the log was kept on paper. The Administrator stated this log should have been plugged into the computer program the facility utilized. The Administrator stated Staff G gave the log to the DON who then plugged them in. The Administrator acknowledged that Staff G did not have access to the computer program and they are in the process of switching systems. The Administrator stated Staff G and the DON's working relationship was rocky. The Administrator stated when necessary the 2 talk to each other. The Administrator stated she would not say the DON and Staff G like each other. The Administrator acknowledged that Staff G had been in the IP position since 2/19/24. The Administrator stated the DON was in charge of the training needed to run the computer program for tracking trends, antibiotics use, and infections. The Administrator stated the DON had been tracking these. The Administrator stated when the DON saw trends she completed audits. The

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F 835	Continued From page 47 Administrator stated when the covid outbreak started August 26 2024 a trend was noticed that the outbreak started back in the CCDI unit. The Administrator stated would have expected more audits on personal protective equipment (PPE) use and hand washing. The Administrator stated those audits were not completed that she was aware of. The Administrator acknowledged Staff G was working most night shifts during the Covid outbreak and the DON had Covid. The Administrator stated the MDS and herself should have completed audits based on the trends. The Administrator recognized Staff G had worked a lot of overnights but feels that she should be able to complete IP work as well as nursing duties when working overnights. The Administrator stated Staff G had not shared any concerns with inability to complete IP work or having access to the computer program that tracks trends, infections and antibiotic use. The Administrator stated she has tried in the last month or so to have Staff G connect with the nurse specialist to be trained but always seemed to have to work overnights when training was available. The Administrator stated there was enough staff but it was a matter of the staff showing up to work. The Administrator stated after survey team had talked to the administration they developed a grievance for Resident #10 related to the PRN pain medication incident with Staff G. The Administrator stated the administration is working on education or discipline being given to Staff G and was waiting for HR to approve. The Administrator acknowledged the investigation of this incident should have occurred earlier. The Administrator stated she thought Staff G was reporting Resident #10 was having a behavior and it did not occur to her the issue with pain medication administration. The Administrator stated there	F 835		

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F 835	Continued From page 48 was always someone on the floor from nursing. The Administrator stated she never saw the staff all go out to smoke together. The Administrator stated just did education with staff that only one person can be out smoking at a time. The Administrator stated the education was completed 9/25/24. The Administrator stated there was a resident family call and a grievance was made about all nursing staff smoking outside at one time. The Administrator stated no one on management staff had not reported to her that staff were smoking outside together and no nursing staff was on the floor. The Administrator stated with regards to restorative management was talking about that this morning. The Administrator stated restorative was part of the CNA's tasks and if it is red then they did not complete their POC charting. The Administrator stated the DON was in charge of reviewing that every day. The Administrator stated the DON had not reported any missed restorative. The Administrator stated management had talked to staff and have explained that when the staff are dressing the residents they are moving their arms for ROM. The Administrator stated she feels like the administration was still learning each other. The Administrator stated all of the administration is fairly new and learning what works and what doesn't. The Administrator stated the administration does not know each other well enough as a team yet. The Administrator stated they had not figured out what needs to be worked on. The Administrator stated she felt like administration needs to be better for sure. The Administrator stated she did not know that Staff G having access to the program that tracked trends, infections and antibiotic use would have affected the outcome of residents who develop Covid. The Administrator stated management failed with	F 835		

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F 835	Continued From page 49	F 835		

the Covid outbreak in education to the staff, monitoring outbreak, and identifying concerns with PPE use. The Administrator stated she had really worked on team building and has been trying everything she can think of and feels she was losing a battle. The Administrator stated there was a divide among management, she knows it affects the residents, and she is trying to make it better for them.

On 9/24/24 at 7:50 AM Staff B, Licensed Practical Nurse (LPN) stated surveyors should be looking at management. Staff B stated staff report things to the management and management did nothing. Staff B stated at times management leaves and dumps everything on the floor nurse. Staff B stated if you complain you will be written up.

Review of the facility's survey results binder revealed the following repeated deficiencies at the facility from 5/17/22 - 9/30/24. 5/17/22 - 550 and 880, 3/30/23 - 550 and 725, 2/26/24 - 725 and 880, 6/24/24 - 550, and 9/30/24 - 550, 725, and 880.

Review of document titled, Job Description: Assistant Director of Nursing (ADON) dated 11/16/23 documented the primary purpose of your job position is to provide support to the Director of Nursing (DON) and overall management and operation of nursing services while providing superb leadership to the nursing staff and drive the overall success of the facility. The essential job functions are to follow the leadership of the DON to plan, develop, organize, implement, evaluate, and direct the nursing service department, as well as its programs and activities, in accordance with current rules,

