STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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
E 000	Initial Comments An Emergency Preparedness Survey was conducted June 22, 2022, by the Department of Health, Health Regulation and Licensing Administration, in accordance with 42 CFR 494.62. The survey found that the facility was in compliance with Emergency Preparedness requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 494.62. The census was 162.	E 000	Serenity Rehabilitation and Health Center Disclaimer: The facility submits this plan of correction under procedures established by the department of Health in order to comply with the departments directives to change conditions which the department alleges are deficient under state regulations related to Long term care. This should not be construed as either a waiver of the facility's right to appeal or to challenge the accuracy or severity of alleged deficiencies or any admission of any wrongdoing.	09/23/202
F 000	INITIAL COMMENTS An unannounced Recertification Survey was conducted at this facility on June 14 - 29, 2022. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census during the survey was 162 and the survey sample included 67 residents. The following complaints were investigated during this survey: DC00010161, DC00010279, DC00010280, and DC00010578. The following Facility Reported Incidents were investigated during this survey: DC00010151, DC00010195, DC00010264, DC00010316, DC00010379, DC00010402, DC00010403, DC00010416, DC00010439, DC00010486, DC00010609, DC00010680, DC00010684, DC00010685, DC00010735, DC00010774, DC00010802, DC00010821, and DC00010825. Federal and/or Local deficiencies were cited related to the investigation(s) of: DC00010151, DC00010161, DC00010264, DC00010316, DC00010379, DC00010402, DC00010403, DC00010486, DC00010578, DC00010680, DC00010685, DC00010735, DC00010774,	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Funmilayo Tashola, T | TITLE: LNHA | (X6) DATE: 9/21/22

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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DC00010802, DC00010821, and DC00010825.

After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.

This survey identified actual harm at F600 for Residents #108 and #145.

The following is a directory of abbreviations and/or acronyms that may be utilized in the report:

AMS - Altered Mental Status
ARD - Assessment Reference Date
AV- Arteriovenous
BID - Twice- a-day
B/P - Blood Pressure
cm - Centimeters
CFR- Code of Federal Regulations
CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CRF - Community Residential Facility
CRNP- Certified Registered Nurse Practitioner
D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
D/C- Discontinue
Dl- Deciliter
DMH - Department of Mental Health
DOH- Department of Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
F - Fahrenheit
FR.- French
G-tube- Gastrostomy tube
HR- Hour

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HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
IPCP- Infection Prevention and Control Program
LPN- Licensed Practical Nurse
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD- Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)
M- minute
mL - milliliters (metric system measure of volume)
mg/dl - milligrams per deciliter
mm/Hg - millimeters of mercury
MN midnight
N/C- nasal canula
Neuro - Neurological
NFPA - National Fire Protection Association
NP - Nurse Practitioner
O2- Oxygen
PASRR - Preadmission screen and Resident Review
Peg tube - Percutaneous Endoscopic Gastrostomy
PO- by mouth
POA - Power of Attorney
POS - physician ' s order sheet
Prn - As needed
Pt - Patient
Q- Every
RD- Registered Dietitian
RN- Registered Nurse
ROM Range of Motion
RP R/P - Responsible party
SBAR - Situation, Background, Assessment,

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F 000	Continued From page 3 Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram	F 000	F550 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT : Incontinent care was provided to Resident#256 by the licensed nurse on 6/26/22 after being notified by Resident #256. Resident #256 was reassessed head- toe on 8/17/22 by the Unit Manager/Designee, Resident suffered no negative outcome.	09/23/22
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. 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	F 550	The assistant director of nursing/unit manager will conduct house wide audit to ensure that assigned nursing assistant, provide incontinent care in a timely manner to all residents that require assistance with incontinent care. Any negative findings will be corrected by 9/23/22. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents with requiring assistance with incontinent care have the potential to be affected.	

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F 550	Continued From page 4 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 record review and interview, the facility staff failed to provide dignity for a resident as evidenced by not providing incontinent care in a timely manner for one (1) of 67 sampled residents (Resident #256). The findings include: Resident #256 was admitted to the facility on 06/10/22 with multiple diagnoses including Diarrhea, Recurrent Enterocolitis due to Clostridium Difficile (C Diff) and Generalized Muscle Weakness,. Record review revealed the following: 06/10/22 [Admission Nursing Note] - "... admitted to the facility at 6:45 PM form [local hospital]...with discharge diagnoses of C Diff Colitis... abdominal pain and diarrhea ...discharge summary [Resident's name] is C diff positive on PO (by mouth) Vancomycin [antibiotic] for 14 days..." 06/13/22 [Concerns and Comment Form] written by resident's sister - "They are not staffed to meet residents' needs. They allowed [resident's name] to lay for hours in her fecese [feces]. They are not	F 550	MEASURES TO PREVENT RECURRENCE: Education will be provided to all facility staff by the Facility Staff Developer on resident rights which includes treating each resident with dignity and respect and providing care in a timely manner by 09/23/22.	09/23/22

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F 550	Continued From page 5 answering the call [light] when button pushed. [Resident #256] washed at 3:00 PM..." 06/15/22 [Admission Minimum Data Set] showed the resident had a Brief Interview for Menatal Status summary score of "15", indicating the resident was cognitively intact. Also, Resident #256 was coded for being totally dependent on the physical assistance of one person for toileting and always being incontinent of bowel. Review of Care Plan dated 06/12/22 revealed the following: Focus area - [Resident's name] has a ADL (activities of daily living) self-care performance deficit r/t (related to) pain and generalized weakness. Intervention: The resident requires ... assistance by one staff with personal hygiene and oral care. During a face-to-face interview on 06/14/22 at approximately 1:00 PM, Resident #256 stated that the staff treated residents terribly. When asked what does that mean? Resident #256 stated, "They left me in my stool for 5 hours." The resident said that she called the desk several times [Employee #31], came in and threw the supplies to clean her on the foot of her bed, and said she was feeding residents [breakfast] and would come back when she was finished. Resident #256 stated that staff did not provide care until her sister came to the facility around 1:00 PM and started complaining. During a telephone interview on 06/14/22 at approximately 1:10 PM, Resident #256's sister	F 550	MONITORING CORRECTIVE ACTIONS: The Assistant Director of Nursing and Unit Managers will conduct house wide audit to ensure that facility assigned Nursing Assistant provide incontinent care in a timely manner to all residents that require assistance from the facility staff for incontinent care. Any issue found during this audit will be corrected by 09/23/22. This audit will be done weekly x4 and then monthly x3. The report will be presented to Quality Assurance Performance Improvement QAPI Committee.	09/23/22

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F 550	Continued From page 6 [the complainant] stated that she was on the phone with the resident around 8:00 AM or 9:00 AM when she heard an employee [Employee #31] say she would change the resident after she finishes feeding other residents. The complaint then said because her sister kept calling her about not being changed, she came to the facility around 1:00 PM and complained to staff, and then a resident's ambassador changed her sister. During a face-to-face interview on 06/24/22 at 9:50 AM, Employee #28 (Manager-on Duty, LPN) stated that she came to the floor around 1:00 PM and noticed that the resident's light was on, and she went to the room. The resident informed her that she needed to be changed, so she provided incontinent care and gave the family member [sister] a Concerns and Comment form to document her concerns. During a face-to-face interview on 06/27/22 at 1:00 PM, Employee #31 (Assigned CNA) stated that Resident #256 put the light on about four times when she started her shift at 7:00 AM, but the resident didn't tell her until "9:45 AM she needed to be changed". The employee then said, "I told her [Resident #256] I'm in the middle of passing trays. I'll change you as soon as I can." When asked if she checked to see if the resident was incontinent, Employee #31 stated, "I don't know if she was incontinent because I had to pass my trays and I don't start AM care until 10:00 AM." Additionally, the employee stated that at 10:00 AM security announced over the loud speaker to report to Room 330 because the resident wanted to be changed. Continued interview revealed that [Resident 28] changed the resident.	F 550	F584 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: The bathroom vents that were soiled in resident rooms #115 and #214 were cleaned on 6/24/22 by the facility housekeeping staff. Residents in room #115 and #214 were reassessed on 8/17/22 and suffered no negative outcomes. The Privacy Curtains in residents rooms 110B, 229, 244A, and 313B, were replaced with curtains in good condition on 06/29/22. Resident #110B, #212A, #229, #244A, and #313B were reassessed on 8/17/22, they suffered no negative outcome. Resident room 229 bathroom was cleaned and sanitized on 6/28/22 by the facility housekeeping staff. The oxygen concentrator in resident room 212A was cleaned on 6/29/22	9/23/22

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F 550	Continued From page 7 During a face-to-face interview on 06/27/22 at 2:00 PM, Employee #21 (RN/Unit Manager) stated that she spoke with the resident and the family member and apologized for staff not providing incontinent care for multiple hours. Employee #21 also said she talked with Employee #31 and re-educated her on responding to call lights and attending to residents' needs in a timely manner.	F 550	F584 IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility has potential to be affected.	09/23/22
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		

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F 584	Continued From page 8 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interview, facility staff failed to provide housekeeping services necessary to maintain a safe, clean, comfortable environment as evidenced by soiled bathroom vents in three (2) of 34 resident's rooms, soiled privacy curtains in four (4) of 34 resident's rooms, a worn out, dirty floor in one (1) of 34 resident's bathroom, and one (1) of one (1) dusty oxygen concentrator in one (1) of 34 resident's rooms. The findings include: During an environmental walkthrough of the facility on June 14, 2022, at approximately 11:00 AM, and on June 24, 2022, between 10:50 AM and 1:00 PM the following were observed: 1. Bathroom vents were soiled in resident rooms #115 and #214, two (2) of 34 resident's rooms. 2. Privacy curtains were soiled in four (4) of 34 resident's rooms including rooms #110B, #229, #244A and #313B	F 584	F584 MEASURES TO PREVENT RECURRENCE: The facility housekeeping Supervisor / Designee will conduct weekly visual audit of all facility rooms vents to ensure they are clean and free from dust. Any issue identified during this audit will be corrected by 09/23/22. Education will be provided to facility housekeeping staff by the facility Staff Development on importance of maintaining a safe clean, comfortable environment by 9/23/22. The facility Housekeeping Department head / Designee will conduct grand rounds on week days to ensure that the facility maintain a safe, clean, comfortable environment. Any issues identified during the grand round will be corrected by 9/23/22. Education will be provided to facility Licensed Nurse by the facility Staff Development on importance of maintaining a clean and dust free Oxygen concentrator for the resident use by 09/23/22	09/23/22

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F 584	Continued From page 9 3. The floor in the bathroom of one (1) of 34 resident's rooms (#229) was soiled throughout. 4. The oxygen concentrator in Resident room #212A, one (1) of 34 resident's rooms, was dusty throughou.t These observations were acknowledged by Employee #43 and/or Employee #44 during a face-to-face interview on June 27, 2022, at approximately 3:00 PM.	F 584	F584 MONITORING CORRECTIVE ACTIONS: The facility housekeeping Supervisor / Designee will conduct visual audit of all facility rooms vents to ensure they are clean and free from dust. This audit will be done weekly times 4 and then monthly times 3. The facility housekeeping supervisor / designee will conduct visual audit of all facility residents' rooms to ensure all privacy curtains are clean and intact. This audit will be done weekly times 4 and then monthly times 3.	09/23/22
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility's staff failed to ensure two (2) of seven (7) residents in the sample with allegations of abuse, were free from alleged/witnessed non-consensual sexual contact by Resident #126. (Residents #108 and #145).	F 600	The facility housekeeping Supervisor / Designee will conduct visual audit of all facility residents' rooms to ensure the bathrooms floors are clean. This audit will be done weekly times 4 and then monthly times 3. The Assistant Director of Nursing and Unit Managers will conduct house wide audit of Oxygen concentrators in residents rooms to ensure that they are clean and free of dust. This audit will be done weekly times 4 then monthly times 3. Findings will be corrected immediately and reported to Quality Assurance Performance Improvement QAPI committee.	

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F 600	Continued From page 10 This failure resulted in actual harm to Residents #108 and #145. The findings include: Review of the facility's policy titled, "Prohibition of Abuse", with a revision date of 05/22, defined sexual abuse as "... non-consensual sexual contact of any type with a resident includes but is not limited to sexual harassment coercion or sexual assault..." Resident #126 was admitted to the facility on 05/07/21 with multiple diagnoses including Major Depressive Disorder and Dementia without Behavioral Disturbances. Review of the resident's medical record showed the following: A Quarterly Minimum Data Set-(MDS) assessment dated 03/02/22 documenting a Brief Interview for Mental Status (BIMs) summary score of "99", indicating the resident was unable to complete the assessment. The resident was not coded for exhibiting physical behavior symptoms directed toward others. Further review of the MDS showed the resident was coded for using a wheelchair, not walking in the room or corridor, and being frequently incontinent of stool. Review of a Care Plan with an initial date of 05/27/22 revealed the following Focus Area - [Resident #126] has problematic manner in which resident acts characterized by inappropriate sexual behavior physical related to: resident touches other residents &/ or staff inappropriately ...	F 600	F600 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: Resident #108 was assessed head to toe by the facility licensed nurse on 5/26/22, no sign of pain/discomfort nor facial grimace expressed. No physical signs of trauma observed, no redness, no bruises around the perineal area and buttocks. Resident was transferred to the hospital emergency room on 5/26/22 for further evaluation. Resident returned to the facility from ER/ hospital visit on 05/27/22. Licensed nurse performed a head to toe assessment on the resident and no negative outcomes were found on 5/27/22.	09/23/22

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F 600	Continued From page 11 Goal: [Resident #126] will have reduced incidents of inappropriate sexual behavior. Interventions: Protect other residents if unable to protect themselves; Remove resident from the public area when behavior is disruptive/unacceptable ...; Document a summary of each episode. A 06/02/22 quarterly MDS documented - Resident #126 had a Brief Interview for Mental Status (BIMs) summary score of "06", indicating the resident was severely impaired cognitively. The resident was not coded for exhibiting physical behavior symptoms directed toward others. Further review of the MDS showed the resident was coded for using a wheelchair, not walking in the room or corridor, and being frequently incontinent of stool. Also, the resident was coded as weighing 257 pounds and being 6 feet tall. Review of Treatment Administrator Records (TAR) from 05/01/22 to 06/17/22 showed nurses documented hourly the resident's location in the facility. -06/13/22 at 1:47 PM [Nursing Note] - " ...at 1200 [12:00 PM] resident was observed wandering and pacing the hallway with his wheelchair, entering other resident's room, resident was redirected at all times by staff. NP ... notified, recommends to monitor and redirect as required and psych consult for behavioral disturbances ...." Review of progress notes, Medication Administration Records, and Treatment Administration Records for 06/13/22 to 06/17/22 failed to reveal documented evidence Resident #126 was re-evaluated by psych for wandering in residents' rooms as ordered by the NP on	F 600	Resident #145 was assessed head to toe by the facility licensed nurse on 06/17/22 for pain and trauma, no apparent injury observed. Resident transferred to the hospital emergency room on 06/17/22 for further evaluation. Responsible Party was notified of the transfer on 6/17/22. Resident never returned back to the facility. A well check call was done with the RP on 6/20/22.	09/23/22

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F 600	Continued From page 12 06/13/22. A 06/17/22 at 8:04 AM [Nursing Supervisor's Note] documented the following- "At about 5:40 AM ...writer was informed by nurse [Resident #126] was observed in bed with [Resident #145] ...MD order to transfer [Resident #145] ... to ER for further evaluation ...[Officer's name and Detective's name] ... the detective interviewed writer, [Resident #126], assigned nurse ...and said they will continue with their investigation ..." Further review of the June TAR showed that on 06/17/22 at 5:00 AM the nurse documented "IB" indicating that she observed Resident #126 in bed at that time. Continued review of the Care Plan showed that the facility's staff revised the care plan on 06/17/22 with the following information: -Focus Area - "Staff reported that [Resident #126] was observed on top of [Resident #145] in Room 313 B." -Intervention- One-on-one monitoring X 24 hours every day for safety precautions. 1A. Resident #108 was admitted to the facility on 12/10/19 with multiple diagnoses including Alzheimer's Disease and Major Depression. An MDS assessment dated 04/11/22 documented Resident #108 had a Brief Interview for Mental Status (BIMs) summary score of "99" indicating the resident was unable to complete the assessment. Further review of the MDS showed Resident #108 was coded for being totally dependent on the physical assistance of two staff members for bed mobility and one staff member for personal hygiene. Resident #108 was also	F 600	F600 The RP also said that Resident #145 will not be returning to the facility and that she is currently seeking a new placement for resident. Resident #145 never returned back to the facility. Resident#126 was assessed head to toes on 6/17/22 by the facility licensed nurses for any signs of pain or trauma,no apparent injury or pain observed. Resident #126 was placed on 1 on 1 monitoring X24hrs everyday for safety precaution. This intervention for Resident #126 will remain until cleared by the Attending Physician/Designee and the Psychiatrist/ Designee. Resident #126 was assessed by Psychiatrist, Psych NP, and FNP, medication review and behavioral management on 06/17/22. Medical treatment was updated on 6/17/22. The resident is not exhibiting sexual behavior towards other residents and staff.	09/23/22

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F 600	Continued From page 13 coded for always being incontinent of urine and bowel. Review of a Facility Reported Incident (DC00010774) dated 05/26/22 [Thursday] at 11:21 PM, documented, "At 3:30 PM...Writer received report that [Resident #126] was observed sitting in his wheelchair at the bedside of [Resident 108] room 112-A at about 8:30 PM on 05/25/22 [Wednesday]. It was reported that [Resident #126] was observed with feces on his left hand ...[Resident #108] was observed with feces on her thigh and bed spread...[Resident #126] was transferred to Unit 3 ...[MD's name] gave orders to transfer [Resident #108] to ER (emergency room) for further evaluation of possible physical abuse ..." Review of Resident #108's medical record showed the following: -05/26/22 at 3:30 PM [ADON Note] - "At about 3:30pm writer received [two police officers names and badge numbers] in the facility who said they had a call for alleged abuse for [Resident #108] in room 112-A. Writer received report from staff that [Resident #126] who resided in room 147 Bed A was observed sitting in his wheelchair at the bedside of [Resident #108] Room 112-A at about 8:30pm on 5/25/22. It was reported that [Resident #126] was observed with feces on his left-hand front, back, and underneath his fingernails. It was also reported that [Resident #108] was observed with feces on her thigh and her bed spread. [Resident #126] was immediately removed from the scene and [MD's name] notified and order given to transfer [Resident #126] to Unit 3 - Room 310-B. Also, [Detective's name and badge number] was called to the facility by the police.	F 600	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected.	09/23/22

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F 600	Continued From page 14 After meeting with the residents and talking to staff members the detective issue report ... No arrest was made. However, [MD's name] also gave order to transfer [Resident #108] to ER (emergency room) via 911 for further evaluation for possible physical abuse... Resident ... left the facility at 17:28pm [5:28 PM] to [local hospital] ..." -05/26/22 at 4:41 PM [Physician's Order] "transfer resident to ER via 911 for further evaluation for possible physical abuse" Late entry dated 05/27/22 at 5:16 PM showed, "05/25/22 at 5:03 PM [Activity Note]- "Incident Report: When preparing to leave for the evening I [Employee #26 Activities Director] found [Resident #126]... sitting in his wheelchair at the bedside of [Resident #108] in room 112-A. Writer [Employee #26] observed feces on [Resident #126's] left hand front, back, and underneath his fingernails. Feces was also noticed on [Resident #108's] thigh and her bed spread. [Resident #126] was immediately removed from the scene and... relocated to Unit-3 room 310-B." It should be noted that this was a late entry note that was created on 05/27/22 at 5:16 PM (approximately 2 days after the incident) with an effective date of 05/25/22 at 5:03 PM. Late entry created on 05/27/22 at 7:33 AM showed, "05/25/22 at 8:30 PM [Nursing Supervisor Note]- "During the evening shift at about 8:30pm writer was made aware by the nurse that Activity Director saw [Resident #126] in resident`s [Resident #108's] room. [Resident #126] was sitting at the bedside in his wheelchair and had feces on his left hand. [Resident #108] was assessed from head to toe. No injury was	F 600	F600 MEASURES TO PREVENT RECURRENCE: In-service will be provided by Staff Development /designee to all facility staff on abuse prohibition by 9/23/22 In-service will be provided by Staff Development /designee to all facility staff about care plan intervention in place for residents with sexual behavior, behavior with the potential to abuse others, and wandering behavior. In-service will be provided by Staff Development /designee to all Licensed Nursing staff on the importance of ensuring that residents identified with sexual behavior have a person-centered care plan that clearly state the type of behavior they are exhibiting and that they are always provided supervision to prevent such behavior. Repeat in-service will be provided as needed. Charge nurses will ensure that residents identified with sexual behavior, or behavior with the potential to abuse others, and wandering behavior have adequate supervision and monitored during all shifts, and that there is documentation in place for any behavior observed. Any issues found will be corrected by 09/23/22.	09/29/22

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F 600	Continued From page 15 observed. No sign of pain nor discomfort expressed upon assessment. [Resident #108] was assisted with incontinent care and resident`s [responsible party's name] made aware. resident was monitored through the shift with no other concerns reported ... BP (blood pressure) 122/67, P(pulse) 74, R18, O2 (oxygen) 99% ra (room air), T temperature) 97.8." It should be noted that this was a late entry note that was created on 05/27/22 at 7:33 AM (approximately 2 days after the incident) with an effective date of 05/25/22 at 8:30 PM. A 05/27/22 at 6:53 AM [Nursing Note] documented- "[Resident #108] returned from [local hospital] at about 5:10am ... The medic ... who accompanied her from the hospital stated no evidence of physical assault was observed after examination by the doctor and she is free to resume all activities and treatment active prior to transfer to the ER..." The Situation, Background, Assessment, Result Form signed and dated on 5/31/22 by Nursing Supervisor (Employee #11) showed, "During the evening shift at about 8:30 pm writer was made aware by the nurse that Activity Director saw [Resident #126] ...sitting at the bedside [of Resident 108] in his wheelchair and had feces on his left hand. [Resident #108] was unable to explain what happened due to diagnosis of Cognitive Communication Deficit. [Resident #108] was assessed from head to toe by the nurse, no sign of pain/discomfort nor facial grimace expressed. No physical signs of trauma observed, no redness, no bruises around the perineal area and buttocks. [MD's name] made aware, new order was given to transfer resident	F 600	Unit Mangers and Shift Supervisors will conduct rounds during their shift to ensure that resident with sexual behavior, behavior with the potential to abuse others, and wandering behavior are monitored and adequate supervision is provided. Any issues found will be corrected by 9/23/22 . MONITORING CORRECTIVE ACTION: House wide audit will be conducted by Assistant Director of Nursing (ADON)and Unit Managers to identify residents demonstrating sexual behavior, with the potential to abuse others, and residents who wander to ensure that appropriate care plans are established consistent with the exhibited behaviors and provided with adequate supervision to ensure such behavior is prevented. Any issue found during this audit will be addressed by 9/23/22 Unit Mangers and Shift Supervisors will conduct rounds during their shift to ensure that resident with sexual behavior, behavior with the potential to abuse others, and wandering behavior are monitored and adequate supervision is provided. Rounds /audit will be conducted weekly times 4 then monthly times 3.	09/23/22

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to ER (emergency room) via 911 for further evaluation for possible physical abuse."