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F 835	Continued From page 50 regulations, and guidelines that govern the skilled nursing and long-term care facility. Assist with hiring, training, and development of the nursing staff. Manage clinical operations and develop care plans. Assist with the preparation of the nursing staff schedule and shift assignments. Ensure that the nursing staff follows departmental procedures and policies. Assist as needed with budget preparation and expense management. Conduct resident rounds. Ensure compliance with resident and employee records for compliance and accuracy. Meet with nursing personnel as scheduled to assist in identifying and correcting problems and/or improvement of services. On-call duties as required. Overtime may be required. Essential functions of this position must be performed in person. Review of document titled, Job Description: Director of Nursing (DON) dated 11/15/23 documented the primary purpose of your job position is to plan, organize, develop, and direct the overall operation of our nursing service department in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be directed by the Executive Director to ensure that the highest degree of quality care is maintained at all times. The essential job functions Plan, develop, organize, implement, evaluate, and direct the nursing service department, as well as its programs and activities, in accordance with current rules, regulations, and guidelines that govern the skilled nursing and long-term care facility. Develop, maintain, and periodically update written policies and procedures that govern the day-to-day functions of the nursing service department. Develop and implement a nursing service organization structure. Make	F 835		

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F 835	Continued From page 51 written, oral reports and recommendations to the Executive Director, as necessary, concerning the operation of the nursing service department. Develop methods for coordination of nursing services with other resident services to ensure the continuity of the residents' total regimen of care. Develop, implement, and maintain an ongoing quality assurance program for the nursing service department. Participate in facility surveys (inspections) made by authorized government agencies. Assist the Quality Assessment & Assurance Committee in developing and implementing appropriate plans of action to correct identified deficiencies. Assist social services and discharge planning in developing, implementing and periodically updating the written procedures for the discharge planning program. Assist the resident and discharge planning coordinator in planning the nursing services portion of the resident's discharge plan. Perform administrative duties such as completing medical forms, reports, evaluations, studies, charting, etc., as necessary. Audit documentation for errors or inconsistencies and make necessary changes to prevent further errors. Determine the staffing needs of the nursing service department necessary to meet the total nursing needs of the residents. Recommend the number and level of nursing personnel to be employed. Direct the hiring and onboarding for clinical personnel. Assign a sufficient number of clinical personnel to ensure that quality care is maintained. Ensure that all nurse aide trainees are under the direct supervision of a licensed nurse. Develop work assignments and schedule duty hours, and/or assist nursing supervisory staff in completing and performing such tasks. Delegate to nursing service supervisory personnel the administrative	F 835		

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F 835	Continued From page 52 authority, responsibility, and accountability necessary to perform their assigned duties. Make routine rounds of the nursing service department to ensure that all nursing service personnel are performing their work assignments in accordance with acceptable nursing standards. Monitor absenteeism/tardiness to ensure that an adequate number of nursing care personnel are on duty at all times. Develop, maintain, and periodically update the written procedure for ensuring that professional nursing personnel have valid and current licenses as required by this State. Review complaints and grievances made or filed by department personnel. Provide complaint/grievance reports to the Administrator as required or as may be necessary. Ensure that departmental disciplinary action is administered fairly and without regard to race, color, creed, national origin, age, sex, religion, handicap, or marital status. Assist the Quality Assurance - Infection Preventionist or designated nurse in establishing a TB management program for employees. Report occupational exposures to blood, body fluids, infectious materials, and hazardous chemicals in accordance with the facility's policies and procedures governing accidents and incidents. Ensure that all CNA's credentials are verified through the applicable state registry. Ensure that appropriate adverse personnel actions relative to CNA's employment criteria are reported to the applicable state registry. Conduct employee performance evaluations, counseling, and discipline as needed but no less than yearly to ensure quality care for residents and equal opportunities for all employees of the nursing department. Meet with nursing personnel as scheduled to assist in identifying and correcting problems and/or improvement of services. On-call duties as	F 835		

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F 835	Continued From page 53 required. Overtime may be required. Essential functions of this position must be performed in person. Review of document titled, Job Description: Executive Director - LNHA (Administrator) dated 11/15/23 documented the Executive Director - Licensed Nursing Home Administrator (LNHA) directs the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines and regulations that govern assisted living facilities to assure that the highest degree of quality care can be always provided to our residents. Follow all established policies and procedures to include nursing care procedures, safety regulations, human resources policies, departmental policies, and procedures to assure that quality resident care and an effective operation can be maintained. Responsible for developing and driving occupancy growth and engagement of the assisted living community, including external marketing and overall customer satisfaction. Essential job functions are to lead all department leadership and operations in achieving the company mission, vision, values, goals, and objectives. Lead the facility management staff and consultants in developing and working from a business plan that focuses on all aspects of facility operations, including setting priorities and job assignments. Lead facility QA committee and ensure compliance with regulations for state of operation. Monitor each activity, communicate policies, evaluate performance, provide feedback, assist, and observe, coach and discipline as needed. Develop an environment that allows for creative thinking, problem solving, and empowerment in the development of the facility management	F 835		

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F 835	Continued From page 54 team. Oversee and conduct regular rounds to monitor delivery of nursing care, operation of support departments, cleanliness and appearance of the facility, morale of the staff, and ensure resident and tenant needs are being addressed. Exhibit positive customer service both to internal and external customers through the ongoing support and implementation of customer service initiatives and business objectives. Utilize survey information to address areas of importance as defined by customers. Ensure consultants and other support resources are appropriately utilized, all staff is appropriately trained, and a high level of interdepartmental teamwork is maintained. Ensure the building and grounds are appropriately maintained and that equipment and work areas are clean, safe, and orderly, and any hazardous conditions are timely addressed. Monitor Human Resources to ensure compliance with employment laws, company policies, and to ensure practices maintain high morale and staff retention, including effective communication, prompt problem resolution, and a proactive work environment. Develop positive relationships on behalf of the company with government regulators, residents, tenants, families, area healthcare providers, physicians, and the community. Manage facility budgets and business practices to include labor costs, payables, and receivables. Ensure a marketing strategy for the facility is developed and implemented that reflects service opportunities, completion, potential market area changes, and maximizes census, payer mix, and ancillary revenues. Knowledge and adherence to safety / disaster preparedness plan. In-person attendance is an essential function of this position. All other duties as needed.	F 835		

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F 842 F 842 SS=E	Continued From page 55 Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners,	F 842 F 842	1. In continuing compliance with F 842 Resident Records-Identifiable Information, Accura Healthcare of Pleasantville corrected the deficiency by educating and terminating employment with Staff B and G on medication administration by 10/1/2024 for residents #10 and all like residents. Staff H was educated on 9/30/2024 on standards of care by DON to ensure resident #20 and all like residents receive appropriate incontinence care. 2. To correct the deficiency and to ensure the problem does not recur, all nurses and CMAs were educated by 10/1/2024 by the DON on medication administration. All CNAs were educated by DON by 10/1/2024 on standards of care. The DON and/or designee will audit for compliance three times weekly for four weeks, two times weekly for four weeks then one time weekly for four weeks and then as needed to ensure continued compliance. 3. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Executive Director/DON and/or designee will report identified concerns through the community's QA Process.	10/1/2024

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F 842	Continued From page 56 medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on electronic health records (EHR) review, personnel file review, observations, resident interview, staff interview, and policy review the facility failed to provide complete and accurately documented electronic health records for 2 of 5 residents (Residents #10, and #20) reviewed. The facility reported a census of 45 residents.	F 842		

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Findings include:

1. Review of Resident #20's MDS dated 9/16/24 revealed an admission date of 9/16/24 from another nursing home.

Review of Resident #20's Care Plan with a revision date of 9/17/24 revealed that Resident #20 is at risk for skin breakdown related to incontinence.

During continuous observation 9/24/24 from 12:10 PM to 2:53 PM Resident #20 was getting up from the lunch table and was observed to have a large wet area to the back of the Residents pants. Staff H, Certified Nurse Assistant (CNA) was observed to have her hand on the wet spot on Resident #20's back when the transfer occurred. Resident #20 was transferred with an assist of one with a gait belt by Staff H CNA to the living room couch to lay down. Staff H then hand sanitized and left Resident #20 on the couch laid down with a wet spot on His back.

Review of the Electronic Health Record (EHR) page titled tasks revealed 9/24/24 at 1:42 PM Staff H documented that Resident #20 was incontinent of urine.

Interview 9/24/24 at 2:53 PM Staff H revealed residents should be checked, changed, and repositioned every hour or so, and at most every two hours. Staff H further confirmed that She had charted that Resident #20 was incontinent at 1:42 pm without checking him, and thought another staff member had taken the resident to the bathroom. Resident #20 was noted to have a large wet area down the left side of his clothing at this time.

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Interview 9/24/24 at 4:00 PM with the Director of Nursing (DON) revealed She would expect correct and accurate documentation.

Review of a personnel file for Staff B, Licensed Practical Nurse (LPN) revealed a document titled Employee corrective action form dated 4/30/24 that Staff B had signed the Treatment Activity Record (TAR) for a Resident indicating she had removed this Resident's sutures from his left eyebrow. This document further revealed that the DON was rounding the next day and noted that this Resident still had the sutures in place and that they were not removed.

2. The Minimum Data Set (MDS) dated 7/9/24 documented Resident #10 had a Brief Interview for Mental Status (BIMS) of 15 which indicated no cognitive impairment.

Review of Resident #10's medication administration records documented a physician's order for Tramadol 50 mg to give one tab by mouth as needed for pain.

Review of Resident #10's medication administration records for 9/21/24 documented Staff G, LPN signed off administration of medication at 3:00 AM.

On 9/23/24 at 3:48 PM Resident #10 stated Staff G was the nurse 9/20/24 overnight to 9/21/24. Resident #10 stated Staff G brought her in medications on that overnight around 2:30 AM Resident #10 stated there were 2 pills in the medication cup and she asked Staff G if Tylenol

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was in the medication cup. Resident #10 stated when she takes Tramadol and Tylenol together in the middle of the night at times it keeps her awake. Resident #10 stated she told Staff G that she did not want both the Tramadol and Tylenol that is why she asks for them separately. Resident #10 stated Staff G then left her room. Resident #10 stated Staff I, Registered Nurse (RN) gave her just the Tramadol that she had requested around 3:00 AM about 30 minutes later.

Review of document titled, Daily Staff Schedule Sheet dated 9/20/24 for shift 10:00 PM - 6:00 AM revealed Staff G as the front of the house nurse orienting Staff I.

On 9/24/24 at 11:40 AM the Director of Nursing (DON) stated Resident #10 told her on the overnight 9/20/24 - 9/21/24 that Staff G brought Resident #10 Tylenol and Tramadol together and that she did not want Tylenol.

On 9/25/24 at 2:15 PM the DON stated stated if Resident #10 did not take the medication at that time to reproach with Staff I and have Staff I sign administration of medication when it was given. The DON stated after the medication is administered to the resident that is when the staff was supposed to sign the MAR.