During multiple observations from 06/19/22 to 06/22/22 from approximately 11:00 AM to 4:00 PM, Resident #108 was observed in bed sleeping or eyes open and not responding to verbal stimuli. Resident #108 was not interviewable.

During a face-to-face interview on 06/22/22 at 3:00 PM, Employee #26 (Activity Director) stated that he was made aware that Resident #126 was in another resident's room uninvited but could not remember the date. The employee stated on 05/25/22 at approximately 8:00 PM, he went to look for Resident #126's and could not find him in his room (#147) or in the hallway where he usually sits playing cards with other residents. Employee #26 said he then alerted the nursing staff, and they all started looking for the resident. The employee said he found Resident #126 in Room 112 sitting in his wheelchair at the bedside of Resident #108, who was in bed A. The employee then called nursing staff to Room 112 and moved Resident #126 into the hallway.

Further interview revealed Employee #26 asked the resident why he was in Resident 108's room, but Resident #126 did not provide an answer. The employee also observed the resident with feces on his left hand. The employee asked the resident if he had a bowel movement, and the resident said, "No." However, when he went back into Room 112 with the nursing staff, he noticed Resident #108's bedspread had stool on it. When asked did Resident #108 say anything, he stated, No, she's non-verbal." Additionally, the employee stated that Resident #126 was moved to the third floor 310B after the incident.

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During a face-to-face interview on 06/23/22 at 9:37 AM, Employee #3 (ADON) stated that the incident with Resident #126 and Resident #108 was discussed in the morning stand-up meeting on 05/26/22. However, he was unaware the incident was a physical assault until he saw the police in the facility on 05/26/22 responding to a call for "alleged abuse" against Resident #108. When asked who called the police, Employee #3 said that he did not know. Additionally, the employee said he made the physician aware and was given an order to transfer Resident #108 to the emergency room to be evaluated for possible physical assault.

During a face-to-face interview on 06/24/22, Employee #25 (CNA) stated she was looking for Resident #126 when Employee #26 called her to Room 112. Resident #126 was sitting in the hallway with stool [feces] on his left hand. She also observed Resident #108 "diaper was off, and she had stool [feces] smeared all over her stomach and thighs." The employee said she provided incontinent care for Resident #108. When asked did Resident #108 say anything, the employee said, "No", she doesn't talk. She just had tears rolling down her face."

Additionally, the employee stated that when she assisted Resident #126 to his room, the resident kept trying to hide his left hand under his leg. When she asked him what was on his hand, the resident said, "Dirt." The employee said that it was not dirt; it was stool [feces]. The employee stated, "I changed him [Resident #126], and he was not incontinent of stool. I only found stool on his hand." The employee said, "The police came the next day [05/26/22] when they received an

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anonymous call."

A review of records and staff interviews revealed that the facility's staff failed to ensure Resident #108 was safe from Resident #126's alleged inappropriate non-consensual sexual touch.

(Cross reference 42 CFR 483.12, F607 Resident #121)

1B. Resident #145 was admitted on 02/08/22 with multiple diagnoses including Dementia in other Disease classified elsewhere without Behavioral Disturbances, Cognitive Communication Deficit, and Generalized Muscle Weakness.

Review of the 05/06/22 Quarterly Minimum Data Set (MDS) revealed the following: Resident #145 had a Brief Interview for Mental Status summary score of "99" indicating the resident was unable to complete the assessment. Further review of the MDS showed Resident #145 was coded for requiring extensive assistance from one staff person for bed mobility, transferring, and personal hygiene. Also, the resident was coded as weighing 93 pounds and being 5 feet tall.

Review of the Facility Reported Incident (DC00010821) dated 06/17/22 at 10:32 AM, documented, " ...Writer was informed by the nurse that [Resident #126] was observed in bed with [Resident #145] in Room 313B ...[Resident #126] was redirected to leave the room ... [Resident #145] was assessed ... no signs of trauma observed...[MD's name] gave orders to transfer [Resident #145] via 911 to ER (emergency room) for further evaluation... "

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Review of the medical record revealed the following:

-06/17/22 at 5:07AM [Physician order] - Transfer resident to ER for further examination due to possible physical abuse.

-6/17/22 at 7:38 AM [Nursing Note] - " ...At 5:00 AM... CNA [Employee #15] was doing AM care...she observed the Resident in [from] room 310B [Resident #126] was on top of the [Resident #145] in room 313B ...Writer called the supervisor immediately and the other staff on the floor. Supervisor redirected the resident [Resident #126] to his room. Initiated a 1:1 (one-to-one) around the clock monitoring until further notice. A head-to-toe assessment was done [for Resident #145] by supervisor and writer. No bruises ...skin tear... bleeding noted. Resident denied pain or any discomfort at this time. Police was called on the seen [scene]. Emergency responders were called on the seen [scene] too. An assessment was done by emergency responders, and they came to a conclusion to transfer resident to the nearest ER for further evaluation per physician's orders. Responsible party was notified. V/S (vital signs) T 97.6 P 87 BP 142/67 R 18 O2 SAT 98% Room Air."

-06/17/22 at 8:23 AM [Nursing Supervisor Note]- "At about 5:40am, writer received a call from [Resident #126's name] assigned nurse requesting writer to report to the third floor ASAP (as soon as possible). When writer arrived on the floor, writer observed [Resident #126's name] walking to his room. He had his gown on and he was wearing a diaper. Writer was informed by the nurse that [Resident #126] was observed in the bed with [Resident #145] in Room 313B.

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According to the nurse, [Resident #126] was immediately redirected to leave the [his] room ... [Resident #145] was assessed by writer and the two other nurses on the floor. Her skin warm and dry to touch, she denied pain upon further assessment. No signs of trauma observed as resident remain calm and cooperative ...brief was intact and appropriate, no moisture/urine observed. Writer and the other nurses could not observe any signs of an open brief on full head to toe assessment ...MD (medical doctor) gave order to transfer ...via 911 to ER for further evaluation/treatment ... [Resident #145] left facility..."

During a face-to-face interview on 06/17/22 at approximately at 8:30 AM, Employee #14, LPN (assigned nurse) stated that the CNA [Employee #15] was very upset and called her to room 313. When she arrived at the room, she observed Resident #126 naked laying on top of Resident #145, who was also naked. The employee then said that the staff helped her get Resident #126 off Resident #145. Then the staff helped him get dressed and escorted him to his room.

A Situational Background, Assessment, Request (SBAR) dated 06/17/22 at 8:32 AM documented, "... At about 5:40 AM writer was informed by the nurse that [Resident #126] was observed in the bed with [Resident #145] in Room 313B... [Resident #145] was assessed no signs of pain expressed. Her brief was intact/appropriate, no moisture/urine observed ...911 called [Resident #145] left facility ...to ER ...police called [Officer's name and Detective's name] came to facility ... and interviewed writer [Employee 20], nurse [Employee #14], and [Resident #126]..."

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During a face-to-face interview on 06/17/22 at approximately 9:15 AM, Resident #126 stated that he went to Resident #145's room naked, sat on her bed, rubbed her legs, then pull her gown up and open her incontinent pad and laid on top of her. When asked, if she [Resident #145] invited him into her room, Resident #126 stated, "No". When asked, what did [Resident #145] do when he laid on top of her, Resident #126, stated, "She didn't do nothing and didn't say anything". When asked, why did he lay on top of [Resident #145] if she didn't invite him into her room, Resident #126 stopped answering questions.

A nursing note documented by the Unit Manager on 6//17/22 at 10:26 AM indicated, "Writer made a f/u (follow-up) call to the RP (responsible party) ...to notified about the resident [Resident #145] transfer ...to ER for further examination due to possible physical abuse."

A note from the Attending Physician dated 06/17/22 at 6:37 PM documented " ... Nursing staff reported that during monitoring round that a male resident [Resident 126] was found in bed with resident [Resident #145] early morning of 7/17/2022 [06/17/22] ... Resident [Resident #145] has been evaluated by assault forensic specialist at the acute care hospital emergency department ... I have updated resident's daughter... She has requested another facility for resident ..."

Review of witness statements for staff on duty at the time of the incident (Employee #15-CNA, Employee #14-LPN, Employee #16-RN, Employee #19-LPN, and Employee #20-RN Nursing Supervisor consistently indicated that staff reported to Resident #145's room and noted Resident #126 naked on top of Resident #145

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who was also naked.

During a face-to-face interview on 06/17/22 at 3:00 PM, Employee #45 (Unit Manager) stated that Resident #126 was recently [05/26/22] moved to her floor from the first floor after staff suspected that he inappropriately touched a female resident. The employee then said that the staff consistently monitored Resident #126 for inappropriate sexual behavior. When asked if she provided staff education about Resident #126's alleged inappropriate behavior after he moved to the floor, the employee stated that she did but did not have documented evidence of what she taught to staff.

During a face-to-face interview on 06/17/22 at approximately 3:30 PM, Employee #22 (Temporary Nursing Aide), stated that she worked on the floor since April 2022. The employee said that she was not provided any education about Resident #126 when he was moved to the floor.

During a face-to-face interview on 06/22/22 at approximately 7:30 AM, Employee #24 (CNA), stated that she worked on the floor for three years. The employee said that she was not provided any education about Resident #126 when he was moved to the third floor.

During a face-to-face interview on 06/22/22 at approximately 7:45 AM, Employee #25 (CNA) stated that she has worked on the floor for 5 years. The employee said she was not provided any education about Resident #126 when he moved to the floor. It should be noted that Employee #25 worked the morning of 06/17/22 when Resident #126 was observed naked on top of Resident #145.

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F 600	Continued From page 23 During a face-to-face interview on 06/24/22 at approximately 4:00 PM, Employee #13 (Educator) stated that she provides education annually, as needed, and when there is a concern in the facility. When asked did she provide education to staff after Resident #126 was moved to the third floor for allegedly inappropriately touching a female resident, she stated that she did not provide education to staff. An attempt was made to interview the Administrator and the Director of Nursing regarding the failure to keep residents safe from Resident #126, however they did not provide a response. It should be noted that after the incident on 06/17/22 the facility implemented an intervention of one-to-one services for Resident #126, and he remained on that intervention throughout the survey.	F 600		09/23/22
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced	F 607		

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F 607	Continued From page 24 by: Based on record review and staff interviews, for seven (7) of 67 sampled residents, facility staff failed to implement: their "Prohibition of Abuse" policy by not reporting allegations of sexual abuse to the State Survey Agency within two (2) hours for Residents #108 and #145; and their "Investigation Process" policy by not interviewing or obtaining statements from all potential witnesses with knowledge of an incident for Residents' #108, #145, #86, #112, #121, #303 and #304. The findings included: Review of the facility's policy titled, "Prohibition of Abuse", with a revision date of 05/22, defined sexual abuse as non-consensual sexual contact of any type with a resident includes but is not limited to sexual harassment coercion or sexual assault ...All alleged violations, the Administrator, Director of Nursing, or designee shall notify the Department of Health [State Agency] via the Event Reporting System electronically ...within two (2) hours if seriously bodily injury occurred ... 1. The facility's staff failed to follow their "Prohibition of Abuse" policy by not reporting allegations of resident-to-resident alleged inappropriate non-consensual sexual touch [sexual abuse] for Resident #108 or willful non-consensual sexual contact [sexual abuse] for Resident #145 to the State Agency within two hours. 1a. The facility's staff failed to report an allegation of resident-to-resident inappropriate non-consensual sexual touch [sexual abuse] for Resident #108.	F 607	F607 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: Resident #108 was assessed head to toe on 5/26/22, for pain and trauma. No apparent injury observed. Resident was transferred to the hospital emergency room on 5/26/22 for further evaluation for possible sexual abuse. Resident returned to the facility from ER/ hospital visit on 05/27/22. Licensed nurse performed a head to toe assessment on the resident and no negative outcomes were found on 5/27/22. Resident #108 was reassessed head to toe on 8/17/22 by the facility licensed nurse no evidence of physical abuse was observed.	09/23/22

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F 607	Continued From page 25 Resident #108 was admitted to the facility on 12/10/19 with multiple diagnoses including Alzheimer's Disease and Major Depression. Situation, Background, Assessment, Result Form signed and dated on 5/31/22 by Nursing Supervisor (Employee #11) showed "During the evening shift at about 8:30pm writer was made aware by the nurse that activity director saw [Resident #126] ...sitting at the bedside [of Resident 108] in his wheelchair and had feces on his left hand. [Resident #108] was unable to explain what happened due to diagnosis of cognitive communication deficit. [Resident #108] was assessed from head to toe by the nurse, no sign of pain/discomfort nor facial grimace expressed. No physical signs of trauma observed, no redness, no bruises around the perineal area and buttocks. [MD's name] made aware, new order was given to Transfer resident to ER (emergency room) via 911 for further evaluation for possible physical abuse." It should be noted that the order to transfer Resident #108 to ER was not written until 05/26/22 at 4:41 PM after police came to facility after receiving a call for a call of physical abuse for Resident #108. 05/26/22 at 4:41 PM [Physician Order] transfer resident to ER via 911 for further evaluation for possible physical abuse. 05/26/22 at 3:30 PM [ADON Note] - "At about 3:30pm writer received [two police officers names and badge numbers] in the facility who said they had a call for alleged abuse for [Resident #108] in room 112-A. Writer received report from staff that [Resident #126 who resided in room 147 bed A was observed sitting in his wheelchair at the	F 607	Resident #145 was assessed head to toe by the facility Licensed nurse on 06/17/22 for pain and trauma, no apparent injury observed. Resident #145 was transfer to the hospital emergency room on 06/17/22 for further evaluation for possible sexual abuse. Resident #145 Responsible Party was notified on 6/17/22. Resident #145 never returned back to the facility.	09/23/22

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F 607	Continued From page 26 bedside of [Resident #108] room 112-A at about 8:30pm on 5/25/22. It was reported that [Resident #126] was observed with feces on his left-hand front, back, and underneath his fingernails. It was also reported that [Resident #108] was observed with feces on her thigh and her bed spread. [Resident #126] was immediately removed from the scene and [MD's name] notified and order given to transfer [Resident #126] to Unit 3 - Room 310-B. Also, [Detective's name and badge number] was called to the facility by the police. After meeting with the residents and talking to staff members the detective issue report .... No arrest was made. However, [MD's name] also gave order to transfer [Resident #108] to ER (emergency room) via 911 for further evaluation for possible physical abuse. Resident was unable to explain what happened due to diagnosis of cognitive communication deficit, vascular dementia, and Alzheimer's disease ...911 emergency arrive the facility at 17:0pm [5:00 PM] and left the facility at 17:28pm [5:28 PM] to [local hospital] ..." Review of the facility's investigative report revealed a DOH (Department of Health) Incident Report form that documented the facility's staff reported the incident of alleged resident-to-resident alleged inappropriate non-consensual sexual touch [sexual abuse] on 05/26/22 at 6:46 PM (approximately 22 hours after the incident). During multiple observations from 06/19/22 to 06/22/22 from approximately 11:00 AM to 4:00 PM, Resident #108 was observed in bed sleeping or eyes open and not responding to verbal stimuli. Resident #108 was non-interviewable.	F 607	Resident #126 was assessed head to toe on 6/17/22 by the facility licensed nurses for any signs of pain or trauma. No apparent injury found nor complains of pain reported. Resident on 1 on 1 monitoring X 24hrs everyday for safety precaution. The monitoring intervention will remain until cleared by the Attending Physician/Designee and the Psychiatrist/ Designee. Resident #126 was assessed by Psychiatrist, Psych NP, and FNP, for medication review and behavioral management on 06/17/22. Medical intervention was updated on 6/17/22. Resident continues to be on 1 x 1, 24 hours and have not acted inappropriately. Resident will remain on 1 on 1 monitoring x 24 hours everyday.	09/23/22

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F 607	Continued From page 27 During a face-to-face interview on 06/28/22 starting at approximately 4:00 PM, Employee #3 (ADON) stated that the State Agency was notified on 06/26/22, the day after the alleged incident of "physical abuse" [sexual abuse] on 06/25/22, because the evening supervisor failed to make him aware of the incident. When asked if the facility's supervisors are to make the State Agency aware of any incidents of alleged abuse, Employee #3 stated, "Yes," but he did not know why she did not notify the State Agency immediately or within two hours of the incident. Cross Reference 42 CFR 483.12, F600 1b. The facility's staff failed to report an allegation of resident-to-resident alleged willful non-consensual sexual contact [sexual abuse] to the State Agency within two hours for Resident #145. Resident #145 was admitted on 02/08/22 with multiple diagnoses including Dementia in other Disease classified elsewhere without Behavioral Disturbances, Cognitive Communication Deficit, and Generalized Muscle Weakness. 06/17/22 at 5:07AM [Physician order] - Transfer resident to ER (emergency) for further examination due to possible physical abuse. 06/17/22 at 7:38 AM [Nursing Note] - " ... At 5:00 AM GNA/CNA was doing AM care ... She observed the Resident in [from] room 310B (Resident #126) was on top of the Resident (Resident #145) in room 313B and called writer to the room. Writer called the supervisor immediately and the other staff on the floor. Supervisor redirected the resident (Resident	F 607	Resident #86 , Resident #112, Resident #303, Resident #304, and Resident #121 were reassessed by the Unit Managers on 8/17/222 No new incident or occurrences of allegation of abuse observed. Resident #145, Resident #108, Resident #86 ,Resident #112, Resident #303, Resident #304, and Resident #121 did not suffer any negative outcome for not reporting incidences within required time as stipulated by the CMS regulation & requirement to State Agency or for not conducting interviews and obtaining statements from potential witness of allegation of abuse. Resident #120 no longer residing in the facility and was discharged 05/05/22.	09/23/22

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F 607	Continued From page 28 #126) to his room. Initiated a 1:1 around the clock monitoring until further notice. A head-to-toe assessment was done [for Resident #145] by supervisor and writer. No bruises noted, no skin tear, no bleeding noted. Resident denied pain or any discomfort at this time. Police was called on the seen [scene]. Emergency responders were called on the seen [scene] too. An assessment was done by emergency responders, and they came to a conclusion to transfer resident to the nearest ER (emergency room) for further evaluation per physician's orders. Responsible party was notified. V/S (vital signs) T 97.6 P 87 BP 142/67 R 18 O2SAT 98% Room Air." During a face-to-face interview at approximately 8:45 AM, Employee #2 (DON) stated that she was making the surveyor (Representative of the State Agency) aware of the incident of resident-to-resident alleged abuse with Resident #145 and Resident #126. When asked if the facility's staff informed the Department of Health (State Agency) electronically information about the incident? She stated, "No." It should be noted that the facility's staff made the State Agency aware approximately 3 hours after the incident. Cross Reference 42 CFR 483.12, F600 Review of the facility's policy titled, "Investigation Process', with a revision date of 06/22, documented, interview and/or obtain statements from potential witnesses as determined by the scope of the investigation ... 2. The facility's staff failed to follow their "Investigation Process" policy by not interviewing or obtaining statements from all potential witnesses for the following allegations:	F 607	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility has potential to be affected. House wide audit will be conducted by The Assistant Director of Nursing (ADON)/Designee to ensure reporting of all incidences of unusual occurrences to the State Agency via reporting system within required time as stipulated by the CMS regulation & requirement and within 2 hours if seriously bodily injury occurred. Any issue found during this audit will be corrected by 9/23/22 The Assistant Director of Nursing (ADON)/ Designee will complete house wide review/audit of all incidences of unusual occurrences to ensure investigation is thoroughly conducted and all potential witnesses and all staff present provided statements are interviewed and statements are obtained. Any issue found during this audit will be addressed by 9/23/22	09/23/22