On 9/25/24 at 1:00 PM Staff G, Licensed Practical Nurse (LPN) / Assistant Director of Nursing (ADON) / Infection Preventionist (IP) stated she was orienting Staff I to the overnight shift. Staff G stated she took the Tramadol and Tylenol to Resident #10 and when entered the room Resident #10 requested to see the medication. Staff G stated she told Resident #10

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F 842	Continued From page 60	F 842		

that when she calmed down she would bring the medication back to her. Staff G stated she returned to the nurses station and asked Staff I to take the medication to Resident #10. Staff G acknowledged that she signed in the MAR administration of Tramadol at 3:00 AM. Staff G stated she did not remember why she documented she gave the Tramadol instead of Staff I. Staff G acknowledged that she did not administer the Tramadol to Resident #10 that Staff I did.

On 9/25/24 at 3:25 PM Staff I, RN stated she is familiar with Resident #10. Staff I stated she was orienting on the front of the house by Staff G, LPN on the overnight of 9/20/24 - 9/21/24 Staff I stated Staff G ended up not giving Resident #10 the PRN medication. Staff I stated she did return to the resident and administered the Tramadol alone. Staff I stated she returned to give Resident #10 the Tramadol by itself. Staff stated she did not remember if she signed off the medication when it was administered but if she gave it she should have. Staff I stated she did not remember if she actually administered the medication. Staff I stated she did not remember that night at all. Staff I stated she did not remember if she had given the medication or not.

On 9/25/24 at 2:15 PM the DON stated it was not her or the facility's expectation that 2 PRN pain medication would not be administered without request from the resident. The DON stated if Resident #10 did not take the medication at that time. The DON acknowledged Resident #10 was reapproached by Staff I. The DON acknowledged that Staff I should have signed the Tramadol off on the Medication Administration Record (MAR) when it was given. The DON

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F 842	Continued From page 61 stated the MAR should be signed off after the medication was administered. On 9/24/24 at 12:40 PM the Administrator stated Staff G had said something to her about Resident #10 was yelling at her about not wanting her Tylenol and Tramadol at the same time. The Administrator stated Staff G stated she she just stepped out for a little bit and was going to reproach Resident #10 later. The Administrator stated when Resident #10 rang her call light a little later the Staff I brought the Tramadol only down. Review of undated document titled, Medication Administration Procedures documented staff was to explain to the resident the type of medication being administered. After administration, return to cart and document administration in MAR. If a resident refuses medication, document refusal on MAR. Once removed from the package or container, unused doses should be disposed of according to facility policy.	F 842		
F 880 SS=K	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880	1. In continuing compliance with F 880 Infection Prevention and Control, Accura Healthcare of Pleasantville corrected the deficiency by educating and later terminating employment with Staff G on Infection Control policy and her responsibilities as Infection Preventionist by 10/1/2024. Staff J, L, F, and H were educated by DON on 9/24/2024 on proper PPE use and EBP. The Executive Director and DON were educated on 9/25/2024 on Infection Control Manual by Regional Nurse Specialist. The facility will ensure that infection control guidelines are followed for resident #16 and all like residents. 2. To correct the deficiency and to ensure the problem does not recur, all staff were educated by 9/24/2024 by the Executive Director on where PPE was located, staff responsibility to read isolation signs and understand different types of isolation precautions. All staff have been educated on hand washing, donning and doffing of PPE, and EBP precautions by DON by 10/1/2024 or next shift. The DON and/or designee will audit for compliance three times weekly for four weeks, two times weekly for four weeks then one time weekly for four weeks and then as needed to ensure continued compliance. 3. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Executive Director/DON and/or designee will report identified concerns through the community's QA Process.	10/1/2024

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a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

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F 880	Continued From page 63 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, observations, and policy review the facility failed to provide a safe environment to prevent the development and transmission of communicable diseases and infections by not appropriately wearing Personal Protective Equipment (PPE) and the facility not making PPE available to wear while caring for all Covid 19 residents at the facility leading to Resident #16 becoming positive for Covid 19. Resident #16 was transferred to the hospital related to shortness of breath with oxygen levels of 89 percent on 6 liters (L) of oxygen requesting to be sent to the ED. Resident #16 tested positive for Covid 19 on 9/6/24. Resident #16 had a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) as well as Congestive Heart Failure (CHF). Staff reported not having eye protection or gowns available until 9/23/24. Staff acknowledged appropriate PPE was not worn during Covid 19 outbreak at the facility. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of August	F 880		

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26, 2024 on September 24, 2024 at 4:50 p.m.. The facility staff removed the IJ on September 25, 2024 through the following actions:

On 9/24/2024, all facility staff were educated or will be educated by next shift on the appropriate use of personal protective equipment in the facility. All residents on isolation have isolation carts stocked and available.

On 9/24/2024, competencies were completed with all staff currently at the facility. All staff not present will have competencies completed prior to their next shift.

The facility initiated on-going audits of isolation and personal protective equipment three times weekly on 9/24/2024. There have been no issues identified through these audits.

Any concerns will be reported to the administrator immediately and addressed in facility QA.

The facility did correct the deficiency surveyors ensured the facility implemented education and their policy and procedures. The facility was in compliance at that time.

The facility identified a census of 45 residents.

The scope lowered from "K" to "E" at the time of the survey after ensuring the facility implemented the education, auditsand their policy and procedures.

Findings include:

Review of document titled Resident Covid Positive documented 26 out of 45 residents

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tested positive for Covid 19 infection between 8/26/24 - 9/15/24.

1. The Minimum Data Set (MDS) dated 9/14/24 documented Resident #9 had a Brief Interview for Mental Status (BIMS) of 9 which indicated moderate cognitive impairment.

Progress Note dated 9/15/24 at 3:48 PM documented that Resident#9 tested positive for Covid.

On 9/23/24 at 1:54 PM Staff J, Certified Nursing Assistant (CNA) stated Resident #9 did not have drawers or personal protective equipment (PPE) at the end of the hall near her room. Staff J stated Resident #9 was coming out for meals until 9/22/24. Staff J stated the day that she tested positive she questioned the DON about what the staff were wearing and the DON stated only N95's.

On 9/24/24 at 7:30 AM Staff N, Occupational therapist stated she had worked with Resident #9. Staff N stated would not have known Resident #9 was Covid positive unless she did not look at the Resident #9's electronic health records (EHR). Staff N stated there was no sign for isolation precautions until surveyors entered on 9/22/24 gowns and eye protection were unavailable. Staff N stated N95 masks were present about 3 weeks ago. Staff N stated if there were signs they were very inconsistent. Staff N stated the only way staff knew for sure about Covid dx was to look in the resident's EHR. Staff N stated the first concern was reported to the administration last week with Resident #9.

On 9/24/24 at 11:20 AM Staff F, CNA stated

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Resident #9 isolated only one day last week, maybe 9/20/24 for breakfast. Staff F stated Resident #9 was out for lunch that day though. Staff F stated the nurse told the CNA's that Resident #9 needed to be out for meals. Staff F stated Resident #9 was out for meals on all days but that 9/20/24 for breakfast. Staff F stated Resident #9 was symptomatic the whole time with a moist cough.

On 9/24/24 at 1:53 PM Staff M, CNA stated she had brought Resident #9 up for meals when the resident was Covid positive. Staff M stated the nurse said Resident #9 had to come out for breakfast even when Covid positive.

2. The Minimum Data Set (MDS) dated 8/2/24 documented Resident #12 had a Brief Interview for Mental Status (BIMS) of 9 which indicated moderate cognitive impairment. MDS also documented Resident #12 utilized a catheter.

Review of Resident #12's medication administration record (MAR) documented a physician's order for catheter change with 18 french instill 10 cc in balloon.

On 9/23/24 at 5:07 PM an observation was made outside of room #14 Resident #12's room. Observation revealed garbage was removed from the room by Staff J, CNA and Staff L, CNA were exiting the room with garbage. Observation revealed no gowns in the garbage bag. Upon entering the room, observation of no gowns in the room's garbage.

On 9/23/24 at 5:12 PM Resident #12 stated the staff just currently provided personal care to her,

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F 880	Continued From page 67 and did not wear any gowns. On 9/24/24 at 11:15 AM Resident #12 stated the staff frequently do not wear gowns when emptying her catheter. On 9/24/24 at 11:20 AM Staff F, CNA stated other staff frequently do care on Resident #12 without gowns. Staff F stated she had completed catheter cares for Resident #12 without a gown on. On 9/24/24 at 11:30 AM Staff J, CNA stated staff do not wear gowns with catheter cares. Staff J stated staff were supposed to wear gowns when completing care with feeding tubes or catheters. Staff J Stated staff rarely wear gowns when working with catheters. Staff J stated staff do not wear gowns when the gowns were unavailable to be worn. Staff J stated gowns were made available on 9/23/24. 3. The Minimum Data Set (MDS) dated 8/11/24 documented Resident #16 had a Brief Interview for Mental Status (BIMS) of 15 which indicated no cognitive impairment. MDS also documented use of oxygen, and diagnosis of COPD. Review of Resident #16's EHR on 9/6/24 Staff P, MDS Coordinator documented Resident with complaints of being more short of breath and not feeling well his chest feels heavier and congested, COVID tested- test came back positive, VS 124/78, 88, 98.0, 91% on 6L, 20 called on call provider and physician gave the following verbal orders: Doxycycline 100 milligrams (mg) twice a day (BID) x 7 days, Decadron 6 mg daily for 6 days, Paxlovid 300 mg	F 880		

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F 880	Continued From page 68 BID for 5 days. Obtain a chest x-ray on 9/7/24. Resident #16 was aware. Review of Resident #16's electronic health records (EHR) Staff B, LPN documented on 9/10/24 at 11:41AM resident was having a hard time catching his breath with oxygen level 89% on 6 liters via nasal cannula. Resident was wheezing with a temp of 98.7. Resident stated he wanted to be seen at the emergency room. Physician gave an order to send Resident #16 via ambulance to the emergency room for evaluation and treatment. On 9/24/24 at 7:50 AM Staff B, Licensed Practical Nurse (LPN) stated Resident #16 was on 6 L and had COPD. Staff B stated she could not get Resident #16's oxygen saturation above 89% on 6L. Staff B stated Resident #16 was very scared and that is why he was sent out to the emergency room. On 9/24/24 at 11:40 AM the DON stated Resident #16 was Covid positive when he was sent to the emergency room. The DON stated Resident #16's primary complaint when sent out was shortness of breath. The DON stated Resident #16 was wheezing and wanted to be seen in the emergency room. The DON acknowledged Resident #16 remained in his room a lot. The DON stated professionally if the gown and eye protection was worn appropriately may have stopped Resident #16 from contacting Covid. The DON stated she was very skeptical as to the effectiveness of proper personal protective equipment (PPE) utilization in preventing the transmission of the Covid virus. The DON stated she would expect that appropriate PPE would be	F 880		

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worn when completing care on anyone with enhanced barrier precaution (EBP).