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F 607	Continued From page 29 resident-to-resident inappropriate non-consensual sexual touch [sexual abuse] for Resident #108; resident-to-resident altercation for Resident #86, sexual abuse of Resident #112, resident-to-resident incident involving Resident #121, staff physical abuse of Resident #303's and staff neglect of Resident #304. 2a. Facility staff failed to obtain statements/interviews from all potential witnesses who might have knowledge of the resident-to-resident inappropriate non-consensual sexual touch [sexual abuse] for Resident #108. Resident #108 was admitted to the facility on 12/10/19 with multiple diagnoses including Alzheimer's Disease and Major Depression. 05/25/22 at 8:59 PM [Situation, Background, Assessment, Result Form]- "During the evening shift at about 8:30pm writer was made aware by the nurse that activity director saw [Resident #126] ...sitting at the bedside [of Resident 108] in his wheelchair and had feces on his left hand. [Resident #108] was unable to explain what happened due to diagnosis of cognitive communication deficit. [Resident #108] was assessed from head to toe by the nurse, no sign of pain/discomfort nor facial grimace expressed. No physical signs of trauma observed, no redness, no bruises around the perineal area and buttocks. [MD's name] made aware, new order was given to Transfer resident to ER (emergency room) via 911 for further evaluation for possible physical abuse." It should be noted that the order to transfer Resident #108 to ER was not written until 05/26/22 at 4:41 PM after police came to facility after receiving a call for a call of physical abuse for Resident #108	F 607	MEASURES TO PREVENT RECURRENCE: The facility Staff Development/ Designee will provide an education /In-service to facility Director of Nursing, ADON, Unit Managers and Supervisors on the process of reporting of incident of unusual occurrences to the State Agency within required time as stipulated by the CMS regulation & requirement. The in-service/education will explain the importance of reporting incidences timely. The compliance date for this intervention 9/23/22. The facility Staff Development/Designee will provide education to the facility Unit Managers and Supervisors on the importance of following facility protocol of conducting interviews and obtaining statement from potential witnesses and everyone that work on that shift during an investigation of all incidences of unusual occurrences,The compliance date for this intervention 9/23/22.	09/23/22

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F 607	Continued From page 30 05/26/22 at 4:41 PM [Physician Order] transfer resident to ER via 911 for further evaluation for possible physical abuse. 05/26/22 at 3:30 PM [ADON Note] - "At about 3:30pm writer received [two police officers names and badge numbers] in the facility who said they had a call for alleged abuse for [Resident #108] in room 112-A. Writer received report from staff that [Resident #126 who resided in room 147 bed A was observed sitting in his wheelchair at the bedside of [Resident #108] room 112-A at about 8:30pm on 5/25/22. It was reported that [Resident #126] was observed with feces on his left-hand front, back, and underneath his fingernails. It was also reported that [Resident #108] was observed with feces on her thigh and her bed spread. [Resident #126] was immediately removed from the scene and [MD's name] notified and order given to transfer [Resident #126] to Unit 3 - Room 310-B. Also, [Detective's name and badge number] was called to the facility by the police. After meeting with the residents and talking to staff members the detective issue report .... No arrest was made. However, [MD's name] also gave order to transfer [Resident #108] to ER (emergency room) via 911 for further evaluation for possible physical abuse. Resident was unable to explain what happened due to diagnosis of cognitive communication deficit, vascular dementia, and Alzheimer's disease ...911 emergency arrive the facility at 17:0pm [5:00 PM] and left the facility at 17:28pm [5:28 PM] to [local hospital] ..." Review of the staff assignment revealed Unit 1 had two licensed staff and four (4) CNAs working on evening shift (3:00 PM to 11:00 PM) on	F 607	MONITORING CORRECTIVE ACTION: The Assistant Director of Nursing (ADON)/ Designee will complete house wide review/audit of all incidences of incidence of unusual occurrences vial State Agency reporting system within required time as stipulated by the CMS regulation & requirement and within 2 hours if seriously bodily injury occurred. weekly times 4, then, monthly times 3 months. The Assistant Director of Nursing (ADON)/ Designee will complete house wide review/audit of all incidences of unusual occurrences to ensure investigation was conducted and potential witnesses and everyone that work on that shift are interviewed and statement are obtained weekly times 4, then, monthly times 3 months. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	9/23/22

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05/25/22. However, review of the facility's investigative report lacked documented evidence of the four (4) CNAs [potential witnesses] interviews or statements.

During a face-to-face interview on 06/28/22 starting at approximately 4:00 PM, Employee #3 (ADON) stated that they are working on their process of investigating incidents.

Cross Reference 42 CFR 483.12, F600

2b. Facility staff failed to obtain statements/interviews from all potential witnesses who might have knowledge of the resident-to-resident altercation for Resident #86.

Resident #86 was admitted to the facility on 08/28/18 with multiple diagnoses including: Dementia without Behavioral Disturbances and Generalized Muscle Weakness.

Review of a Facility Reported Incident [DC00010685] dated 04/14/22 at 9:09 PM documented, "Around 11:00 AM writer was informed by the smoking monitor that ... [Resident #86] was hit in the face by [Resident #120] ...[Resident #86] stated it all started when [Resident #120] didn't want to ride with me in the elevator to go to the smoke patio ...[Resident #120] approached him and smacked him [in] his face and promised to do so each time he [sees] him ...writer called 911 for intervention. [Officer's name] ... reassured [Resident #86] that he was taking [Resident #120] to the ER for evaluation ..."

Review of the medical record showed the following:

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04/19/22 at 11:25 PM [MD Note] - "Resident complained another resident [Resident # 120] who was unprovoked struck him on the right side of the neck two days ago ...Plan continue admission to skilled NH (nursing home) ..."

04/20/22 at 1:47 PM [Social Work Note] - "The writer and recreation director was informed of a physical altercation between [Resident #86] and [Resident #120] on 04/14/22 ...[Resident #86] expressed that he does not feel safe if [Resident #120] returns to the facility ...I want to press charges ...This writer and activities director accompanied [Resident #86] to the 7th District Police Prescient to report incident and press charges ... "

Review of facility's investigative report showed the following:

04/18/22 [Employee's #27's statement - smoke monitor]- documented, "I was on the smoke patio with [Resident #86] and [another resident] when [Resident # 120] entered the patio cussing [cursing] and making verbal treats [threats] to [Resident #86] ...[Resident #120] stated nobody can't stop me from getting to you ...I better not catch in the elevator ... because I got something for your [expletive] ..."

Further review of the lacked documented evidence of an interview of statement from the other resident that was present on the smoking patio at the time of the incident.

During a face-to-face interview on 06/28/22 starting at approximately 4:00 PM, Employee #3 (ADON) stated that they are working on their

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process of investigating incidents.

2c. Facility staff failed to obtain statements/interviews from all potential witnesses who might have knowledge of a sexual abuse allegation made by Resident #112.

Resident #112 was admitted to the facility on 08/03/20 with diagnoses that included: Schizophrenia, Psychotic Disorder and Anxiety Disorder.

Review of a Facility Reported Incident (FRI) received on 07/19/21 documented, "Writer was informed by the charge nurse at 14:40p.m (2:40 PM) that [Resident #112] informed the PT (physical therapist) staff that she was raped all night, that she is feeling so horrible about this place that if she sees a gun, she can just kill herself ..."

Review of Resident #112's medical record revealed the following:

02/09/21 [Physician's Order] "Sertraline (antidepressant) HCl (hydrochloride) Tablet 50 MG (milligram) give 1 tablet by mouth in the morning for Depression/Anxiety"

03/20/21 [Physician's Orders] "Quetiapine Fumarate (antipsychotic) Tablet 50 MG give 1 tablet by mouth at bedtime for Schizophrenia"

A Quarterly Minimum Date Set (MDS) dated 05/04/21 where that facility staff coded: ta brief Interview for Mental Status (BIMS) summary score of 10, indicating moderately impaired cognition, no indicators for psychosis, no verbal or physical behaviors directed to others,

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extensive assistance to total dependence with one person physical assist for bed mobility and transfers, impairment on both sides for lower extremities, wheelchair mobility device and received antipsychotics on a routine basis in the last 7 days.

07/12/21 at 3:19 PM [Psychiatric Nurse Practitioner Progress Note] "...The patient was seen for f/u (follow up). She has a history significant for depression, anxiety. She is seen lying on the bed, alert and oriented generally to self, generally to place, receptive to visit ... Stable at this time ..."

07/19/21 at 1:43 PM [Social Work Progress Note] "Sexual assault note: This worker received a report from the ADON (Assistance Director of Nursing) stating the resident informed staff she was sexually assaulted by several men while she was in the facility... Once the resident spoke to the ADON and the SW director it was determined that the alleged incident could not have happen due to [Resident #112] stating the men came from outside of the facility. Due to visitation of the facility being very limited do to covid protocols no outside visitors have been allowed to any resident's room. The social work and nursing staff will continue to document any of the statement that are made by [Resident #112]."

07/19/21 at 3:52 PM [Nurses Note] "Writer was informed by the charge nurse at 14:40p.m that [Resident #112] informed the PT staff that she was raped all night, that she is feeling so horrible about this place that if she sees a gun, she can just kill herself ... [Resident #112] said "that someone from the community has been following her from all her street homes and also followed

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her to four different hospitals that she been to raping her and touching her inappropriately". Writer reassured the resident of her safety while being a resident in the facility. [Resident #112] said the individual does not work in this facility ... was unable to provide the mane of any individual. NP (Nurse Practitioner) ...was notified ... Resident's RP (representative) ... son was informed of the alleged rape ...Staff will continue to monitor resident for safety and document/report any abnormal concerns to the doctor ..."

07/19/21 at 7:50 PM [Nurse Practitioner Progress Note] "... Follow up - "patient verbalized to physical therapist of being rapped last night" ... Thorough assessment done by multi-disciplinary team members on follow up of patient comment of rape. Facility well secured and monitored by security staff, staff making frequent rounds, visitors/guests do not enter facility without prior authorization. Facility protocols followed on this comment by patient ..."

Review of the facility's investigation documents on 06/23/22 lacked documented evidence to show that facility staff obtained statements from all staff that might have knowledge of the alleged incident.

During a face-to-face interview on 06/23/22 at 2:15 PM, Employee #3 acknowledged the finding and made no further comment.

2d. Facility staff failed to obtain statements/interviews from all potential witnesses who might have knowledge of the alleged resident-to-resident incident involving Resident #121.

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Resident #121 was admitted to the facility on 02/27/21 with diagnoses that included: Schizophrenia, Pressure Ulcer of Sacral Region Stage 4, Paraplegia, Neuromuscular Dysfunction of Bladder and Schizophrenia.

Review of a grievance made by Resident #121 dated 05/27/22 documented, "...Wed (Wednesday) May 25, 2022 @ (at) 1:30 AM I was woke by a strange man [Resident #126] in a wheelchair @ (at) the bottom side of my bed. I screamed and called the nurse. He left ... [Nurse's Name] came in and said he was looking for snacks..."

Review of Resident #121's Quarterly Minimum Data Set (MDS) dated 05/16/22 showed that facility staff coded the following: a Brief Interview for Mental Status (BIMS) summary score of 15, no potential indicators of psychosis and no verbal or physical behavior symptoms directed towards others.

05/25/22 at 2:11 AM [Nurses Note] "Late Entry: At about 2; 11am a male resident wandered into room 144 A and was redirected back to his room. Writer asked [Resident #121] if the resident touched her, resident stated that no, he did not touch me, writer asked Ms Freeman again, do you have food on the table, resident answered, no he was touching the table and there was no food on the table, it was trash that was on the table."

Review of the "Grievance Written Decision/Resolution Form" dated 05/27/22 documented, "... Based on these findings, the grievance/alleged abuse case was ... confirmed

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Although confirmed as abuse on the grievance form, facility staff failed to file an incident report of the resident-to-resident incident.

During a face-to-face interview conducted on 06/22/22 at approximately 1:00 PM with Employees #6 (Unit 1 Social Worker) and #3, Employee #6 stated, "Once I get a grievance, I speak to the resident and staff involved and get interviews. I then put together a packet and it's given to [Director of Social Services Name] and then goes to the Administration."

At the time of the aforementioned interview, Employee #3 acknowledged the finding and stated, "An incident report should've been done and sent to DOH (Department of Health)."

2e. Facility staff failed to obtain statements/interviews from all potential witnesses who might have knowledge of Resident #303's physical abuse allegation.

Resident #303 was admitted to the facility on 12/13/21 with diagnoses that included: Type 2 Diabetes Mellitus, Lack of Coordination and Urinary Tract Infection.

A FRI was received on 01/02/22 that documented, "During end of shift rounds at about 8:30am on Dec. 31st 2021, writer was informed by Speech Therapist that during her session this morning ... [Resident #303] said one of the nurses hit her on her hand ..."

Review of Resident #303's medical record revealed the following:

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An Admission Minimum Data (MDS) dated 12/21/21 where facility staff coded: a brief Interview for Mental Status (BIMS) summary score of 15, indicating intact cognition, no potential behaviors of psychosis, no verbal or physical behaviors directed towards others, no refusal of care, extensive assistance with one-person physical assist for bed mobility, transfers and personal hygiene and impairment on one side for lower extremity range of motion.

12/31/21 at 6:56 AM [Nurses Note] "Late Entry... During end of shift rounds at 8:30AM, writer was approached by Speech Therapist, she said [Resident #303] just informed her that she was hit on the hand by a nurse last night. Writer went to [Resident #303's] room and asked her what happened last night. She said, the female nurse hit her on her left wrist around 11:30PM and 12:00AM last night (Dec. 30th 2021). She denied injury, and there was no swelling, or skin discoloration observed at the alleged skin area in question. She denied pain. [Resident #303] was advised that her complaint will be investigated."

Review of the facility's investigation documents on 06/27/22 lacked documented evidence that all potential witnesses with knowledge of the incident were interviewed or provided a statement.

During a face-to-face interview conducted on 06/27/22 at 9:14 AM, Employee #3 acknowledged the finding and made no further comment.

2f. Facility staff failed to implement its policy for investigations evidenced by failure to interview all staff who might have knowledge of neglect allegation of Resident #304.

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Resident #304 was admitted to the facility on 11/02/21 with multiple diagnoses that included: Low Back Pain, Urinary tract infection (UTI), Diabetes Mellitus.

A Facility Reported Incident (FRI) received on 11/04/21 documented, "...Resident complained that yesterday night [11/03/21] her assigned staff did not respond to her call light on time when she requested fro (sp) assistance ...that the CNA (Certified Nurse Aide) was ignoring her calls/requests ... Resident also reported that this morning she was assisted to the bathroom but the staff CNA never came to assist her back to the bed..."

Review of Resident #304's medical record revealed the following:

11/02/21 [Care Plan] "[Resident #304] has an ADL self-care performance deficit r/t generalized weakness s/p (status post) lumbar spinal fusion ... Encourage the resident to use bell to call for assistance."

An Admission Minimum Data Set (MDS) dated 11/08/21 showed that facility coded the following: a Brief Interview for Mental Status (BIMS) summary score of 14, indicating intact cognition, no potential behaviors of psychosis, no refusal of care, required extensive assistance with one-person physical assist for be mobility, transfers, toilet use and personal hygiene, no limitations in range of motion for upper and lower extremities, used a walker and wheelchair for mobility devices, always incontinent of bladder and frequently incontinent for bowel.

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F 607	Continued From page 40 Review of the facility's investigation documents on 06/22/22 showed no documented evidence that the staff who worked with Resident #304 on the night of 11/03/21 were interviewed or provided statements. During a face-to-face interview on 06/22/22 at 12:55 PM, Employee #7 (Unit 1 Nurse Manager) acknowledged the findings and provided no further comments.	F 607	F609 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT : Resident #108 was assessed head to toe by the facility Licensed nurse on 5/26/22, for pain and trauma,no apparent injury observed.	09/23/22
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 609	Resident #108 was transfer to the hospital emergency room on 5/26/22 for further evaluation for possible physical abuse. Incident was reported to the State Agency late, approximately 22 hours after the incident. Resident #108 returned to the facility from ER/hospital visit on05/27/22. Licensed nurse performed a head to	

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F 609	Continued From page 41 Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, for nine (9) of 67 sampled residents, facility staff failed to: report allegations of resident-to-resident alleged/witness sexual abuse (inappropriate non-consensual sexual touch /willful non-consensual sexual contact) to the State Survey Agency immediately or no later than two hours of the allegation for Residents #108 and #145; report the results of investigations to the State Survey Agency, within 5 working days of the incident for Residents' #8, #84, #86, #108, #145, #112, #303 and #304; and report a resident-to-resident incident involving Resident #121. Residents' #108, #145, #8, #84, #86, #112, #303, #304 and #121. The findings included: 1. The facility's staff failed to report allegations of resident-to-resident alleged/witness sexual abuse (inappropriate non-consensual sexual touch /willful non-consensual sexual contact) to the State Suvey Agency immediately or no later than two hours of the allegation for Residents' #108 and #145. 1a. Resident #108 was admitted to the facility on 12/10/19 with multiple diagnoses including Alzheimer's Disease and Major Depression. Review of the medical record revealed the following: Situation, Background, Assessment, Result Form	F 609	Resident #145 was assessed head to toe by the facility Licensed nurse on 06/17/22 for pain and trauma, no apparent injury observed. Resident #145 was transfer to the hospital emergency room on 06/17/22 for further evaluation for possible physical abuse. Resident #145 Responsible Party was notified . The incident was reported to State Agency late approximately 3hours after the	09/23/22

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F 609	Continued From page 42 signed and dated on 5/31/22 by Nursing Supervisor (Employee #11) showed, "During the evening shift at about 8:30pm writer was made aware by the nurse that activity director saw [Resident #126] ...sitting at the bedside [of Resident 108] in his wheelchair and had feces on his left hand. [Resident #108] was unable to explain what happened due to diagnosis of cognitive communication deficit. [Resident #108] was assessed from head to toe by the nurse, no sign of pain/discomfort nor facial grimace expressed. No physical signs of trauma observed, no redness, no bruises around the perineal area and buttocks. [MD's name] made aware, new order was given to transfer resident to ER (emergency room) via 911 for further evaluation for possible physical abuse." It should be noted that the order to transfer Resident #108 to ER was not written until 05/26/22 at 4:41 PM after police came to facility after receiving a call of physical abuse for Resident #108. 05/26/22 at 3:30 PM [ADON Note] - "At about 3:30pm writer received [two police officers names and badge numbers] in the facility who said they had a call for alleged abuse for [Resident #108] in room 112-A. Writer received report from staff that [Resident #126 who resided in room 147 bed A} was observed sitting in his wheelchair at the bedside of [Resident #108] room 112-A at about 8:30pm on 5/25/22. It was reported that [Resident #126] was observed with feces on his left-hand front, back, and underneath his fingernails. It was also reported that [Resident #108] was observed with feces on her thigh and her bed spread. [Resident #126] was immediately removed from the scene and [MD's name] notified and order given to transfer [Resident #126] to Unit 3 - Room 310-B. Also, [detective's name and badge	F 609	Resident #126 was assessed head to toe on 6/17/22 by the facility licensed nurses for any signs of pain or trauma. No apparent injury found nor complains of pain reported. Resident on 1 on 1 monitoring X 24hrs everyday for safety precaution. The monitoring intervention will remain until cleared by the Attending Physician/Designee and the Psychiatrist/ Designee. Resident #126 was assessed by Psychiatrist, Psych NP, and FNP, for medication review and behavioral management on 06/17/22. Medical intervention was updated on 6/17/22. Resident will remain 1 on 1 monitoring x 24 hours everyday. Resident has not acted sexually inappropriate towards others.	09/23/22