On 9/23/24 at 11:20 AM Staff O, Life Enrichment Director stated she did not see people wearing gowns appropriately with the Covid outbreak. Staff O stated Staff B was told she had to work while positive with Covid. Staff O stated Staff E, Staff J, Staff L, and Staff M were told they had to work Covid positive. Staff O stated when she bought it up in the meeting she was told that the staff were essential. Staff O stated a couple weeks ago corporate was at the facility. Staff O stated the cooperate gal was upset because there were no N95 masks and had witnessed a nurse giving a test to resident, after resident, after resident with no mask no gown no gloves.

On 9/23/24 at 1:54 PM Staff J, CNA stated she caught Covid recently about 2 weeks ago. Staff J stated she was tested at the facility related to the outbreak. Staff J stated she was told to apply an N95 and keep on working. Staff J stated she was feeling fine and the Staff B tested positive as well. Staff J stated both of them worked with N95's on and kept working. Staff J stated staff was testing positive and just kept working. Staff J stated the facility did not always have N95's available. Staff J stated the facility was out of N95's. Staff J stated the N95's were in the basement or the garage. Staff J stated they did not isolate residents during the outbreak. Staff J stated there were no gown or eye shield available and they were not worn during the whole outbreak. Staff J stated the DON only wore a surgical mask when she was positive with Covid.

On 9/23/24 at 2:25 PM Staff L, CNA Stated she

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F 880	Continued From page 70 and Staff C,CNA brought concerns to the Administrator about not having N95, gowns, and eye protection. Staff L stated she did not even know they had them available until 9/22/24. Staff L stated she had cared for Covid positive residents. Staff L stated residents were not isolated when they were Covid positive. On 9/24/24 at 7:50 AM Staff B, LPN stated when she had Covid she called in one day because she was horribly sick and had the next day off. Staff B stated the ADON stated she was going to have to work with symptoms and positive for Covid. Staff B stated in other departments the facility put staff off for 5 days. Staff B stated she was symptomatic when she was required to work. Staff B stated other staff had been required to work while positive with Covid as well. Staff B stated she brought her own N95. Staff B stated the facility had no gowns or eye protection provided until the survey team entered on 9/22/24. Staff B stated the facility did have gowns at one time but they were not available or utilized during the Covid outbreak. Staff B stated the lack of masks, gowns, and eye protection was brought to the management. Staff B stated the management told her they could just wear surgical masks. On 9/24/24 at 11:20 AM Staff F, CNA stated there were times when staff did not have gowns. Staff F stated there were no face shields available. Staff F stated this outbreak was not taken seriously at all. Staff F stated she had not worn gowns or face shields and no one wore PPE appropriately during the Covid outbreak. Staff F stated the Covid outbreak started in the back and came up to the front of the facility. Staff F stated she asked about going back and forth between	F 880		

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the units. Staff F stated she did not know what EBP was. Staff F stated if the resident has a catheter or any infectious disease they were supposed to be worn. Staff F stated she would wear gowns if they were available. Staff F stated staff had to grab gowns from another room. Staff F stated the facility did not have gloves and masks in the hangers in the rooms on the back of the door. Staff F stated for a good portion of the Covid outbreak there were no gowns available. Staff F stated she told the ADON there were no gowns.

On 9/24/24 at 11:40 AM the DON stated when Covid hit the facility she was one of the first that caught the virus. The DON stated she was off for a few days. The DON stated gowns were not being utilized for Covid and the facility did not have any eye protection. The DON stated N95 were available. The DON stated she brought N95's and gowns up from the basement. The DON stated she did not think that PPE was available before she brought it up from the basement. The DON stated there were boxes out on the station so they were available. The DON stated when staff call in and are sick if the staff were symptom free the staff were allowed to wear N95 and work. The DON stated she did see a concern with staff not wearing gowns or eye protection and entering rooms with Covid positive residents. The DON stated she could not answer why the staff didn't not wear appropriate PPE. The DON stated gowns were not available and had to get a few from another facility. The DON stated she reached out to another facility on 9/23/24 to get gowns the day that State entered the facility. The DON stated there were only gowns available in the rooms with the residents that had EBP. The DON stated #9 was positive