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F 609	Continued From page 43 number] was called to the facility by the police. After meeting with the residents and talking to staff members the detective issue report [number] .... [Resident #108] was unable to explain what happened due to diagnosis of cognitive communication deficit, vascular dementia, and Alzheimer's disease ... left the facility ... to [local hospital] ..." 05/26/22 at 4:41 PM [Physician Order] transfer resident to ER via 911 for further evaluation for possible physical abuse. Review of the facility's investigative report revealed a facility's staff member notified the State Agency of the incident of alleged resident-to-resident inappropriate non-consensual sexual touch [sexual abuse] on 05/26/22 at 6:46 PM (approximately 22 hours after the incident). During a face-to-face interview on 06/28/22 starting at approximately 4:00 PM, Employee #3 (ADON) stated that the State Survey Agency was notified on 05/26/22 because the evening supervisor on 05/25/22 failed to notify the State Survey Agency. Cross reference 42 CFR 483.12, F600 1b. Resident #145 was admitted on 02/08/22 with multiple diagnoses including Dementia in other Disease classified elsewhere without Behavioral Disturbances, Cognitive Communication Deficit, and Generalized Muscle Weakness. Review of the medical record revealed the following: 06/17/22 at 5:07AM [Physician order] - Transfer	F 609	Resident#145 was discharged from the facility on 6/26/2022 Result of the investigation report was sent to the State agency via the reporting portal on 7/14/22.Resident #145 suffered no negative outcome from not reporting the result of incident investigation to the State Agency within 5 working days as stipulated by CMS requirement and regulation. Resident #108 was reassessed head to toe by the Unit Manager on 8/17/22for pain and trauma,no apparent injury observed. . Result of the incident investigation report was sent to the State Agency via the reporting portal on 7/14/22 Resident #86 was reassessed head to toe by the Unit Manager on 8/17/22. There were no negative outcomes. The incident report was sent to the State Agency on 7/14/22. Resident #8 was reassessed head to toe by the Unit Manager on 8/17/22for pain and trauma,no apparent injury observed. . Result of the incident investigation report was sent to the State Agency via	09/23/22

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F 609	Continued From page 44 resident to ER (emergency) for further examination due to possible physical abuse. 06/17/22 at 7:38 AM [Nursing Note] - " ... At 5:00 AM GNA/CNA was doing AM care ... She observed ... [Resident #126 from] room 310B ... [laying] on top of the [Resident #145] in room 313B and called writer to the room ... A head-to-toe assessment was done [for Resident #145] by supervisor and writer. No bruises noted, no skin tear, no bleeding noted. Resident denied pain or any discomfort at this time. Police was called on the seen [scene] ... An assessment was done by emergency responders, and they came to a conclusion to transfer resident to the nearest ER (emergency room) for further evaluation ..." During a face-to-face interview at approximately 8:45 AM, Employee #2 (DON) stated that she was making the surveyor (Representative of the State Agency) aware of the incident of resident-to-resident alleged abuse with Resident #145 and Resident #126. When asked if the facility's staff informed the Department of Health (State Agency) electronically about the incident? She stated, "No." It should be noted that the facility's staff made the State Survey Agency aware of the previously mentioned incdient of sexual abuse approximately 3 hours after the incident. Cross reference 42 CFR 483.12, F600 2. Facility staff failed to report the results of their investigations to the State Survey Agency within 5 working days of the incident for Residents #145, #108, #86, #8, #84 #112, #303, #304.	F 609	Resident #108 was reassessed head to toe by the Unit Manager on 8/17/22for pain and trauma,no apparent injury observed. . Result of the incident investigation report was sent to the State Agency via the reporting portal on 7/14/22 Resident #112 was reassessed head to toe by the Unit Manager on 8/17/22. Result of the incident investigation report was sent to the State Agency via the reporting portal on 7/14/22. Resident suffered no negative outcome from not reporting the result of incident investigation to the State Agency within 5 working days. Resident #303 was reassessed head to toe by the Unit Manager on 8/17/22. Result of the incident investigation report was sent to the State Agency via the reporting portal on 7/14/22. Resident suffered no negative outcome from not reporting the result of incident investigation to the State Agency within 5 working days. Resident #304 was reassessed head to toe by the Unit Manager on 8/17/22. Result of the incident investigation report was sent to the State Agency via the reporting on 7/14/22. Resident #121 was reassessed head to toe by the Unit Manager on 8/17/22. No apparent evidence of physical abuse or allegation of abuse. Moving forward any confirmed incidence of allegation of abuse for Resident #121 will be reported timely. The result of the investigation was sent to the state agency on 7/14/22. Resident suffered no negative outcome.	09/23/22

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F 609	Continued From page 45 2a. Resident #8 was admitted to the facility on 05/26/21 with multiple diagnoses including Schizoaffective Disorder, Delusional Disorder, and Bipolar Disorder. Review of the FRI dated 10/18/21 at 10:39 AM, documented, "At 9:13 PM, to Metropolitan officers arrived at the facility and stated that resident in Room 314 called the police and stated that some hit her neck ... Assessment was done, no lumps, no bruises, no trauma observed on resident's neck ... The alleged abuse [Employee #31] is suspended pending investigation ..." Review of the facility's investigative documents related to the previously mentioned FRI lacked documented evidence that the facility reported its investigation results to the State Survey Agency. Cross reference 42 CFR 483.12, F610 2b. Facility staff failed to report the results of their investigation of Resident #84's Facility reported allegation of neglect to the State Survey Agency within 5 working days of the incident. Resident #84 was admitted to the facility on 05/20/21, with multiple diagnoses that included: Type 2 Diabetes Mellitus Without Complications, Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side, Aphasia Following Cerebral Infarction, Sepsis Unspecified Organism, Unspecified Convulsions, Multiple Sclerosis, Gastrostomy Status and Dysphagia. Review of a Facility Reported Incident (FRI) received on 09/20/21, documented, "A complete head to toe assessment done Multiple scars to left upper back and sacral area. Redness to	F 609	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility has potential to be affected.	09/23/22

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	095015	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 609	Continued From page 46 perineal /sacral area washed with soap and water, pat dry and apply skin barrier cream after each incontinent care, discoloration to left inner leg ..." Review of the facility's investigation documents showed no documented evidence that the facility staff reported the results of the alleged neglect investigation to the State Agency. During a telephone interview conducted on 07/14/22 at approximately, 3:00 PM, Employee #2 (Director of Nursing) acknowledged the findings and stated that they did not send investigation results to the State Agency. 2c. Resident #86 was admitted to the facility on 8/28/18 with diagnoses that included Dementia without Behavioral Disturbance and Generalized Muscle Weakness. Review of the FRI dated 04/19/22 at 1:14 PM documented, "...[Resident #120] ... hit [Resident #86] in the face.." Review of the facility's investigative documents related to the previously mentioned FRI lacked documented evidence that the facility reported its investigation results to the State Survey Agency. 2d. Resident #108 was admitted to the facility on 12/10/19 with multiple diagnoses including Alzheimer's Disease and Major Depression. Review of the FRI dated 05/26/22 at 11:21 PM, documented, "At 3:30 PM writer received [Officers names] in the facility who said they had a call for alleged abuse for [Resident #108] ...Writer received report that [Resident #126] was	F 609	MEASURES TO PREVENT RECURRENCE: The facility Staff Developer/ Designee will provide an education/In-service to facility Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers and Supervisors on the process of reporting of incident of unusual occurrences to the State Agency within the required time as stipulated by the CMS regulation & requirement and within 2 hours if seriously bodily injury occurred. The in-service or education will explain the importance of reporting incidences within the required time as stipulated by the CMS regulation & requirement. The compliance date for this intervention 9/23/22. The facility Staff Developer/Designee will provide education to facility Director of Nursing (DON),Assistant Director of Nursing (ADON), Unit Managers and Supervisors on the importance of the importance of ensuring that results of the incident investigation report are sent to the State Agency via the reporting portal /system within 5 working days of the incident. The compliance date for this intervention 9/23/22. MONITORING CORRECTIVE ACTION: House wide audit will be conducted by Assistant Director of Nursing (ADON)/Designee to ensure reporting of all incidences of unusual occurrences to the State Agency via reporting system timely and within 2 hours if seriously bodily injury occurred, weekly times 4,then, monthly times 3 months. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	09/23/22

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F 609	Continued From page 47 observed sitting in his wheelchair at the bedside of [Resident 108] room 112 A at about 8:30 PM on 05/25/22. It was reported that [Resident #126] was observed with feces on his left hand ... [Resident #108] was observed with feces on her thigh and bed spread...[Resident #126] was transferred to Unit 3 ...[MD's name] gave orders to transfer [Resident #108] to ER for further evaluation of possible physical abuse ..." Review of the facility's investigative documents related to the previously mentioned FRI lacked documented evidence that the facility reported its investigation results to the State Survey Agency. Cross reference 42 CFR 483.12, F600. 2e. Resident #145 was admitted on 02/08/22 with multiple diagnoses including Dementia in other Disease classified elsewhere without Behavioral Disturbances, Cognitive Communication Deficit, and Generalized Muscle Weakness. Review of the Facility Reported Incident dated 06/17/22 at 10:32 AM, documented, " ...Writer was informed by the nurse that [Resident #126] was observed in bed with [Resident #145] in Room 313B ...[Resident #126] was redirected to leave the room ... [Resident #145] was assessed ... no signs of trauma observed...[MD's name] gave orders to transfer [Resident #145] via 911 to ER (emergency room) for further evaluation... " Review of the facility's investigative documents related to the previously mentioned FRI lacked documented evidence that the facility reported its investigation results to the State Survey Agency. Cross reference 42 CFR 483.12, F600	F 609	House wide audit will be conducted by Assistant Director of Nursing (ADON)/Designee to ensure that results of the incident investigation report are sent to the State Agency via the reporting portal /system within 5 working days of the incident, weekly times 4, then, monthly times 3 months. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee. House wide audit will be conducted by Assistant Director of Nursing (ADON)/Designee to ensure that all incidence of allegation of abuse is reported within the required time as stipulated by the CMS regulation & requirement. to the State Agency via the reporting portal /system, weekly times 4, then, monthly times 3 months. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	09/23/22

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F 609	Continued From page 48	F 609		09/23/22

2f. Resident #112 was admitted to the facility on 08/03/20 with diagnoses that included: Schizophrenia, Psychotic Disorder and Anxiety Disorder.

Review of a Facility Reported Incident (FRI) received on 07/19/21 documented, "Writer was informed by the charge nurse at 14:40p.m (2:40 PM) that [Resident #112] informed the PT (physical therapist) staff that she was raped all night, that she is feeling so horrible about this place that if she sees a gun, she can just kill herself..."

Review of the investigation documents showed no documented evidence that facility staff reported the results of the alleged abuse investigation to the State Agency.

2g. Resident #303 was admitted to the facility on 12/13/21 with diagnoses that included: Type 2 Diabetes Mellitus, Lack of Coordination and Urinary Tract Infection.

Review of a FRI was received on 01/02/22 documented, "During end of shift rounds at about 8:30am on Dec. 31st 2021, writer was informed by Speech Therapist that during her session this morning ... [Resident #303] said one of the nurses hit her on her hand..."

Review of the investigation documents showed no documented evidence that facility staff reported the results of the alleged abuse investigation to the State Agency.

2h. Resident #304 was admitted to the facility on 11/02/21 with multiple diagnoses that included: Low Back Pain, Urinary tract infection (UTI),

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F 609	Continued From page 49	F 609		09/23/22

Diabetes Mellitus.

Review of a FRI received on 11/04/21 documented, "...Resident complained that yesterday night [11/03/21] her assigned staff did not respond to her call light on time when she requested fro (sp) assistance ...that the CNA (Certified Nurse Aide) was ignoring her calls/requests ... Resident also reported that this morning she was assisted to the bathroom but the staff CNA never came to assist her back to the bed ..."

Review of the investigation documents showed no documented evidence that facility staff reported the results of the alleged abuse investigation to the State Agency.

During a telephone interview conducted on 07/14/22 at approximately 3:00 PM, Employee #2 (Director of Nursing) acknowledged the findings and stated that they did not send results of their investigations to the State Agency.

3. Facility staff failed to report a resident-to-resident incident involving Resident #121.

Resident #121 was admitted to the facility on 02/27/21 with diagnoses that included: Schizophrenia, Pressure Ulcer of Sacral Region Stage 4, Paraplegia, Neuromuscular Dysfunction of Bladder and Schizophrenia.

Review of a grievance made by Resident #121 dated 05/27/22 documented, "... Wed (Wednesday) May 25,2022 @ (at) 1:30 AM I was woke by a strange man [Resident #] in a wheelchair @ (at) the bottom side of my bed. I

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F 609	Continued From page 50	F 609		

screamed and called the nurse. He left. The nurse [Nurse's Name] came in and said he was looking for snacks..."

Review of Resident #121's Quarterly Minimum Data Set (MDS) dated 05/16/22 showed that facility staff coded the following: a Brief Interview for Mental Status (BIMS) summary score of 15, no potential indicators of psychosis and no verbal or physical behavior symptoms directed towards others.

05/25/22 at 2:11 AM [Nurses Note] "Late Entry: At about 2;11am a male resident wandered into room 144 A and was redirected back to his room. Writer asked [Resident #121] if the resident touched her, resident stated that no, he did not touch me, writer asked Ms Freeman again, do you have food on the table, resident answered, no he was touching the table and there was no food on the table, it was trash that was on the table."

Review of the "Grievance Written Decision/Resolution Form" dated 05/27/22 documented, "... Based on these findings, the grievance/alleged abuse case was ... confirmed..."

Although confirmed as abuse on the grievance form, facility staff failed to file an incident report of the resident-to-resident incident.

During a face-to-face interview conducted on 06/22/22 at approximately 1:00 PM with Employees #6 (Unit 1 Social Worker) and #2, Employee #6 stated, "Once I get a grievance, I speak to the resident and staff involved and get interviews. I then put together a packet and it's

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F 609	Continued From page 51 given to [Director of Social Services Name] and then goes to the Administration." At the time of the aforementioned interview, Employee #3 acknowledged the findings and stated, "An incident report should've been done and sent to DOH (Department of Health)."	F 609	F610 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: The affected Resident #108, was assessed from head to toe by the licensed nurse, no sign of pain/discomfort nor facial grimace expressed. No physical signs of trauma observed, no redness, no bruises around the perineal area and buttocks on 05/25/22. Resident #108 was transfer to the hospital emergency room on 5/26/22 for further evaluation for possible sexual abuse. Licensed nurse performed head to toe assessment on the resident and no negative outcome were found on 5/27/22. Resident was reassessed head to toe by the unit manager/Designee on 8/17/22. No new incident or occurrences of allegation of abuse observed. Resident #86 was reassessed head to toe by the unit manager on 8/17/22. Resident suffered no negative outcome. No new incident or occurrences of allegation of resident to resident altercation or abuse observed.	09/23/22
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, for seven (7) of 67 sampled residents, facility staff failed to: conduct thorough investigations evidenced by failure to interview and/or obtain statements from potential witnesses for: Resident #108's allegation of resident-to-resident inappropriate non-consensual sexual touch [sexual abuse]; Resident #86's allegation of a	F 610		

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resident-to-resident altercation; Resident #8's allegation of staff-to-resident physical abuse; Resident #112's allegation of sexual abuse; Resident #303's allegation of staff-to-resident physical abuse; Resident #304's allegation of staff neglect; and conduct an investigation of Resident #121's resident-to-resident incident. Residents' #108, #86, #8, #112, #303, #304, #121.

The findings included:

Review of the facility's policy titled, "Prohibition of Abuse", with a revision date of 05/22, defined sexual abuse as "... non-consensual sexual contact of any type with a resident includes but is not limited to sexual harassment coercion or sexual assault..."

Review of the facility's policy titled, "Investigation Process", with a revision date of 06/22, documented, "...interview and/or obtain statements from potential witnesses as determined by the scope of the investigation ..."

1. Facility staff failed to conduct thorough investigations evidenced by failure to interview and/or obtain statements from potential witnesses for Residents #108, #86, #8, #112, #303 and #304.

1a. The facility's staff failed to thoroughly investigate an allegation of resident-to-resident inappropriate non-consensual sexual touch [sexual abuse] for Resident #108.

Resident #108 was admitted to the facility on 12/10/19 with multiple diagnoses including Alzheimer's Disease and Major Depression.

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F 610	Continued From page 53 05/25/22 at 8:59 PM [Situation, Background, Assessment, Result Form]- "During the evening shift at about 8:30pm writer was made aware by the nurse that activity director saw [Resident #126] ...sitting at the bedside [of Resident 108] in his wheelchair and had feces on his left hand. [Resident #108] was unable to explain what happened due to diagnosis of cognitive communication deficit. [Resident #108] was assessed from head to toe by the nurse, no sign of pain/discomfort nor facial grimace expressed. No physical signs of trauma observed, no redness, no bruises around the perineal area and buttocks. [MD's name] made aware, new order was given to Transfer resident to ER (emergency room) via 911 for further evaluation for possible physical abuse." It should be noted that the order to transfer Resident #108 to ER was not written until 05/26/22 at 4:41 PM after police came to facility after receiving a call for a call of physical abuse for Resident #108 05/26/22 at 4:41 PM [Physician Order] transfer resident to ER via 911 for further evaluation for possible physical abuse. 05/26/22 at 3:30 PM [ADON Note] - "At about 3:30pm writer received [two police officers names and badge numbers] in the facility who said they had a call for alleged abuse for [Resident #108] in room 112-A. Writer received report from staff that [Resident #126 who resided in room 147 bed A was observed sitting in his wheelchair at the bedside of [Resident #108] room 112-A at about 8:30pm on 5/25/22. It was reported that [Resident #126] was observed with feces on his left-hand front, back, and underneath his fingernails. It was also reported that [Resident #108] was observed	F 610	Resident #8 was reassessed head to toe by the Unit manager on 8/17/22 No new incident or occurrences of allegation of staff to resident physical abuse observed. Resident #8 suffered no negative outcome from not conducting thorough investigation and by not interviewing and or obtaining statements from all potential witnesses and everyone that work on that shift. Resident #112 was reassessed head to toe by the Unit manager on 8/17/22 No new incident or occurrences of allegation of physical or sexual abuse observed. Resident #112 suffered no negative outcome from not conducting thorough investigation and by not interviewing and or obtaining statements all from potential witnesses and everyone that work on that shift	09/23/22

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F 610	Continued From page 54 with feces on her thigh and her bed spread. [Resident #126] was immediately removed from the scene and [MD's name] notified and order given to transfer [Resident #126] to Unit 3 - Room 310-B. Also, [Detective's name and badge number] was called to the facility by the police. After meeting with the residents and talking to staff members the detective issue report .... No arrest was made. However, [MD's name] also gave order to transfer [Resident #108] to ER (emergency room) via 911 for further evaluation for possible physical abuse. Resident was unable to explain what happened due to diagnosis of cognitive communication deficit, vascular dementia, and Alzheimer's disease ...911 emergency arrive the facility at 17:0pm [5:00 PM] and left the facility at 17:28pm [5:28 PM] to [local hospital] ..." Review of the staff assignment revealed Unit 1 had two licensed nurses and four (4) CNAs working on evening shift (3:00 PM to 11:00 PM) of 05/25/22. However, review of the facility's investigative report lacked documented evidence of the four (4) CNAs [potential witnesses] interviews or statements. During a face-to-face interview on 06/28/22 starting at approximately 4:00 PM, Employee #3 (ADON) stated that they are working on their process of investigating incidents. Cross reference 42 CFR 483.12, F600 and F607 1b. The facility's staff failed to thoroughly investigate an allegation of resident-to-resident altercation for Resident #86. Resident #86 was admitted to the facility on	F 610	Resident #303 was reassessed head to toe by the Unit manager on 8/17/22 No new incident or occurrences of allegation of staff to resident physical abuse observed. Resident #303 suffered no negative outcome from not conducting thorough investigation and by not interviewing and or obtaining statements from all potential witnesses and everyone that works on that shift. Resident #304 was reassessed head to toe by the Unit manager on 8/17/22 No new incident or occurrences of allegation of neglect from staff or abuse observed. Resident #303 suffered no negative outcome from not conducting thorough investigation and by not interviewing and or obtaining statements from all potential witnesses and everyone that works on that shift .	09/23/22

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F 610	Continued From page 55 08/28/18 with multiple diagnoses including: Dementia without Behavioral Disturbances and Generalized Muscle Weakness. Review of the medical record showed the following: 04/19/22 at 11:25 PM [MD Note] - "Resident complained another resident [Resident # 120] who was unprovoked struck him on the right side of the neck two days ago ...Plan continue admission to skilled NH (nursing home) ..." 04/20/22 at 1:47 PM [Social Work Note] - "The writer and recreation director was informed of a physical altercation between [Resident #86] and [Resident #120] on 04/14/22 ...[Resident #86] expressed that he does not feel safe if [Resident #120] returns to the facility ...I want to press charges ...This writer and activities director accompanied [Resident #86] to the 7th District Police Prescient to report incident and press charges ... " Review of facility's investigative report showed the following: 04/18/22 [Employee's #27's statement - smoke monitor]- documented, "I was on the smoke patio with [Resident #86] and [another resident] when [Resident # 120] entered the patio cussing [cursing] and making verbal treats [threats] to [Resident #86] ...[Resident #120] stated nobody can't stop me from getting to you ...I better not catch in the elevator ... because I got something for your [expletive] ..." Further review of the lacked documented evidence of an interview of statement from the	F 610	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED.: All residents residing in the facility have the potential to be affected.	09/23/22

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F 610	Continued From page 56 other resident that was present on the smoking patio at the time of the incident. During a face-to-face interview on 06/28/22 starting at approximately 4:00 PM, Employee #3 (ADON) stated that they are working on their process of investigating incidents. 1c. The facility's staff failed to thoroughly investigate an allegation of staff-to-resident physical abuse for Resident #8. Resident #8 was admitted to the facility on 05/26/21 with multiple diagnoses including Schizoaffective Disorder, Delusional Disorder, and Bipolar Disorder ... Review of Facility Reported Incident dated 10/18/21 at 10:39 AM, documented, "At 9:13 PM, to Metropolitan officers arrived at the facility and stated that resident in Room 314 called the police and stated that some hit her neck ... Assessment was done, no lumps, no bruises, no trauma observed on resident's neck ... The alleges abuse [Employee #31] is suspended pending investigation ..." Review of the medical record revealed the following: 08/25/21 [Minimum Data Set - Quarterly] showed Resident #8 had a Brief Interview for Mental Status summary score of "11" indicating the resident's cognition was moderately impaired. Further review revealed the resident was coded for hallucinations, delusions, verbal behavior symptoms directed toward others and receiving antipsychotic medications.	F 610	MEASURES TO PREVENT RECURRENCE: The facility Staff Development/ Designee will provide education to the facility Director of Nursing (DON), Assistant Director of Nursing (ADON),Unit Managers and Supervisors on the importance of following facility protocol by ensuring that investigation is thoroughly conducted, and all potential witnesses and all staff present are interviewed and statements are obtained. during an investigation of all incidences of unusual occurrences MONITORING CORRECTIVE ACTION: The Assistant Director of Nursing (ADON)/ Designee will complete house wide review/audit of all incidences of unusual occurrences to ensure that investigation is thoroughly conducted, and all potential witnesses and all staff present are interviewed and statements are obtained during an investigation of all incidences of unusual occurrences weekly times 4, then monthly times 3 months. The finding of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	09/23/22

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10/13/21 at 11:18 PM [Nursing Note]- "At 9:13 PM, two Metropolitan Officers arrived [to] the facility and stated the resident in room 314 called ...and stated someone hit her neck ... Assessment was done no lumps, no bruises, no trauma observed on resident's neck ...The alleged abuser [employee's name] is suspended pending investigation ..."

10/14/22 at 11:15 AM [ADON Note] - " Writer ... Social Worker Director ... Charge Nurse met with resident to inquired [inquire] from resident her concerns and reason for to speak to the police officer yester. Resident said she could not remember calling the police. Resident said with a flight of ideas ...yes someone hit me on my neck a while back in the group home and I was taken to John Hopkins Hospital ...someone has been stealing money from her bank account ...now Donald Trump is asking her to pay back the money ...The resident RP (resident representative) said resident was hit while in the group home ... [MD's name] notified order given to psych consult for resident with behavioral disturbance and confabulation [known as honest lying] ..."

Review of the facility's investigative report showed the following:

10/31/21 at 9:13 PM [Assigned Nurses Statement] - "I was the nurse on duty when the resident in room 314 called the police and told them someone hit her on the head. The police was [were] here and I did an investigation."

10/14/21 [Employee #31's statement - accused employee] - " ... while working on Wednesday, October 13., 2021. I did not come in contact with

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[Resident #8] verbally, physically, and/or in other manner ... I would never want my family and/or anyone to ever think that I would put my hands on a woman, a defensive [sp] one at that ... My goal is [in] this incident sets precedent to have safety measures put in place to protect staff members." Employee worked in the Activities/Recreation Department

Review of the Unit 3's assignment sheet for 10/13/22 showed the following staff: Dayshift three (3) licensed nurses and 3 CNAs. Evening shift two (2) licensed nurses and 3 CNAs, However, review of the facility's investigative report lacked documented evidence of 4 licensed nurses and 6 CNAs [potential witnesses] interviews or statements.

During a face-to-face interview on 06/28/22 starting at approximately 4:00 PM, Employee #3 (ADON) stated that they are working on their process of investigating incidents.

1d. Facility staff failed to conduct a thorough investigation on Resident #112's sexual abuse allegation evidenced by failure obtain statements/interviews from all potential witnesses who might have knowledge of the incident.

Resident #112 was admitted to the facility on 08/03/20 with diagnoses that included: Schizophrenia, Psychotic Disorder and Anxiety Disorder

Review of a Facility Reported Incident (FRI) received on 07/19/21 documented, "Writer was informed by the charge nurse at 14:40p.m (2:40 PM) that [Resident #112] informed the PT

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(physical therapist) staff that she was raped all night, that she is feeling so horrible about this place that if she sees a gun, she can just kill herself ..."

Review of Resident #112's medical record revealed the following:

02/09/21 [Physician's Order] "Sertraline (antidepressant) HCl (hydrochloride) Tablet 50 MG (milligram) give 1 tablet by mouth in the morning for Depression/Anxiety"

03/20/21 [Physician's Orders] "Quetiapine Fumarate (antipsychotic) Tablet 50 MG give 1 tablet by mouth at bedtime for Schizophrenia"

Quarterly Minimum Date Set (MDS) dated 05/04/21 where that facility staff coded: ta brief Interview for Mental Status (BIMS) summary score of 10, indicating moderately impaired cognition, no indicators for psychosis, no verbal or physical behaviors directed to others, extensive assistance to total dependence with one person physical assist for bed mobility and transfers, impairment on both sides for lower extremities, wheelchair mobility device and received antipsychotics on a routine basis in the last 7 days.

07/12/21 at 3:19 PM [Psychiatric Nurse Practitioner Progress Note] "...The patient was seen for f/u (follow up). She has a history significant for depression, anxiety. She is seen lying on the bed, alert and oriented generally to self, generally to place, receptive to visit ... Stable at this time ..."

07/19/21 at 1:43 PM [Social Work Progress Note]

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"Sexual assault note: This worker received a report from the ADON (Assistance Director of Nursing) stating the resident informed staff she was sexually assaulted by several men while she was in the facility... Once the resident spoke to the ADON and the SW director it was determined that the alleged incident could not have happen due to [Resident #112] stating the men came from outside of the facility. Due to visitation of the facility being very limited do to covid protocols no outside visitors have been allowed to any resident's room. The social work and nursing staff will continue to document any of the statement that are made by [Resident #112]."

07/19/21 at 3:52 PM [Nurses Note] "Writer was informed by the charge nurse at 14:40p.m that [Resident #112] informed the PT staff that she was raped all night, that she is feeling so horrible about this place that if she sees a gun, she can just kill herself ... [Resident #112] said "that someone from the community has been following her from all her street homes and also followed her to four different hospitals that she been to raping her and touching her inappropriately". Writer reassured the resident of her safety while being a resident in the facility. [Resident #112] said the individual does not work in this facility ... was unable to provide the mane of any individual. NP (Nurse Practitioner) ...was notified ... Resident's RP (representative) ... son was informed of the alleged rape ...Staff will continue to monitor resident for safety and document/report any abnormal concerns to the doctor ..."

07/19/21 at 7:50 PM [Nurse Practitioner Progress Note] " ... Follow up - "patient verbalized to physical therapist of being rapped last night" ...

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Thorough assessment done by multi-disciplinary team members on follow up of patient comment of rape. Facility well secured and monitored by security staff, staff making frequent rounds, visitors/guests do not enter facility without prior authorization. Facility protocols followed on this comment by patient ..."

Review of the facility's investigation documents on 06/23/22 lacked documented evidence to show that facility staff obtained statements from all staff that might have knowledge of the alleged incident.

During a face-to-face interview on 06/23/22 at 2:15 PM, Employee #3 acknowledged the finding and made no further comment.

1e. Facility staff failed to conduct a thorough investigation of Resident #303's allegation of physical abuse by an employee evidenced by failure to obtain statements/interviews from all potential witnesses who might have knowledge of the incident.

Resident #303 was admitted to the facility on 12/13/21 with diagnoses that included: Type 2 Diabetes Mellitus, Lack of Coordination and Urinary Tract Infection.

A FRI was received on 01/02/22 that documented, "During end of shift rounds at about 8:30am on Dec. 31st 2021, writer was informed by Speech Therapist that during her session this morning ... [Resident #303] said one of the nurses hit her on her hand ..."

Review of Resident #303's medical record revealed the following:

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An Admission Minimum Data (MDS) dated 12/21/21 where facility staff coded: a brief Interview for Mental Status (BIMS) summary score of 15, indicating intact cognition, no potential behaviors of psychosis, no verbal or physical behaviors directed towards others, no refusal of care, extensive assistance with one-person physical assist for bed mobility, transfers and personal hygiene and impairment on one side for lower extremity range of motion.

12/31/21 at 6:56 AM [Nurses Note] "Late Entry ... During end of shift rounds at 8:30AM, writer was approached by Speech Therapist, she said [Resident #303] just informed her that she was hit on the hand by a nurse last night. Writer went to [Resident #303's] room and asked her what happened last night. She said, the female nurse hit her on her left wrist around 11:30PM and 12:00AM last night (Dec. 30th 2021). She denied injury, and there was no swelling, or skin discoloration observed at the alleged skin area in question. She denied pain. [Resident #303] was advised that her complaint will be investigated."

Review of the facility's investigation documents on 06/27/22 lacked documented evidence that all potential witnesses with knowledge of the incident were interviewed or provided a statement.

During a face-to-face interview conducted on 06/27/22 at 9:14 AM, Employee #3 acknowledged the finding and made no further comment.

1f. Facility staff failed to thoroughly investigate an allegation on neglect for Resident #304 evidenced by failure to obtain statements/interviews from all potential witnesses

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who might have knowledge of the incident.

Resident #304 was admitted to the facility on 11/02/21 with multiple diagnoses that included: Low Back Pain, Urinary tract infection (UTI), Diabetes Mellitus.

A Facility Reported Incident (FRI) received on 11/04/21 documented, "...Resident complained that yesterday night [11/03/21] her assigned staff did not respond to her call light on time when she requested fro (sp) assistance ...that the CNA (Certified Nurse Aide) was ignoring her calls/requests ... Resident also reported that this morning she was assisted to the bathroom but the staff CNA never came to assist her back to the bed..."

Review of Resident #304's medical record revealed the following:

11/02/21 [Care Plan] "[Resident #304] has an ADL self-care performance deficit r/t generalized weakness s/p (status post) lumbar spinal fusion ... Encourage the resident to use bell to call for assistance."

An Admission Minimum Data Set (MDS) dated 11/08/21 showed that facility coded the following: a Brief Interview for Mental Status (BIMS) summary score of 14, indicating intact cognition, no potential behaviors of psychosis, no refusal of care, required extensive assistance with one-person physical assist for be mobility, transfers, toilet use and personal hygiene, no limitations in range of motion for upper and lower extremities, used a walker and wheelchair for mobility devices, always incontinent of bladder and frequently incontinent for bowel.

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Review of the facility's investigation documents on 06/22/22 showed no documented evidence that the staff who worked with Resident #304 on the night of 11/03/21 were interviewed or provided statements.

During a face-to-face interview on 06/22/22 at 12:55 PM, Employee #7 (Unit 1 Nurse Manager) acknowledged the finding and provided no further comments.

2. Facility staff failed to investigate a resident-to-resident incident involving Resident #121.

Resident #121 was admitted to the facility on 02/27/21 with diagnoses that included: Schizophrenia, Pressure Ulcer of Sacral Region Stage 4, Paraplegia, Neuromuscular Dysfunction of Bladder and Schizophrenia.

05/25/22 at 2:11 AM [Nurses Note] "Late Entry: At about 2; 11am a male resident wandered into room 144 A and was redirected back to his room. Writer asked [Resident #121] if the resident touched her, resident stated that no, he did not touch me, writer asked Ms Freeman again, do you have food on the table, resident answered, no he was touching the table and there was no food on the table, it was trash that was on the table."

Review of a grievance made by Resident #121 dated 05/27/22 documented, "... Wed (Wednesday) May 25, 2022 @ (at) 1:30 AM I was woke by a strange man [Resident #] in a wheelchair @ the bottom side of my bed. I screamed and called the nurse. He left. The

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F 610	Continued From page 65 nurse [Nurse's Name] came in and said he was looking for snacks..." Review of Resident #121's Quarterly Minimum Data Set (MDS) dated 05/16/22 showed that facility staff coded the following: a Brief Interview for Mental Status (BIMS) summary score of 15, no potential indicators of psychosis and no verbal or physical behavior symptoms directed towards others. Review of the "Grievance Written Decision/Resolution Form" dated 05/27/22 documented, "... Based on these findings, the grievance/alleged abuse case was ... confirmed ..." Although confirmed as abuse on the grievance form, facility staff failed to investigate the incident as resident-to-resident incident of abuse. During a face-to-face interview conducted on 06/22/22 at approximately 1:00 PM with Employees #6 (Unit 1 Social Worker) and #3, Employee #6 stated, "Once I get a grievance, I speak to the resident and staff involved and get interviews. I then put together a packet and it's given to [Director of Social Services Name] and then goes to the Administration." At the time of the aforementioned interview, Employee #3 acknowledged the finding and stated, "Based on the staff statements, [accused Resident's Name] was looking for food and it was not a safety concern."	F 610		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)	F 625		

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F 625	Continued From page 66 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, for six (6) of 67 sampled residents, facility staff failed to provide written notice of the facility's bed-hold policy to residents or their representative(s). Residents' #35, #54, #93, #97, #110 and #84. The findings include: 1. Resident #35 was re-admitted to the facility on	F 625	F625 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: The facility cannot retroactively correct this deficiency. Resident #35,#54,#93,#97,#110 and #84 were reassessed from head to toe on 8/17/22 by Unit Manager/ Designee. Residents suffered no negative outcome. Resident/Responsible party will be given the updated bed hold policy by 09/23/22.	09/23/22

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F 625	Continued From page 67 03/15/22 with diagnoses including Pneumonia, Type 2 Diabetes Mellitus, Dependence on Renal Dialysis, Personal History of Transient Ischemic Attack (TIA), and Cerebral Infarct without Residual Deficits, and Dysphagia. A Quarterly Minimum Data Set (MDS) dated 04/11/22 showed in Section C (Cognitive Patterns) that facility staff documented the resident as having a Brief Interview For Mental Status Summary Score (BIMS) of "15," indicating intact cognition. Review of Resident #35's clinical record revealed: 03/11/22 Transfer/Discharge Report documented: "Resident returned from dialysis at 4:30 PM with shortness of breath, chest congestion/discomfort, elevated blood pressure, low oxygen level (88%), and temperature 100.5." 03/11/22 at 4:40 PM [Physician's Order] directed, "Transfer patient to the hospital for further evaluation and treatment one time a day for SOB (shortness of breath), chest discomfort, elevated BP (blood pressure), low oxygen saturation." 03/11/2022 at 6:58 PM, [Nurses Notes/Late Entry]: " ...Resident returned from dialysis center ...went straight to bed to relax ...resident was observed with shortness of breath, chest congestion/discomfort, hypertension, and low oxygen level...Resident was transferred to [Local Hospital] ...[Name of Responsible party] made aware of the change in condition and hospital transfer ...Resident was transferred to ER (Emergency Room) with the following documents: Physician order, Diagnoses and Allergies, Recent Vital signs, Face sheet, Copy of Advance directive, Copy of Comprehensive Care Plan	F 625	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected. MEASURES TO PREVENT RECURRENCE: Staff Development/Designee will provide education/in-service to the facility Admission Director/ Designee on the importance of providing the bed hold policy to the resident and/or responsible party/ designee within stipulated time by CMS requirement and regulation. MONITORING CORRECTIVE ACTION: Director of Admission/Designee will conduct house wide audit to ensure that responsible parties are notified or provided with a copy of the bed hold policy when a resident is out of the facility and update them in writing of the bed hold days and ensure documentation of bed hold policy and bed hold days in the resident medical record, weekly times 4, then, monthly times 3 months. Any issues found will be corrected by 9/23/22. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee .	09/23/22

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Goal, Most recent Labs, E-Interact printed and sign[ed] ...negative rapid COVID-19 test result."

A review of Resident #35's medical record showed no documented evidence that facility staff provided the resident or the resident's representative with written information that specified the facility's bed hold policy when Resident #35 transferred to the hospital.

During a face-to-face interview on 06/23/22 at 10:36 AM, when asked to provide written documentation to show that the bed hold policy was provided to Resident #35 or the resident's representative, Employee #29 (Social Worker) stated, "I checked and could not find it."

2. Resident #54 was re-admitted to the facility on 01/08/21 with diagnoses including, Pneumonia, Chronic Obstructive Pulmonary Disease (COPD), Type 2 Diabetes Mellitus, Dependence on Supplemental Oxygen, and Dementia in Other Diseases Classified Elsewhere Without Behavioral Disturbance.

A Quarterly Minimum Data Set (MDS) dated 04/25/22 showed in Section C (Cognitive Patterns) that facility staff documented the resident as having a Brief Interview for Mental Status Summary Score (BIMS) of "03," indicating that the resident had severely impaired cognition.

Review of Resident #54's medical record revealed:

A Transfer Discharge Report dated 04/13/22 documented, "Chief Complaint: Change in mental status observed [a] large quantity of green emesis on bed linens and the floor."

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04/13/22 at 2:49 PM [Physician's Order] directed, "ER transfer for green emesis, tachycardia, elevated temperature, generalized change in condition."

04/13/22 at 4:00 PM [Nurses Note] documented, "During shift rounds at 2 PM, the writer observed a large quantity of green emesis on resident's bed linen and on the floor ...Upon assessment, [the resident was] observed with general body weakness, [and] confusion ...[Name of Nurse Practitioner] made aware and gave [an]order for [the] resident to be transferred to hospital, RP [Resident Representative's Name] [was] also made aware ...The following documents accompanied [the] resident, Covid test done, result negative, verified by two nurses, Face sheet, advance directive, list of medications. Recent labs, history and physical, care plan goals, and bed hold policy."

05/15/22 at 2:00 AM, a [Situational, Background, Assessment (SBAR)...Communication Tool] " ...Situation: ...at about 12:20 AM 5/15/22. 'change in mental status'. An order was written to send out the resident 911 ...Background: ...; Mental status or neuro changes: lethargy ...low response ...difficult to arouse; ...Request ...[Name of Resident#54's Representative] contacted ..."

05/15/22 at 2:25 AM, a document entitled "DOH (Department of Health) Notice of Discharge Transfer or Relocation Form," documented: "(5) If you are being transferred to a hospital or the transfer is for therapeutic leave, attached is this facility's bed-hold policy. Your available number of bed-hold days is: " 0..." Of note, no bed hold policy was included within or attached to this

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form.

During a face-to-face interview on 06/23/22 at 10:36 AM, Employee #29 (Social Worker) stated that the facility staff included the facility's bed hold policy on the DOH (Department of Health) Notice of Discharge Transfer or Relocation Form, which was shared with Resident #54's representative. Employee #29 offered no further comment and provided no documented evidence of a separate bed hold policy that facility staff provided to Resident #54 or the resident's representative when the resident transferred to the hospital on 04/13/22 and

Review of Resident #54's medical record lacked documented evidence that the facility staff provided written information that specified the facility's bed hold policy to Resident #54 when the resident transferred to the hospital on 04/13/22 or 05/15/22.

3. Resident #93 was admitted to the facility on 12/11/18 with multiple diagnoses, including, Unspecified Convulsions, Parkinson's Disease, Hemiplegia following Cerebral Infarct Affecting Right Dominant Side, Aphasia, Gastrostomy Status, Unspecified Dementia without Behavioral Disturbance, Narcolepsy Without Cataplexy and Type 2 Diabetes Mellitus.

A Quarterly Minimum Data Set (MDS) dated 04/12/22 showed that in Section C (Cognitive Patterns), facility staff documented Resident #93's Brief Interview For Mental Status Summary Score (BIMS) as a minus (-) symbol; indicating that the resident was unable to answer the interview questions and had severe cognitive impairment.

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A review of Resident #93's medical record revealed:

05/22/22 at 11:15 AM [Physician's Order] directed, "Send Resident to nearest Emergency Room (ER) via 911 for uncontrollable seizure."

05/22/22 at 12:01 AM [Nurses Notes] documented, " ...Resident was received in bed during round[s] at the start of shift alert and verbally responsive. At 11 AM, [the] writer responded to a code blue ....[the] resident was observed in bed unresponsive, having [a] generalized tonic-clonic seizure...[Name of Physician] made aware, gave [an] order to transfer resident to ER via 911 for evaluation ..."

05/22/22 at 11:24 PM, a document entitled "DOH (Department of Health) Notice of Discharge Transfer or Relocation Form," read: ",,, (5) If you are being transferred to a hospital or the transfer is for therapeutic leave, attached is this facility's bed-hold policy. Your available number of bed-hold days is: 'will attached (sp,).' Of note, there was no bed hold policy attached to this form.