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F 880	Continued From page 72 on the 15th of September. The DON stated she found out after the fact that the staff were bringing Resident #9 out to the meals and the CNA's told her that she had been coming out to meals. The DON stated she did have a concern with Resident #9 being brought out to meals. The DON stated staff would have to help Resident #9 get to her wheelchair and Resident #9 would not have come to the dining room by herself. On 9/24/24 at 12:40 PM the Administrator stated there was PPE available for staff. The Administrator stated there were N95, gowns, gloves, and eye protection available. The Administrator stated the facility did recommend that everyone Covid positive would be isolated. The Administrator stated the facility tried making a table in a room that was just for Covid positive residents. The Administrator stated staff were told to isolate the residents who were positive. The Administrator stated she had witnessed Resident #9 in the dining room while she was Covid positive. The Administrator stated staff never brought it to her attention that they were out of gowns. The Administrator stated staff never brought it to her attention there was no eye protection available. The Administrator stated no one went to get gowns from another facility on 9/23/24. The Administrator stated gowns were obtained because the gowns were the gowns that the staff liked. The Administrator stated she had not made any observations of staff entering rooms without gowns on. The Administrator stated staff are probably supposed to wear gowns if the resident had EBP. The Administrator stated she is not the most up to date about EBP. The Administrator stated the corporation made observations of the staff wearing surgical masks	F 880		

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instead of N95's. The Administrator stated staff with COPD were allowed to wear just surgical masks. The Administrator stated she did not require physician documentation of COPD. The Administrator stated the facility was in crisis mode and positive staff were required to work the floor as long as they were symptom free. The Administrator stated the staff were asked to test at the facility.

On 9/24/24 at 1:53 PM Staff M, CNA stated there was never proper PPE available. Staff M stated there were gloves and N95 but no gowns or eye protection. Staff M stated she is not familiar with EBP. Staff M stated 9/20/24 or 9/21/24 she was in serviced on EBP with catheters. Staff M stated prior to in-service nobody used gowns in the room with residents that had catheters.

On 9/25/24 at 1:00 PM Staff G, LPN / ADON / IP stated she does not do a lot with infection control and when she talked to the Administrator about what to have the staff do if they tested positive. Staff G stated the Administrator told her to have the staff wear an N95 and keep working. Staff G stated Staff J asked about the gowns being available and she was told there were gowns on the back of doors. Staff G stated she had seen staff working with residents that were positive with no gowns or eye protection. Staff G stated she in-serviced every time she observed staff not wearing gowns or eye protection. Staff G stated there were no disciplinary actions as a result of noncompliance of wearing PPE. Staff G stated all the write ups come from the Administrator. Staff G stated she had obtained her IP certificate and she had not been shown how to use the program that tracks trends, antibiotic usage, and

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F 880	Continued From page 74 infections. Staff G stated she just obtained her IP and had not completed any audits during her time as infection prevention. On 9/27/24 at 11:22 AM the Administrator stated Staff G was the IP and she was logging the infections on a log. The Administrator stated the log was kept on paper. The Administrator stated the logs should have been plugged into the facility's computer program that tracked trends, infections, and antibiotic use. The Administrator stated Staff G gives it to the DON and the DON plugs it in. The Administrator stated Staff G did not have access to the computer program and they are in the process of switching systems. The Administrator stated Staff G had been in the IP position since 2/19/24. The Administrator stated the DON was in charge of the training needed to run the program that tracked trends, infections, and antibiotic uses. The Administrator stated the DON had been tracking the trends. The Administrator stated when the DON saw trends she completed audits. The Administrator stated when the outbreak started August 26 trend was noticed that Covid outbreak started back in the CCDI unit. The Administrator stated would have expected more audits on PPE use and hand washing. The Administrator stated those audits were not completed that she was aware of. The Administrator stated Staff G was working most night shifts and the DON had Covid. The Administrator stated the MDS coordinator and herself should have completed audits based on the trends that were occurring with the Covid virus. The Administrator stated she recognized that Staff G had worked a lot of overnights but feels that Staff G should be able to complete IP work as well as nursing duties when working overnights. The Administrator stated staff G had	F 880		

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not shared any concerns with inability to complete IP work or having access to the computer program that tracks trends, infections and antibiotic usage. The Administrator stated she has tried in the last month or so to have Staff G connect with the nurse specialist to be trained but Staff G always seemed to have to work overnights when training was available. The Administrator stated she did not know that IP having access to the tracking and trends of Covid would have affected the outcome of residents who develop Covid. The Administrator stated management failed with the Covid outbreak in education to the staff and identifying concerns with PPE usage.

Review of policy titled, Infection Control General Guidelines updated 9/6/24 documented the purpose of the policy was to prevent and control the spread of communicable / contagious infection / diseases and establish guidelines to follow the implementation of isolation precautions. It was the responsibility of the Executive Director and / or DON through the (QAPI) Committee, to assure that all infection control policies and procedures are implemented and followed. The Infection Preventionist Nurse / DON shall be responsible for making periodic reports, both oral and written to the QAPI Committee concerning changes in established infection control practices. All staff shall be informed of the infection control policies and procedures through orientation program and regularly scheduled in-service training.