A review of Resident #93's medical record showed no documented evidence that facility staff provided the resident or the resident's representative with written information that specified the facility's bed hold policy when Resident #93 transferred to the hospital on 05/22/22.

During a face-to-face interview on 06/23/22 at 10:36 AM, Employee #29 (Social Worker) stated, "I checked and could not find documentation to

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show that the bed hold policy was provided to the resident or the resident's representative."

4. Resident #97 was admitted to the facility on 08/28/20 with multiple diagnoses, including, Chronic Obstructive Pulmonary Disease (COPD), Type 2 Diabetes Mellitus, Chronic Kidney Disease Stage 3, Congestive Heart Failure, Non-Alzheimer's Dementia and Other Symptoms and Signs Concerning Food and Fluid Intake.

A Quarterly Minimum Data Set (MDS) dated 09/14/21 showed that facility staff left Section C (Cognitive Patterns)/Brief Interview For Mental Status Summary Score (BIMS) of "08," indicating that the resident had moderate cognitive impairment.

A review of Resident #97's medical record revealed:

[Face Sheet] documented: [Name of Resident #97] Responsible party.

07/07/21 at 11:41 PM [Nurses Note] documented " ...NP reviewed lab results at 6:30 PM, order received from NP to transfer resident to the nearest ER (Emergency Room) via regular ambulance for abnormal lab AKI (acute kidney indicators) elevated BUN/Creatinine ...RP (representative) notified of pick up, and the hospital resident was transferred to ...The following copies were sent to the hospital with the resident: Physician's order, diagnosis/allergies...advance directives/comprehensive care plan ...A copy of bed hold policy ..."

09/14/21 [Physician's Order] directed, "ER

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(Emergency Room) transfer for resident with altered mental status and severe distended LLQ (left lower quadrant) abdomen."

09/14/21 at 12:20 PM [Nurse Practitioner Note]: documented, "Asked to evaluate resident 'STAT' (immediately) Resident in bed. Drowsy ...A. Altered Mental Status due to? R/o (rule-out) RUE (right upper quadrant) mass. P. ER (Emergency Room) transfer for further evaluation and treatment."

09/14/21 at 2:06 PM, a [Situational, Background, Assessment (RN-Registered Nurse) or Appearance (LPN- Licensed Practical Nurse) and Request] (SBAR)- Physician/NP(Nurse Practitioner)/PA (Physician's Assistance) Communication Tool documented: " ... [the] Resident was observed with Altered Mental Status, and Severe abdominal distention ...Person contacted: [Name of Resident #97's Representative] unable to reach voicemail full ..."

09/20/21 at 8:21 PM [Nurses Note] documented, "Write(r) received a call from [Nurse at Local Hospital] ...that resident expired at 7:28 PM."

During a face-to-face interview on 06/23/22 at 10:36 AM, Employee #29 (Social Worker) stated, "I could not find the bed hold policy documents for that resident. The resident's record is closed." The resident expired in September 2021.

On 06/27/22 at 11:00 AM, the surveyor requested the entire closed record for Resident #97 and asked explicitly for written documentation that showed that the facility's bed hold policy was provided to Resident#97 when the resident transferred to the hospital on

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F 625	Continued From page 74 07/07/21 and 09/14/21. A review of Resident #97's closed medical record, and transfer documents provided by Employee #29 showed no documented evidence that facility staff provided the resident with written information that specified the facility's bed hold policy when the resident #97 transferred to the hospital on 07/21/21 or 09/14/21." 5. Facility staff failed to provide to Resident #110's or their representative(s) written notice of the bed-hold policy when she was transferred to the hospital. Resident #110 was admitted to the facility on 11/08/19 with diagnoses that included: Osteoarthritis, Type 2 Diabetes Mellitus, Peripheral Vascular Disease and Dysphagia. Review of Resident #110's medical record revealed the following: 04/26/22 at 4:37 PM [Nurses Note] "... At 12:30pm writer was called by wound nurse while doing her regular rounds that resident's second left toe is infected. NP (Nurse Practitioner).. made aware, assessed resident and gave order to transfer resident to ER (emergency room) by 911 for left 2nd toe wet gangrene ... [RP Name]... was informed..." 04/26/22 at 9:50 PM [Nurses Note] "At 9:45pm call made to [Hospital Name]... resident is admitted..."	F 625		

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A Significant Change (MDS) dated 05/20/22 showed facility staff documented: a Brief Interview for Mental Status (BIMS) summary score of 12, indicating moderately impaired cognition.

When asked to provide a copy of the written bed-hold policy provided to Resident #110 or their representative for the hospitalization on 04/26/22, facility staff was unable to provide the document.

During a face-to-face interview conducted on 06/24/22 at 12:04 PM, Employee #6 (Unit 1 Social Worker) stated, "I am not sure what happened. I can only find the notice of bed hold policy for 2021. I can't find one for the most recent hospitalization. It must've have been missed; it wasn't done.

6. The facility's staff failed to provide a written notice of the facilities bed-hold policy to Resident #84 and the Resident's Representative on multiple occasions when Resident #84 was transferred to the Hospital from the facility.

Resident #84 was admitted to the facility on 05/20/21, with multiple diagnoses that included: Type 2 Diabetes Mellitus Without Complications, Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side, Aphasia Following Cerebral Infarction, Sepsis Unspecified Organism, Unspecified Convulsions, Multiple Sclerosis, Gastrostomy Status and Dysphagia.

Review of the Quarterly Minimum Data Set (MDS) dated 02/18/22, revealed that the facility staff coded the following: Section C (cognitive

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Patterns): "Should a Brief Interview for Mental Status be Conducted? "NO"

Review of the physician orders showed the following: 04/07/22, "Resident returned from hospital ..."

Review of the nurse's progress notes revealed the following:

01/03/22 at 3:37 PM "Resident was observed with bright red blood saturated brief during incontinent care at 1:30 PM. Assessment revealed profuse bleeding from her vagina ...NP (nurse practitioner) was notified and oder (sp) given to transfer resident to ER (Emergency room) ..."

02/20/22 at 4:29 PM " ...resident was observed again vomiting large amount of coffee ground emesis and continuously bleeding fresh red blood from both nostrils ...911 was called, paramedics arrived at resident bedside at 5PM assessed resident and left the unit with resident to (Hospital name) ..."

03/31/22 at 7:33 PM " ...nurse observed resident with dislodged G-(Gastrostomy)Tube during medication administration ...writer attempt to replace G-tube unable on two attempts with resistance. Resident with (Hospice name) made aware and give order to send resident to nearest ER for G-tube replacement ...911 call at 7:55pm and EMT arrived at 8:05 pm bed side assessment done, and resident was transfer ..."

There is no documented evidence in the medical record of a notice of the bed hold policy being given to resident or resident representative.

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F 625	Continued From page 77 A face-to-face interview was conducted on 06/24/22 at 11:57 AM with Employee #29 (Licensed Social worker) the surveyor asked for documented evidence that the resident or resident representative was notified of the facilities bed hold policy for each of resident's hospitalizations. Employee # 29 was unable to provide any documented evidence and stated "I cannot find the 6-108 for the January 3 and February 22nd hospitalizations for Ms. (Resident #84)"	F 625		09/23/22
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656	F656 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: Resident #150 was reassessed from head to toe by Unit Manager /Licensed Nurse on 8/17/22 Resident suffered no negative outcome. A comprehensive care plan was developed on 8/10/22 to address use of Plavix (anticoagulant) . Resident #354 was reassessed from head to toe by Unit Manager /Licensed Nurse on 8/17/22 Resident suffered no negative outcome Care plan intervention was implemented on management of the central line insertion site on 6/14/22. Dressing to the central line insertion site was changed immediately after being notified on 6/14/22 by the licensed nurse.	

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F 656	Continued From page 78 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, for two (2) of 67 sampled residents, facility staff failed to: (1) develop a comprehensive care plan to address Resident #150's use of Plavix (anticoagulant) and (2) implement the care plan intervention for changing Resident #354's central line dressing. The findings included: 1. Facility staff failed to develop a comphrehensive care to address Resident #150's use of Plavix. Resident #150 was admitted to the facility on 03/08/22 with the multiple diagnoses including Peripheral Vascular Disease and Coronary Atherosclerosis due to Lipid Rich Plasma. Review of the medical record reveals a physician's order dated 05/17/22 instructed,	F 656	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have potential to be affected.	09/23/22

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F 656	Continued From page 79 "Plavix [anticoagulant] 75 mg (milligrams) give one (1) tablet by mouth one time a day for PAD (Peripheral Arterial Disease)." Review of Resident #150's comprehensive care plans lacked documented evidence the of a care plan to address the resident's use of Plavix. During a face-to-face interview on 06/28/22 at 2:30 PM, Employee #21 (RN/Unit Manager) stated that it was an oversight, and she would develop a care plan to address the resident's use of Plavix. 2. Facility staff failed to implement the care plan interventions of changing Resident #354's central line dressing every seven (7) days. According to the Centers for Disease Control (CDC), "... Replace dressings used on short-term CVC (central venous catheter) sites at least every 7 days..." https://www.cdc.gov/infectioncontrol/guidelines/bsi/index.html#rec6 During an observation on 06/14/22 at 10:40 AM, Resident #354 was observed receiving intravenous (IV) antibiotics via a peripherally inserted central catheter (PICC). The resident stated, "I told the staff they needed to change the dressing. It has not been changed since it was put in in the hospital." Upon closer observation, the dressing was noted to have the date "6/6/22" in bold, black ink. Review of Resident #354's medical record revealed the following:	F 656	F656 MEASURE TO PREVENT RECURRENCE: The facility Staff Development will provide education/in-services to all facility licensed nurses on the importance of : 1. Developing comprehensive care plan to address the needs of the resident. 2. Implementation of the care plan interventions to address / meet the needs of the residents This will be completed by 9/23/22.	09/23/22

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F 656	Continued From page 80 Resident #354 was admitted to the facility on 06/10/22 with diagnoses that included: Infection and Inflammatory Reaction Due to Other Internal Joint Prosthesis. Care Plan focus area"[Resident #354] has an right upper line picc line" initiated on 06/10/22 documented "... Interventions: Change transparent dressing on insertion site every 7 days ... Monitor right upper line picc line q (every) shift ..." 06/11/22 at 10:43 AM [Nurses Progress Note] "Late Entry...Admitted with right upper picc line and left shoulder surgical wound..." 06/11/22 [Physician's Order] "Observe right upper arm and call MD (medical doctor)/NP (Nurse Practitioner) for bleeding, swelling s/s (signs and symptoms) of infection or any IV related complications every shift" The evidence showed that facility staff failed to change the transparent dressing to Resident #354's insertion site every 7 days as specified in the care plan. During a face-to-face interview conducted on 06/14/22 at 11:10 AM, Employee #5 (Registered Nurse) acknowledged the finding and stated, "I didn't notice that the dressing was due to be changed. I will change it today."	F 656	MONITORING CORRECTIVE ACTION: The Unit Manager/ Designee will complete house wide review/audit of all residents on Anticoagulant therapy. Audit will be done weekly times 4, then, monthly times 3 months. Any negative findings will be corrected by 9/23/22. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee. The Unit Manager/ Designee will complete house wide review/audit of all residents to identify potential residents with an Intravenous line to ensure that the licensed nurses implement the care plan intervention for changing resident intravenous line insertion site dressing according to the plan of care and as needed.Audit will be done weekly times 4, then, monthly times 3 months. Any negative findings will be corrected by 9/23/22. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	09/23/22
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657		

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SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 657	Continued From page 81 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) out of 67 sampled residents, facility staff failed to revise Resident #124's comprehensive care plan reflect the resident's preference to not be discharged. The findings include: Review of the facility policy "Interdisciplinary Team Meeting (IDT) Care Plan Meeting" revised 02/22 documented, "It is the policy of [Facility Name] to develop and implement a person-centered care plan for each resident that	F 657	F657 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: The facility cannot retroactively correct this deficiency Resident #124 was discharged from the facility 07/1/2022. Resident suffered no negative outcome IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have potential to be affected.	09/23/22

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F 657	Continued From page 82 includes the instructions needed to provide effective and person-centered care that meet professional standards of quality care..." Resident #124 was admitted to the facility on 04/21/21 with diagnoses that included: Difficulty Walking, Hypothyroidism, Hypertension, Anemia and Dysphagia. Review of Resident #124's medical record revealed the following: Care Plan focus area "[Resident #124's] goal and expectation for discharge is to return back to the community" initiated on 04/22/21, documented, "... 05/2/22 IDT meeting held today. Care plan reviewed and updated. Continue with POC (plan of care)..." 02/01/22 at 3:27 PM [Social Work Progress Note] "Care Plan Note: IDT (interdisciplinary team) Meeting was held on behalf of resident...There are no plans for discharge at this time, resident will continue to be a long term care resident in the facility..." 05/03/22 at 11:27 AM [Social Work Progress Note] "The clinical/IDT team met to review resident's care plan. Social worker, Activity, Nursing, Dietitian, Rehab services were in attendance. Resident chose not to attend the meeting...There were no changes since the last update, this worker will continue to work with the resident to assist with any needs or issues. There are no plans for discharge at this time, resident will continue to be a long term care resident in the facility." 05/14/22 Quarterly Minimum Data Set (MDS)	F 657	F657 MEASURE TO PREVENT RECURRENCE: The facility Staff Development will provide education/in-services to the facility social worker on the importance of ensuring resident comprehensive care plan is revised to reflect resident preferences not to be discharged and to remain in Long Term Care. This will be completed by 9/23/22 MONITORING CORRECTIVE ACTION: The Director of Social Service/ Designee will complete house wide review/audit of all residents to identify any residents with the preference not to be discharged, and ensure that the comprehensive care plan reflects the resident's preference to remain in long term care. Any issue found during this audit will be corrected by 9/23/22. The audit will be conducted weekly times 4, then, monthly times 3 months. The findings of these audits will be presented monthly for 3 months to the Quality Assurance Performance Improvement (QAPI) committee.	09/23/22

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F 657	Continued From page 83 showed facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 15, indicating intact cognition, no potential for psychosis, no verbal or physical behavioral symptoms directed towards others, independent for locomotion on and off the unit and no active discharge planning for the resident to return to the community. The evidence showed that facility staff failed to revise Resident #124's care plan to reflect that she was to remain in the longterm care facility. During a face-to-face interview on 06/16/22 at 10:31 AM, Employee #6 (Unit 1 Social Worker) stated, "Discharge was discussed but the resident never verbalized a desire to leave the facility. That was the original goal (discharge) when she first was admitted here, it (care plan) should have been changed to say that she wanted to be long term care."	F 657		09/23/22
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b)	F 676	F676 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: The facility cannot retroactively correct this deficiency. Resident#84 received a shower immediately on 6/23/22 after being notified and was documented accordingly. Resident was reassessed by the Unit Manager/Designee on 8/17/2022 Resident suffered no negative outcome. And will be assisted with Activity of Daily Living including bathing and all the care provided. These will be documented in the resident medical record ongoing. Resident #4 received a shower immediately on 6/28/22 after being notified and was documented accordingly. Resident was reassessed by the Unit Manager/Designee on 8/17/2022 Resident suffered no negative outcome. And will be assisted with Activity of Daily Living including bathing and all the care provided. These will be documented in the resident medical record ongoing.	

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F 676	Continued From page 84 of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interview for two (2) of 67 sampled residents, facility staff failed to ensure that residents are given the appropriate treatment and services to maintain or improve their ability to carry out activities of daily living by not providing documented evidence that residents were provided with ADL(activities of daily living) care such as personal hygiene care on multiple days. (Residents' #84 and #4). The findings included: 1. Facility staff failed to provide documented	F 676	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have potential to be affected.	09/23/22

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F 676	Continued From page 85 evidence of bathing Resident #84 on multiple days during the month of May 2022. Review of a Facility Reported incident (FRI) received by DOH (Department of Health) on 09/20/21, concerning Resident #84 documented " ...A complete head to toe assessment done Multiple scars to left upper back and sacral area. Redness to perineal /sacral, area. ..." The incident is categorized as an allegation of Resident/Patient Neglect. Resident #84 was admitted to the facility on 05/20/21, with multiple diagnoses that included: Type 2 Diabetes Mellitus Without Complications, Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side, Aphasia Following Cerebral Infarction, Sepsis Unspecified Organism, Unspecified Convulsions, Multiple Sclerosis, Gastrostomy Status and Dysphagia. Review of the Quarterly Minimum Data Set (MDS) dated 02/18/22, revealed that the facility staff coded the following: Section C (Cognitive Patterns): "Should a Brief Interview for Mental Status be Conducted? "NO" Section G (Functional Status): Bed Mobility, "Extensive assistance" requiring "One-person physical assist" Transfer, "Extensive assistance" requiring "Two-person physical assist" Toilet use, "Extensive assistance" requiring "One-person physical assist" Personal hygiene, "Extensive assistance" requiring "One-person physical assist" Bathing "Total dependence" Upper extremity "Impairment on one side" Lower extremity "Impairment on one side"	F 676	MEASURE TO PREVENT RECURRENCE: The facility Staff Developer will provide education/in-services to the facility licensed nurses and nursing assistants on the importance of assisting and providing Activity of Daily Living (ADL) and importance of documentation of care provided for the residents. This will be completed by 9/23/22	09/23/22

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F 676	Continued From page 86 Review of the physicians' orders showed the following: 04/06/22 "Adjust to nursing home placement; Promote good nutritional status and skin care; &/or Improve physical function; Meet ADL (Activities of daily living) needs daily ..." Review of the care plan with a focus area of "[Resident #84] has an ADL self-care performance deficit r/t (related to) Hemiplegia and Hemiparesis following cerebral infarction affecting right dominant side, adult failure to thrive" initiated on 05/21/21, included the following interventions: "(Resident #84) requires 2 staff participation with transfers ...the resident is totally dependent on staff to provide a bath as necessary ...[Resident #84] requires total assistance with personal hygiene care ... The resident is totally dependent on staff for dressing ..." Review of the document titled "Documentation Survey Report v2" which is part of the electronic health record where the CNA's (Certified Nurse Aides) document ADL and other care that they provide dated from, 05/01/22 to 05/31/22, shows that there was no documented evidence of Resident #84 being bathed on the following dates: 05/11/22, 05/14/22, 05/15/22, 05/16/22, 05/17/22, and 05/29/22 During a face-to face interview conducted on 06/23/22 at 11:01 AM, Employee #33 (Unit Manager 2nd Floor) stated "Its not documented" Employee #33 acknowledged the findings and made no further comment.	F 676	MONITORING CORRECTIVE ACTION: The Unit Manager/Designee will conduct house wide review/audit to identify residents that require ADL assistance including bathing and ensure that the appropriate assistance is provided. This audit will be completed weekly times 4, then, monthly times 3 months. The Unit Manager/Designee will conduct house wide review/audit of residents' and ensure that Activity of Daily Living (ADL) care provided are documented in the resident medical records accurately. This audit will be conducted weekly times 4, then, monthly times 3 months. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	09/23/22

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F 676	Continued From page 87	F 676		

2. Facility staff failed to provide documented evidence of bathing Resident #4 on multiple days in May and June 2022.

Resident #4 was admitted to the facility on 05/23/22 with multiple diagnoses that included: Pressure Ulcer Sacral Region Stage 4, Type 2 Diabetes Mellitus with Unspecified Complications, Legal Blindness as Defined in USA, Unspecified Glaucoma, and Muscle Weakness.

Review of the Admission Minimum Data Set (MDS) dated 05/27/22, revealed that the facility staff coded the following:

Section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) Summery Score "02" Indicating severely impaired cognition.
Section G (Functional Status): Bed Mobility, "Extensive assistance" requiring "Two-person physical assist"

Transfer, "Activity did not occur"
Dressing, "Total dependence" requiring "One-person physical assist"
Toilet Use, "Total dependence" requiring "Two-person physical assist"
Personal hygiene, "Total dependence" requiring "One-person physical assist"
Bathing, "Total dependence"
Upper extremity "Impairment both sides"
Lower extremity "Impairment on both sides"
Section H (Bladder and Bowel): Indwelling Catheter
Urinary Continence "Not rated"
Bowel Continence "Always Incontinent"

Section M (Skin Conditions): The facility staff coded that resident has two (2) stage three

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F 676	Continued From page 88	F 676		

pressure ulcers that were present on admission, one (1) unstageable pressure ulcer present on admission and moisture associated skin damage. Review of the physicians' orders revealed the following: 05/21/22, " ...Meet ADL (activities of daily Living) needs daily ..."

Review of the care plan with a focus area of: "[Resident #4] ADL self-care deficit related to physical limitations, visual impairment, change in mental status ..." initiated on 05/23/22, included the following interventions: "Assist to Bathe/Shower as needed ...Assist with daily hygiene, grooming, dressing, oral care and eating as needed ..."