Review of policy titled, Antibiotic stewardship Program updated 5/6/24 documented the

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Antibiotic Stewardship Program will optimize the treatment of infections by ensuring that residents who require an antibiotic are prescribed the appropriate antibiotic, reducing the risk of adverse side effects, including the development of antibiotic-resistant organisms, from unnecessary or inappropriate antibiotic use, to improve resident outcomes. The antibiotic stewardship program promotes the appropriate use of antibiotics and includes a system of surveillance, monitoring and preventative measures to improve resident outcomes and reduce antibiotic resistance. Antibiotic(s) will be prescribed for the correct indication, dose, and duration to appropriately treat the resident while also attempting to reduce the development of antibiotic-resistant organisms. When the nurse suspects that the resident has an infection, the nurses will perform an evaluation of the resident that includes: Complete set of vitals. Interview with resident for symptoms. Assessment of signs and symptoms. Nurses will utilize the appropriate Infection Criteria Protocol (GI, Skin/Soft Tissue/Mucosal,UTI, Respiratory) based upon the resident's signs and symptoms to determine if it is necessary to treat with antibiotics or if adjustments in therapy need to be made. The nurse will notify Physician/Practitioner of resident change of condition and evaluation information. The Nurse will communicate to the Physician/Practitioner the Infection ControlCriteria Protocol to treat the respective infection.

Review of policy titled, Covid-19 outbreak updated 9/6/24 documented if the facility has one or more resident who test positive for Covid a N95 mask, gown, eye protection, and gloves are required in the presumptive and positive

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F 880	Continued From page 77 resident's room. When the facility has a staff member who has worked in the previous 48 hours and tests positive for Covid, that staff member will need to be off work for an isolation period. The resident with confirmed Covid infection will be placed in a single-person room, when possible. The door should be kept closed (if safe to do so). Ideally, the resident should have a private bathroom, if possible. Centers for Disease Control and Prevention website titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), visited 7/11/24 and updated 7/12/22 revealed recent changes included, additional rationale for the use of Enhanced Barrier Precautions (EBP) in nursing homes, including the high prevalence of multidrug-resistant organism (MDRO) colonization among residents in this setting. Expanded residents for whom EBP applies to include any resident with an indwelling medical device or wound (regardless of MDRO colonization or infection status). Expanded MDROs for which EBP applies. Clarified that, in the majority of situations, EBP are to be continued for the duration of a resident's admission. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status and Infection or colonization with an MDRO. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care.	F 880		

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F 880	Continued From page 78 2. During an interview 9.25.24 at approximately 2 p.m. the Clinical Nurse Supervisor indicated the COVID-19 outbreak began 8.26.24. During an interview 9.25.24 at 1:50 p.m. the Executive Director confirmed the facility as out of outbreak status on 9.19.24. An observation 9.22.24 at 12:40 p.m. revealed Staff A, Dietary Aide wiped down/cleansed dining room tables in the main dining area without a mask. During an interview 9.22.24 at 1:21 p.m. with Staff B, Licensed Practical Nurse (LPN) indicated she had been unaware of the facilities current procedure with the use of PPE. During an interview 9.22.24 at 1:15 p.m. Staff C, Certified Nursing Assistant (CNA) indicated she had been unaware if staff were supposed to wear masks or not and that the COVID-19 outbreak had been over for three (3)weeks but staff have not been directed as to the facilities expectations with PPE. During an interview 9.23.24 at 1:35 p.m. Staff C indicated the facility provided PPE when in outbreak status however the facility staff failed to use the equipment according to expectations ie. staff failed to wear gowns and shields and properly position their regular face masks to cover their nose and mouth. The staff member also confirmed facility staff cross contaminated the residents as they worked both the CCDI and South units on the same shift without the use of proper PPE, failed to utilize proper signage for visitors to educate them on the facilities outbreak status and/or screen the said visitors.	F 880		

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During an interview 9.23.24 at 2:06 p.m. Staff E, CNA indicated when residents who resided in the CCDI unit tested positive for COVID-19 staff went back and forth from the unit to the front of the building when the worked their shifts on the same day. The staff member confirmed staff failed to wear masks, gowns and shields during the facility outbreak status and failed to screen visitors.

During an interview 9.25.24 at approximately 2 p.m. the Clinical Nurse Supervisor indicated the COVID-19 outbreak began 8.26.24.

During an interview 9.25.24 at 1:50 p.m. the Executive Director confirmed the facility as out of outbreak status on 9.19.24.

An observation 9.22.24 at 12:40 p.m. revealed Staff A, Dietary Aide wiped down/cleansed dining room tables in the main dining area without a mask.

During an interview 9.22.24 at 1:21 p.m. with Staff B, Licensed Practical Nurse (LPN) indicated she had been unaware of the facility's current procedure with the use of PPE.

During an interview 9.22.24 at 1:15 p.m. Staff C, Certified Nursing Assistant (CNA) indicated she had been unaware if staff were supposed to wear masks or not and that the COVID-19 outbreak had been over for three (3) weeks but staff have not been directed as to the facilities expectations with PPE.

During an interview 9.23.24 at 1:35 p.m. Staff C

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F 880	Continued From page 80 indicated the facility provided PPE when in outbreak status however the facility staff failed to use the equipment according to expectations ie. staff failed to wear gowns and shields and properly position their regular face masks to cover their nose and mouth. The staff member also confirmed facility staff cross contaminated the residents as they worked both the CCDI and South units on the same shift without the use of proper PPE, failed to utilize proper signage for visitors to educate them on the facilities outbreak status and/or screen the said visitors. During an interview 9.23.24 at 2:06 p.m. Staff E, CNA indicated when residents who resided in the CCDI unit tested positive for COVID-19 staff went back and forth from the unit to the front of the building when the worked their shifts on the same day. The staff member confirmed staff failed to wear masks, gowns and shields during the facility outbreak status and failed to screen visitors.	F 880		