Review of the document titled "Documentation Survey Report v2" which is part of the electronic health record where the CNA's (Certified Nurse Aides) document ADL and other care that they provide dated 05/21/22 to 6/28/2022, shows that there was no documented evidence of Resident #4 being bathed on the following dates: 05/22/22, 05/24/22, 05/29/22, 06/07/22, 06/25/22, 06/26/22 and 06/28/22

On the above dates staff documented NA (Not Applicable) or RN (Resident Not Available).

An observation and face-to-face interview were conducted on 06/27/22 at 1:15 PM, Resident #4 stated "They are short, and they do not always come to give me a bath."

During a face-to-face interview conducted on 06/28/22 at 10:37 AM, Employee #3 (Assistant Director of Nursing) stated, "She (Resident #4) was available the staff failed to document appropriately."

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F 676	Continued From page 89 Employee #3 acknowledged that there was no documented evidence that staff bathed resident on multiple days in May and June 2022.	F 676		09/23/22
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, for three (4) of 67 sampled residents, facility staff failed to ensure that residents who were unable to independently carry out activities of daily living (ADLs) were provided services necessary to maintain personal hygiene. Residents' #4, #19, #84 and #93. The findings included: 1. Facility staff failed to provide documented evidence of bathing Resident #4, who is dependent on staff for ADL care, on multiple days in May and June 2022. Resident #4 was admitted to the facility on 05/23/22 with multiple diagnoses that included: Pressure Ulcer Sacral Region Stage 4, Type 2 Diabetes Mellitus with Unspecified Complications, Legal Blindness as Defined in USA, Unspecified Glaucoma, and Muscle Weakness. Review of the Admission Minimum Data Set (MDS) dated 05/27/22, revealed that the facility staff coded the following:	F 677	F677 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident #4,#19 #84,#93 ADL care including shower were given immediately after being notified and document was completed accordingly. Residents were reassessed by by the Unit Manager/Designee on 8/17/22 Resident suffered no negative outcome. Residents will be assisted with Activity of Daily Living including bathing , and all the care provided will be documented in the residents' medical record ongoing.	

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F 677	Continued From page 90	F 677		09/23/22

Section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) Summery Score "02" Indicating severely impaired cognition.

Section G (Functional Status): Bed Mobility, "Extensive assistance" requiring "Two-person physical assist"
Transfer, "Activity did not occur"
Dressing, "Total dependence" requiring "One-person physical assist"
Toilet Use, "Total dependence" requiring "Two-person physical assist"
Personal hygiene, "Total dependence" requiring "One-person physical assist"
Bathing, "Total dependence"
Upper extremity "Impairment both sides"
Lower extremity "Impairment on both sides"

Section H (Bladder and Bowel): Indwelling Catheter
Urinary Continence "Not rated"
Bowel Continence "Always Incontinent"

Section M (Skin Conditions): The facility staff coded that resident has two (2) stage three pressure ulcers that were present on admission, one (1) unstageable pressure ulcer present on admission and moisture associated skin damage. Review of the physicians' orders revealed the following: 05/21/22, " ...Meet ADL (Activities of Daily Living) needs daily ..."

Review of the care plan with a focus area of: "[Resident #4] ADL self-care deficit related to physical limitations, visual impairment, change in mental status ..." initiated on 05/23/22, included the following interventions: "Assist to Bathe/Shower as needed ...Assist with daily

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F 677	Continued From page 91 hygiene, grooming, dressing, oral care and eating as needed ..." Review of the document titled "Documentation Survey Report v2" which is part of the electronic health record where the CNA's (Certified Nurse Aides) document ADL and other care that they provide dated 05/21/22 to 6/28/2022, showed no documented evidence of Resident #4 being bathed on the following dates: 05/22/22 05/24/22 05/29/22 06/07/22 06/25/22 06/26/22 06/28/22 On the above dates staff documented NA (Not Applicable) or RN (Resident Not Available). An observation and face-to-face interview were conducted on 06/27/22 at 1:15 PM, Resident #4 stated, "They are short, and they do not always come to give me a bath." During a face-to-face interview conducted on 06/28/22 at 10:37 AM, Employee #3 (Assistant Director of Nursing) stated, "She (Resident #4) was available the staff failed to document appropriately." Employee #3 acknowledged that there was no documented evidence that staff bathed resident on multiple days in May and June 2022. 3. Facility staff failed to provide documented evidence of bathing Resident #84 who is dependent on staff for ADL care, on multiple days	F 677	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have potential to be affected.	09/23/22

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F 677	Continued From page 92 during the month of May 2022. Review of a Facility Reported incident (FRI) received by DOH (Department of Health) on 09/20/21, concerning Resident #84 documented " ...A complete head to toe assessment done Multiple scars to left upper back and sacral area. Redness to perineal /sacral, area. ..." The incident is categorized as an allegation of Resident/Patient Neglect. Resident #84 was admitted to the facility on 05/20/21, with multiple diagnoses that included: Type 2 Diabetes Mellitus Without Complications, Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side, Aphasia Following Cerebral Infarction, Sepsis Unspecified Organism, Unspecified Convulsions, Multiple Sclerosis, Gastrostomy Status and Dysphagia. Review of the Quarterly Minimum Data Set (MDS) dated 02/18/22, revealed that the facility staff coded the following: Section C (Cognitive Patterns): "Should a Brief Interview for Mental Status be Conducted? "NO" Section G (Functional Status): Bed Mobility, "Extensive assistance" requiring "One-person physical assist" Transfer, "Extensive assistance" requiring "Two-person physical assist" Toilet use, "Extensive assistance" requiring "One-person physical assist" Personal hygiene, "Extensive assistance" requiring "One-person physical assist" Bathing "Total dependence" Upper extremity "Impairment on one side" Lower extremity "Impairment on one side" Review of the physicians' orders showed the following: 04/06/22 "Adjust to nursing home	F 677	F677 MEASURE TO PREVENT RECURRENCE: The facility Staff Developer will provide education/in-services to the facility licensed nurses and nursing assistants on the importance of assisting and providing Activity of Daily Living (ADL) to residents who are unable to independently carry out activities of daily living (ADLs) and the importance of accurate documentation of care provided for the residents by 09/23/22. Charge nurses will ensure the nursing assistants are providing ADL's which include but not limited to shower/bath, shaving, grooming and personal hygiene to the residents as indicated during their shift. Any issues found will be corrected by 9/23/22. Random rounds will be conducted weekly by supervisors to ensure that the residents are given showers on their schedule date. Any issues found will be corrected by 9/23/22.	09/23/22

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F 677	Continued From page 93 placement; Promote good nutritional status and skin care; &/or Improve physical function; Meet ADL (Activities of daily living) needs daily ..." Review of the care plan with a focus area of "[Resident #84] has an ADL self-care performance deficit r/t (related to) Hemiplegia and Hemiparesis following cerebral infarction affecting right dominant side, adult failure to thrive" initiated on 05/21/21, included the following interventions: "(Resident #84) requires 2 staff participation with transfers ...the resident is totally dependent on staff to provide a bath as necessary ...[Resident #84] requires total assistance with personal hygiene care ... The resident is totally dependent on staff for dressing ..." Review of the document titled "Documentation Survey Report v2" which is part of the electronic health record where the CNA's (Certified Nurse Aides) document ADL and other care that they provide dated from, 05/01/22 to 05/31/22, shows that there was no documented evidence of Resident #84 being bathed on the following dates: 05/11/22 05/14/22 05/15/22 05/16/22 05/17/22 05/29/22 During a face-to face interview conducted on 06/23/22 at 11:01 AM, Employee #33 (Unit Manager 2nd Floor) stated, "Its not documented." Employee #33 acknowledged the findings and made no further comment.	F 677	F677 MONITORING CORRECTIVE ACTION: The Unit Manager/Designee will conduct house wide review/audit to identify residents who are unable to independently carry out activities of daily living (ADLs) to ensure that facility staff provide necessary assistance maintain residents' personal hygiene and that services provided are accurately documented in the residents' medical record. Any issue found during this review/audit will be corrected by 9/23/22. This audit will be conducted weekly times 4, then, monthly times 3 months. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	09/23/22

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2. Facility staff failed to provide Resident #19 with grooming/shaving assistance on his shower days.

Resident #19 was admitted to the facility on 12/29/2016 with diagnoses that include, Dementia without Behavioral Disturbance, Amenia, Peripheral Vascular Disease, Hypertension, Cataracts, Osteoarthritis, amputation at level between Left Hip and Knee.

According to the Quarterly Minimum Data Set Completed 4/13/2022 the resident was coded as having a BIMs score of "11" indicating that he has moderately impaired cognition Under Section C Cognitive Patterns. Under Section G Functional Status, the resident was coded as requiring extensive assistance with one person assistance under personal hygiene.

According to the physician's order dated 01/02/2021 directs, "Resident may take shower twice a week every night shift [Monday], [Thursday]"

During a face-to-face interview on 6/22/22 at 11:01 AM with the responsible party for Resident #19 she stated ...I have to tell the staff about grooming him [Resident #19] ...They tell me they gave him a shower but they don't shave him. I have to keep asking them to shave him ..."

On 6/22/22 at 2:33 PM Resident #19 was observe seated in his wheelchair in his room and unshaven.
During a face-to-face interview on 6/22/22 at approximately 11:12 AM with Resident #19 he stated I preferred to be shave. They are

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supposed shave me on my shower days. They were supposed to do it and they didn't."

Review of the skin sweep observation sheets show the following:
6/16/22, 6/22/22 - resident had a shower
6/20/22- bed bath given

On 6/22/22 at 3:12 PM, a certified nurse aide on the unit stated that she would shave Resident #19.

There was no evidence that facility staff shaved Resident #19 who is unable to grooming himself without assistance from the staff on his shower days.

During a face-to-face interview on 6/27/22 at 10:53 AM with the Employee # 2, she acknowledged the finding.

4. Facility staff failed to provide documented evidence that assistance was provided to a Residet #93 who is dependent upon facility staff for bathing and personal hygiene.

Resident #93 was admitted to the facility on 12/11/18 with multiple diagnoses, including, Unspecified Convulsions, Parkinson's Disease, Hemiplegia following Cerebral Infarct Affecting Right Dominant Side, Aphasia, Gastrostomy Status, Unspecified Dementia without Behavioral Disturbance, Narcolepsy Without Cataplexy and Type 2 Diabetes Mellitus.

A Quarterly Minimum Data Set (MDS) dated 04/12/22, revealed in Section C (Cognitive

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Patterns)/ Brief Interview For Mental Status Summary Score (BIMS), documented that the resident was unable to answer the interview questions and had severe cognitive impairment. In Section G (Functional Status), facility staff recorded that Resident #93 required extensive assistance from one staff person for personal hygiene and total assistance for bathing.

On 6/23/22 at 12:47 PM, a review of the Shower Book on Unit 2 revealed that Resident #93's bath/shower days were Mondays and Thursdays during the night shift.

Review of Resident #93's medical record revealed:

[Care Plan] initiated on 03/05/21 with Focus: "[Resident #93] has an ADL (assisted daily living) r/t (related to) limited mobility decline in healthcare status related to Parkinson's disease. Goal: Assist [Name of Resident #93] with ADLs; Interventions: ...Assist resident with bathing/showers ...Assist resident with personal hygiene and oral care."

Skin Sweep Observation Sheets for 05/01/22 to 05/31/22 documented that facility staff gave Resident #93 a bed bath on 05/09/22, 05/12/22, and 05/16/22.

Skin Sweep Observation Sheets for 06/01/22 to 06/29/22 (last day of survey), documented that facility staff gave Resident #93 a bed bath on one day; 06/09/22.

Certified Nurse's Assistant (CNA) Documentation Survey Report for May 2022 revealed that facility staff failed to document that they provided a bath

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F 677	Continued From page 97 and personal hygiene for Resident #93 on 05/10/22, and failed to note that they offered a bath for Resident #93 on 05/13/22, 05/14/22 and 05/15/22. Certified Nurse's Assistant (CNA) Documentation Survey Report for June 2022 revealed that facility staff failed to document they provided a bath for Resident #93 on 06/10/22. During a face-to-face interview on 06/23/22 at 11:51 AM, Employee #3, Assistant Director of Nursing (ADON), acknowledged that facility staff failed to document that they provided baths and personal hygiene to Resident #93 in May and June. The employee stated, "When the CNAs provided baths and personal hygiene to Resident #93, they should have documented that the care was done on the resident's Skin Sweep Observation Sheets and the CNA Documentation Survey Reports."	F 677	F684 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident#126 was reassessed by the Unit Manager/Designee on 8/17/22 Resident suffered no negative outcome. Resident's comprehensive care plan was updated on 6/17/22 including the exhibited inappropriate sexual behavior and interventions are now in place.	09/23/22
F 684 SS=E	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 observations, record reviews, and staff interviews, for 13 of 67 sampled residents, facility staff failed to ensure that residents received	F 684		

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F 684	Continued From page 98 treatment and care per the comprehensive care plan or in accordance with professional standards of practice as evidenced by failure to: provide care in accordance with Resident #126's comprehensive care plan for inappropiate sexual beavior, subsequently Resident #145 was subjected to non-consenual sexual contact; provide Resident #28 with restorative nursing services as ordered by the physician; follow the nurse practitioner's recommendation for a psychiatric consult for behavioral disturbances [wandering in residents' rooms] for Resident #126; ensure Resident #11 received a complete and accurate skin assessment; provide Resident #32 with restorative nursing services as ordered by the physician; provide Resident #95 with her prescribed rehabilitative equipment (right hand splint) as specified in the resident's comprehensive care plan; follow Resident #133's physician's order when administering pain medication; follow the care plan interventions for changing Resident #354's central line dressing every seven (7) days; turn and reposition Resident #138 according to care plan; follow a physician's order to complete a sign in sheet in residents' room every time care is rendered for Resident #102; not place 2 incontinent briefs on Resident #85; administer Resident #54's supplemental oxygen as ordered by the physician; and administer pain medication to Resident #250 in accordance with the physician's order. Residents' #145, #28, #126, #11, #32, #95, #133, #354, #138, #102, #85, #54 and #250. The findings included: Review of the policy "Restorative Nursing Care" revised 02/22 documented, "Restorative nursing is offered to all residents who have completed	F 684	Resident#28 was reassessed by the Unit Manager/Designee on 8/17/22 Resident suffered no negative outcome. Resident's right resting hand splint was applied immediately and psychiatric consult was completed after being notified on 7/19/22.The Unit manager will ensure that Resident #28 receives right resting hand splint as ordered by the physician.	09/23/22

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F 684	Continued From page 99 skilled OT (Occupational Therapy) or PT (Physical Therapy) services ... Our facility has an active program of restorative nursing which is developed and coordinated through the resident's care plan ...Restorative nursing care is performed for those residents who require such service ... initiate point click care list for each resident placed on program ..." Review of the policy "Pain Management" revised 02/22, documented, "...The licensed nurse will obtain order from the attending physician/designee for pain management and administer the order as indicated ..." Review of the policy "Medication/Treatment Administration Record and Initials" revised 03/22 documented, "... Prior to administration of medication and treatment, the licensed nurse assigned to the resident must check and validated the ten Rights of Medication which includes ... right assessment, right evaluation ... Licensed nurses will administer medication and treatment to residents following the physician orders ..." 1.The facility's staff failed to provide care in accordance with Resident #126's comprehensive care plan for inappropiate sexual beavior, subsequently Resident #145 was subjected to non-consenual sexual contact; Resident #126 was admitted to the facility on 05/07/21 with multiple diagnoses including Major Depressive Disorder and Dementia without Behavioral Disturbances. Review of the medical record revealed the	F 684	Resident#126 was reassessed head to toe by the Unit Manager/ Designee on 8/17/22 Resident#126 was last seen by Psychiatry Nurse Practitioner on 8/10/2022. Resident remains on 1 on 1 monitoring 24 hrs/ daily for safety precautions. Resident#11 was reassessed head to toe including a skin assessment by the licensed nurse on 8/17/22. Resident suffered no negative outcome.	09/23/22

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F 684	Continued From page 100 following: 05/27/22 at 7:00 AM [Psychiatric NP Note] - "Patient seen to evaluate mental status and adjust medications for behavioral disturbances ...He was counseled about the risk of invading other people's personal spaces or touching others inappropriately. He was also encouraged to respect other peoples' personal spaces and not to touch anyone inappropriately; and he was receptive ...His Sertralin [antidepressant] ...was increased to 50 mg (milligrams) ... to control his depression and compulsive behavior of wandering or touching others inappropriately ..." 05/27/22 - Comprehensive care plan , documented the following: Focus Area- [Resident #126] have a problematic manner in which residents act characterized by inappropriate sexual behavior related to; resident touches other residents and/or staff inappropriately. Intervention- Protect other residents if unable to protect themselves. 06/17/22 at 8:04 AM [Nursing Supervisor's Note] - "At about 5:40 AM ...writer was informed by nurse [Resident #126] was observed in bed with [Resident #145] ...MD order to transfer [Resident #145] ... to ER for further evaluation ...[Officer's name and Detective's name] ... the detective interviewed writer, [Resident #126], assigned nurse ...and said they will continue with their investigation ..." 06/17/21 [Situation, Background, Assessment, Request]- " ...Writer was informed by the nurse that [Resident #126] was observed on bed with the resident in Room 313B [Resident #145] ..."	F 684	The affected Resident #32 is now receiving restorative services as ordered by the physician. Resident was reassessed from head to toe on 08/17/22 by the licensed nurse and did not suffer any negative outcome. The affected Resident #95 right resting hand splint was applied immediately. Resident was re-evaluated by Occupational therapy on 8/11/22 assessed from head The Unit Manager/Designee, will ensure that Resident #95 receives resting hand splint as ordered by the physician ongoing. Resident #133 was reassessed from head to toe on 08/17/22 by the licensed nurse, Resident to receive medications according to the parameters and as ordered by the physician. Resident did not suffer any negative outcome. The assigned nurse was educated immediately on administration of pain medication as ordered by the physician according to the parameters	09/23/22

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F 684	Continued From page 101	F 684		09/23/22

Review of the facility's investigative report revealed the following employee statements:

06/17/22 [assigned CNA] - " ...At 5:45 AM I started rounds, when I came around the corner, I noticed [Resident #145's room] door closed, I opened the door and saw [Resident #126] naked on top of [Resident #145]."

06/17/22 [assigned LPN] - "Around 5:40 AM writer was called by [CNA] to room 313B ...observed a resident in [from] Room 310B [Resident #126] on top of the resident in room 313B [Resident #145] ..."

During a face-to-face interview on 06/21/22 starting at approximately 1:30 PM, Employee #21 (Unit Manager) stated that Resident #126 was recently moved to her floor after an allegation of inappropriately touching a female resident on the first floor. The employee was asked if she provided education to staff about Resident #126 inappropriate behavior? said, "Yes", but she did not have documented evidence of the education provided. The employee stated that staff monitored [Resident #126] hourly and was positioned near his room. The employee was asked with those interventions in place how did your staff ensure Resident #145's safety from Resident #126's sexual behavior [willful non-consensual sexual contact]? The employee did not provide an answer.

Cross Reference 42 CFR 483.12, F600

2. The facility's staff failed to provide Resident #28 with restorative nursing services as ordered by the physician.

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F 684	Continued From page 102 Resident #28 was admitted to the facility on 10/28/20 with multiple diagnoses including Contracture of Left Hand, Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side, Lack of Coordination and Weakness. Review of the medical record revealed the following: 04/05/22 [Quarterly Minimum Data Set] revealed that restorative services was not coded inducating the resient was not receiving restorative nursing services at the time of the assessment. 04/06/22 [physician order] - "Discontinue skilled OT (occupational therapy) as a patient has achieved highest practical level. Patient will start on RNP (restorative nursing program) 3-5 x (times) a week for 15 minutes. Review of the comprehensive care plan showed the following. Focus area - Resident on restorative nursing for resting/hand splinting/palmar guard to the left upper extremity to prevent further left-hand contracture... Intervention - Discontinue and refer back to OT if redness, swelling, bruising noted ...restorative staff will assist with daily exercise as per order. Observations on 06/17/22 starting at approximately 10:00 AM to 5:00 PM 06/23/22, showed Resident #28 was not wearing a left-hand splint or receiving restorative nursing services.	F 684	Resident #354 PICC line dressing was changed immediately on 6/14/22 after being notified. Resident was reassessed from head to toe on 08/17/22 by licensed burse and suffered no negative outcomes. Resident #138 is being encouraged/assisted to turn and reposition every two hours and as tolerated and is ongoing. Resident reassessed from head to toe on 08/17/22 by licensed nurse. Resident did not suffer any negative outcome. CNA is being educated on proper documentation every time care is provided. Resident #102 was reassessed from head to toe on 08/17/22 by licensed nurse. Resident suffered no negative outcome. The resident care sign-in sheet was immediately implemented. Staff are signing when care is rendered.	09/23/22

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F 684	Continued From page 103 During a face-to-face interview on 06/23/22 at approximately 4:30 PM, Employee #3 (ADON) stated that the resident was not receiving restorative nursing services because his name was accidentally omitted from the facility's list of residents on the restorative nursing program. The employee stated that he would ensure resident start services on 06/24/22. 3. The facility staff failed to follow the nurse practitioner's recommendation for a psychiatric consult for behavioral disturbances [wandering in residents' rooms] for Resident #126. Resident #126 was admitted to the facility on 05/07/21 with multiple diagnoses including Major Depressive Disorder and Dementia without Behavioral Disturbances. Review of the medical record 06/13/22 at 1:47 PM [Nursing Note] - "...at 1200 [12:00 PM] resident was observed wandering and pacing the hallway with his wheelchair, entering other resident's room, resident was redirected at all times by staff. NP (nurse practitioner) ... notified, recommends to monitor and redirect as required and psych consult for behavioral disturbances..." Review of progress notes, consults, medication administration record, and treatment administration records from 06/13/22 to 06/17/22 lacked documented evidence that Resident #126 was evaluated by psych for behavioral disturbance of wandering in other residents' room [uninvited]. During a face-to-face interview on 06/21/22	F 684	The affected Resident #85 was immediately provided with one incontinent brief as standard of care. Resident was reassessed from head to toe on 08/17/22 by licensed nurse. Resident did not suffer any negative outcome. The affected Resident #54 oxygen therapy was administered in accordance with physician order and parameters on 6/23/22 Resident was reassessed from head to toe on 08/17/22 by Unit Manager/Designee, Resident #54 did not suffer any negative outcome. The affected Resident #256 was administered pain medication as ordered by the physician and parameters. Resident was reassessed from head to toe on 08/17/22.Resident did not suffer any negative outcome. Education was provided to the assigned licensed nurse on medication administration according to physician orders and parameters.	09/23/22

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F 684	Continued From page 104 starting at approximately 1:30 PM, Employee #21 (Unit Manager)stated that the psych evaluation was not done. It should be noted that Resident #126 wandered in Resident 145's room on 06/17/22, and he willfully had non-consensual sexual contact with her. Cross Reference 42 CFR 483.12, F600 4. Facility staff failed to ensure Resident #11 received treatment and care in accordance with professional standards of practice as evidenced by failure to conduct a complete and accurate skin assessment. Resident #11 was admitted to the facility on 06/17/19 with diagnoses that included: Hemiplegia and Hemiparesis, Dementia and Cerebral Infarction. Review of Resident #11's medical record revealed the following: A Quarterly Minimum Data Set (MDS) dated 04/18/22 showed that facility staff coded the the resident as: severely cognitively impaired, no potential indicators of psychosis, rejection of care not exhibited, extensive assistance with one person physical assist for bed mobility, transfer, dressing, toilet use and personal hygiene, impairment on one side for upper and lower extremities, wheelchair for mobility device, always incontinent of bladder, frequently incontinent of bowel and no pressure injury, wounds and or other skin problems. 06/11/20 [physician's order] directed, "Weekly	F 684	. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED. All the residents in the facility have the potential to be affected.	09/23/22

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F 684	Continued From page 105 skin assessment by Licensed Nurse every day shift every Thu (Thursday), Sat (Saturday)" Care Plan revised on 05/05/22 showed [Resident #11] has potential for pressure ulcer development r/t (related to) disease process, limited mobility ... Follow facility policies and protocols for the prevention and treatment of skin breakdown ... Resident needs, moisturizer applied daily to my skin ..." 06/16/22 [Weekly Skin Assessment -Licensed Nurse] " ...Complete ...No new skin issue." 06/17/22 at 8:51 PM [Skin Observation Tool (Licensed Nurse)] documented, "right thigh (rear)" indicating the nurse observed a skin intergrity issue. 06/17/22 at 8:51 PM [Situation Background Assessment Request (SBAR)] " ... Situation Resident observed with wound on right thigh (rear)... During incontinent care at 8:45 pm, writer was notified by CNA (Certified Nurse Aide) ... of an opening area on resident's right thigh (rear) ...L (length) =0.5cm (centimeters) X W (width) = 0.6cm. scanty drainage noted from site..." 06/21/22 [Tissue Analytics] " ...Wound Location: Right posterior thigh ... Wound status - new. Acquired in House- yes. Etiology - abscess ..." A face-to-face interview was conducted on 06/27/22 at 10:55 AM with Employee #8 (Registered Nurse) who completed the weekly skin assessment dated 06/16/22. When asked about the skin assessment she documented as completed, Employee #8 stated, "I couldn't do a full skin assessment because the resident	F 684	MEASURE TO PREVENT RECURRENCE: The facility Staff Developer will provide education for the licensed nursing staff to ensure that residents received treatment and care per the comprehensive care plan and in accordance with professional standards of practice. The education will also include how to conduct a complete and accurate skin assessment. Training will be completed by 09/23/22. The facility Staff Developer/Designee will provide education to the facility licensed nurses on the importance of implementing the care plan intervention for changing resident intravenous line insertion site dressing. Training will be completed by 9/23/22. The facility Staff Developer/ Designee will provide education to the facility nursing staff (licensed nurses and Nursing Assistants) on the importance of ensuring that residents with limited range of motion received appropriate treatment and services to prevent further decrease in range of motion and educate staff on the importance of providing restorative nursing services as ordered by the physician. Training will be completed by 09/23/22. In-service will be provided by Staff Development /designee to all facility staff about care plan intervention in place for residents with sexual behavior, behavior with the potential to abuse others, and wandering behavior.	09/23/22

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F 684	Continued From page 106 refused to get back in bed for the assessment. The night shift got her washed, dressed and into the chair. I documented just on the parts I was able to see." Employee #8 further stated that she did not observe Resident #11's rear thigh area as part of the weekly skin assessment she completed on 06/16/22. The evidence showed that facility staff failed to ensure Resident #11 received treatment and care in accordance with professional standards of practice. 5. Facility staff failed to provide Resident #32 with restorative nursing services as ordered by the physician. Resident #32 was admitted to the facility on 03/27/20 with multiple diagnoses that included: Muscle Weakness, Cerebral Infarct and Alzheimer's Disease. Review of Resident #32's medical record revealed the following: A Quarterly Minimum Data Set (MDS) dated 05/13/22 where staff coded the resident as moderately impaired cognition, extensive assistance with two persons physical assist for bed mobility, transfers, toilet use and personal hygiene, range of motion impairment on both lower extremities, wheelchair mobility device and received occupational therapy (OT) services from 04/11/22 to 05/13/22. 05/13/22 [Occupational Therapy Discharge Summary] "... Discharge Status and Recommendations: RNP (Restorative Nursing Program) ...to facilitate maintaining current level	F 684	MONITORING CORRECTIVE ACTION: MONITORING CORRECTIVE ACTION: Assistant Director of Nursing (ADON)/Designee will conduct house wide audit to identify potential residents with sexual behavior to ensure that the proper comprehensive care plan and interventions are in place in accordance with professional standards of practice. Audit will be done weekly times 4, then monthly times 3 months. The facility ADON/Designee will complete house wide review/audit of all facility residents to identify potential residents with limited range of motion to ensure residents receive restorative nursing services including the application of splints to prevent further decrease in range of motion. This audit will be conducted weekly times 4, then monthly times 3. All findings will be corrected. Assistant Director of Nursing (ADON)/Designee will conduct house wide audit to identify potential residents on pain management to ensure pain assessment is completed and residents are treated in accordance with the Physician's order and parameters. This audit will be conducted weekly times 4, then monthly times 3 months. All findings will be corrected. The Unit Manager/ Designee will complete house wide review/audit of all residents to identify residents with Intravenous line to ensure that care plans and interventions are properly implemented including care of the intravenous line insertion site dressing. This audit will be conducted weekly times 4, then monthly times 3 months. All findings will be corrected. The Unit Manager/ Designee will complete house wide review/audit of all residents to identify residents with behavioral problems have Psych consult and being seen by the Psychatrist/ Designee.This audit will be conducted weekly times 4, then monthly times 3 months. All findings will be corrected.	09/23/22

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F 684	Continued From page 107 of performance and in order to prevent decline, development of and instruction in the following RNPs has been completed with the IDT (interdisciplinary team): ROM (range of motion) active..." 05/13/22 [Physician's Order] "D/C (discharge) from OT services as highest functional level achieved. Pt (patient) to start on RNP for 3-5x/week to maintain function." Review of the "Restorative Nursing Program Resident List "provided to the surveyor on 06/21/22 at 9:20 AM, did not include Resident #32 as receiving RNP. During a face-to-face interview on 06/21/22 at 9:26 AM, Employee #10 (Rehab Manager) stated, "[Resident #32] had no issues or complaints when we saw him during the latest round of OT. He (Resident #32) participated and made consistent progress. He was d/c to restorative nursing. Education was provided to the nursing staff on the techniques and ROM to provide." Review of Resident #32's medical record on 06/21/22 showed there was no documented evidence that restorative nursing services were being provided since discharge from OT, approximately 6 weeks (05/13/22 to 06/21/22). During a face-to-face interview on 06/21/22 at 10:38 AM, Employee #3 (Assistant Director of Nursing (ADON)/RNP Program Manager) acknowledged the finding and stated, "It was an oversight on my part." 6. Facility staff failed to provide Resident #95 with her prescribed rehabilitative equipment (right	F 684	The Unit Manager/ Designee will complete house wide review/audit of all weekly skin assessments to ensure that the weekly skin assessments are accurate and complete. All negative findings will be corrected by 9/23/22. This audit will be conducted weekly times 4, then monthly times 3 months The Unit Manager/ Designee will complete a review/audit of ADL care signing sheet in resident room to ensure ADL is provided on every shift according to physician order and the signing sheet is visible in the resident room and signed by nursing assistant and licensed nurses. This audit will be conducted weekly times 4, then monthly times 3 months. The Unit Manager/ Designee will complete house wide review/audit of all incontinent residents to ensure that residents are provided with one incontinent brief as standard of care.This audit will be conducted weekly times 4, then monthly times 3 months. Assistant Director of Nursing (ADON)/Designee will conduct house wide audit to identify potential residents on oxygen therapy to ensure oxygen is administered to residents in accordance with the Physician's order and parameters. This audit will be conducted weekly times 4, then monthly times 3 months. All findings will be corrected. The Unit Manager/ Designee will complete house wide review/audit of all residents to identify residents with inaccurate comprehensive plan of care to ensure that residents receive treatment in accordance to professional standards of practice. This audit will be conducted weekly times 4, then monthly times 3 months. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	09/23/22

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hand splint) as specified in the resident's comprehensive care plan.

During an observation on 06/14/22 at 10:31 AM, Resident #95 was observed in bed with a sign at the head of her bed that directed " ...Apply right hand splint for 6-8 hours daily ..." At the time of this observation, a right hand splint was noted hanging on th e wall above the bed in a clear, plastic bag.

During a face-to-face interview conducted at the time of the observation, Employee #9 (Certified Nurse Aide) stated, "The therapist or the restorative aide applies and removes the splint."

During observations on 06/21/22 at 12:16 PM and 06/24/22 at 3:54 PM, Resident #95 not wearing the right hand splint.

Resident #95 was admitted to the facility on 11/16/18 with multiple diagnoses that included: Muscle Weakness, Cerebral Vascular Disease, Type 2 Diabetes Mellitus and Hypertension.

Review of Resident #95's medical record revealed the following:

06/02/21 [Physician's Order] "Right resting hand splint"

04/12/22 [Revised Care Plan] "[Resident #95] on restorative nursing for PROM (passive range of motion) to bilateral extremities ... right resting hand splint for 6-8hrs to prevent right hand contractures... Restorative staff will assist with daily exercises as per order ..."

A Quarterly MDS dated 05/31/22 showed facility

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staff coded the Resident #95 as severe cognitively impaired, totally dependent on staff with two persons physical assist for bed mobility, toilet use and personal hygiene; range of motion impairment on both sides for upper and lower extremities and received OT services from 04/19/22 to 05/31/22.

06/01/22 [Occupational Therapy Discharge Summary] "... Discharge recommendations: RNP... to facilitate patient maintaining current level of performance and in order to prevent decline, development of and instruction in the following RNPs has been completed with the IDT : bed mobility and R (right) H (hand) splint or brace care..."

Review of the "Restorative Nursing Program Resident List" document provided to the surveyor on 06/21/22 at 9:20 AM, did not list Resident #95 as receiving RNP for the right hand resting hand splint.

Review of Resident #95's medical record showed there was no documented evidence that facility staff was applying the right hand splint as specified by the physician's order and care plan.

During a face-to-face interview conducted on 06/24/22 at approximately 4:00 PM, Employee #3 acknowledged the findings and made no comments.

7. Facility staff failed to follow Resident #133's physician's order when administering pain medication.

Resident #133 was admitted to the facility on 07/08/21 with diagnoses that included: Pain in

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Right Leg and Acute Kidney Failure.

During a medication administration observation on 06/15/22 at 8:46 AM, Resident #133 stated that his pain level was "6" on a scale of 1 to 10. Employee #11 (Registered Nurse) then proceeded to administer Oxycodone (narcotic pain reliever) - APAP (Acetaminophen) 5-325 MG (milligram) 1 tablet by mouth to Resident #133.

Review of Resident #133's medical record revealed the following:

05/27/22 [Physician's Order] "Fentanyl (narcotic pan reliever) Patch 72 Hour 25 MCG (micrograms)/HR (hour) Apply 1 patch transdermally one time a day every 3 day(s) for pain management and remove per schedule"

05/28/22 [Physician's Order] "Acetaminophen (pain reliever) Tablet 500 MG Give 2 tablet by mouth one time a day for Pain 30 minutes prior to wound care"

05/30/22 [Physician's Order] "Oxycodone-Acetaminophen Tablet 5-325 MG (Percocet) (Give 1 tablet by mouth two times a day for Pain [level of] 7-10..."

A Significant Change Minimum Data Set (MDS) dated 06/06/22 showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 15, indicating that the resdeint had an intact cognitive response, received scheduled and PRN (as needed) pain medication and experienced pain occasionally.

Care plan revised on 06/14/22 "[Resident #133] is on pain medication therapy (Percocet) r/t right leg

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pain ... Administer analgesic medications as ordered by physician. Review for pain medication efficacy ..."

Review of the June 2022 Medication Administration Record (MAR) showed that facility staff administered Oxycodone-Acetaminophen Tablet 5-325 MG 1 tablet as followed:

06/01/22 at 9:00 AM and 6:00 PM - Pain level =5
06/02/22 at 9:00 AM and 6:00 PM Pain level =0
06/04/22 at 9:00 AM Pain level =6 and 06/04/22 at 6:00 PM Pain level= 4
06/05/22 at 9:00 AM and 6:00 PM Pain level =0
06/06/22 at 9:00 AM Pain level =2 and 06/06/22 at 6:00 PM Pain level= 0
06/07/22 at 9:00 AM and 6:00 PM Pain level =3
06/08/22 at 9:00 AM and 6:00 PM Pain level =0
06/09/22 at 9:00 AM and 6:00 PM Pain level =0
06/10/22 at 9:00 AM Pain level =2 and 06/10/22 at 6:00 PM Pain level= 0
06/11/22 at 9:00 AM and 6:00 PM Pain level =0
06/12/22 at 9:00 AM and 6:00 PM Pain level =0
06/13/22 at 9:00 AM and 6:00 PM Pain level =0
06/14/22 at 9:00 AM Pain level =2 and 06/14/22 at 6:00 PM Pain level= 0
06/15/22 at 9:00 AM Pain level =6 and 06/15/22 at 6:00 PM Pain level =0
06/16/22 at 9:00 AM Pain level =4

During a face-to-face interview conducted on 06/16/22 at 9:45 AM, Employee #10 acknowledged the finding and stated, "Sometimes when I ask, he (Resident #133) says "6" or something lower but I know it's not possible with what he has going on medically. He has a lot of wounds. I know the pain level he's saying is not possible."

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The evidence showed that facility staff failed to follow the physician's order for administering Resident #133's narcotic pain medication evidenced by licensed staff administering Percocet when the resident's pain level was less than 7 on the pain scale.

8. Facility staff failed to follow the care plan interventions for changing Resident #354's central line dressing every seven (7) days.

According to the Centers for Disease Control (CDC), "...Replace dressings used on short-term CVC (central venous catheter) sites at least every 7 days ..."

https://www.cdc.gov/infectioncontrol/guidelines/bsi/index.html#rec6

During an observation on 06/14/22 at 10:40 AM, Resident #354 was observed receiving intravenous (IV) antibiotics via a peripherally inserted central catheter (PICC). The resident stated, "I told the staff they needed to change the dressing. It has not been changed since it was put in in the hospital." Upon closer observation, the dressing was noted to have the date "6/6/22" in bold, black ink.

Review of Resident #354's medical record revealed the following:

Resident #354 was admitted to the facility on 06/10/22 with diagnoses that included: Infection and Inflammatory Reaction Due to Other Internal Joint Prosthesis.

Care Plan initiated on 06/10/22 "[Resident #354] has an right upper line picc line... Interventions:

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Change transparent dressing on insertion site every 7 days ... Monitor right upper line picc line q (every) shift ..."

06/11/22 at 10:43 AM [Nurses Progress Note] "Late Entry ...Admitted with right upper picc line and left shoulder surgical wound..."

06/11/22 [Physician's Order] "Observe right upper arm and call MD (medical doctor)/NP (Nurse Practitioner) for bleeding, swelling s/s (signs and symptoms) of infection or any IV related complications every shift"

The evidence showed that facility staff failed to change the transparent dressing to Resident #354's insertion site every 7 days as specified in the care plan.

During a face-to-face interview conducted on 06/14/22 at 11:10 AM, Employee #5 (Registered Nurse) acknowledged the finding and stated, "I didn't notice that the dressing was due to be changed. I will change it today."

9. The facility staff failed to turn and reposition Resident #138 according to care plan.

Resident #138 was admitted to the facility on 08/20/21, with multiple diagnoses that included, Chronic Respiratory Failure with Hypoxia, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Pressure Ulcer of Sacral Region Stage 3, Muscle Weakness and Unspecified Abnormalities of Gait and Mobility.

Review of the Quarterly Minimum Data Set (MDS) dated 05/17/22, revealed that facility staff coded the following:

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Section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) summary score "15" indicating intact cognition.

Section G (Functional Status): Bed mobility "Limited assistance" requiring "One-person physical assist", transfer "Limited assistance" requiring "One-person physical assist"; Toilet use "Limited assistance" requiring "One-person physical assist"

Personal hygiene "Extensive assistance" requiring "One-person physical assist"

Bathing "Total dependence"

Mobility devices "Wheelchair"

Section M (Skin Conditions): Facility staff coded the resident as having one (1) stage three pressure ulcer

Review of the care plan initiated on 08/21/21 with a focus area of "[Resident #138] has ADL (Activities of Daily Living) Self care deficit as related to respiratory failure, physical limitations" Interventions included -"Encourage and /or assist to reposition frequently"

Review of the TAR (Treatment Administrative Record) dated from 06/01/22 through 06/24/22 lacked documented staff documented the turning and repostioning of Resident #138.

Review of the document titled "Documentation Survey Report v2" which is part of the electronic health record where the CNA's (Certified Nurse Aides) document ADL care including turning and repositioning residents dated 05/15/22 through

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06/27/22 showed no documented evidence that facility staff turned or repositioned Resident #138 on the following days:

05/15/22
05/24/22
05/26/22
05/28/22
05/29/22
05/31/22
06/01/22
06/04/22
06/09/22
06/11/22
06/15/22
06/18/22
06/20/22
06/21/22
06/26/22

Facility staff either documented "N" which indicates "no" the resident was not turned and repositioned or they documented "NA" which indicates not applicable.

During a face-to-face interview conducted on 06/27/22 at 10:30 AM, Employee #3 (Assistant Director of Nursing) stated, "They (turning and repositioning) are supposed to be done. Resident's care is a priority"

10. Facility staff failed to follow a physician's order to complete a sign-in sheet in Resident #102's room every time care was rendered.

Review of a Complaint received by DOH (Department of Health) on 09/20/21, documented "[Resident #102] says he has only had 13 showers and been out of bed 12 times since he

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has been [admitted]. Some of this issues were addressed during a careplan meeting ..."

Resident #102 was admitted to the facility on 07/30/20, with multiple diagnoses that included the following: Adult Failure to Thrive, Pressure Ulcer of Sacral Region, Stage 3, Contracture Unspecified Joint, Contracture Right Knee, Contracture Left Knee, Moderate Protein Calorie Malnutrition and Muscle Weakness.

Review of the Quarterly Minimum Data Set (MDS) dated 06/02/22, revealed facility staff coded the following:

Section C (Cognitive Patterns): Brief Interview for Mental Status Summary Score "15" indicating intact cognition.

Section E (Behavior): Rejection of Care -Presence & Frequency "0" Behavior not exhibited

Section G (Functional Status): Bed mobility "Extensive Assistance" requiring "Two-person physical assist"

Transfer "extensive assistance" requiring "Two-person physical assist"

Dressing "Extensive assistance" requiring "Two-person physical assist"

Eating "Supervision" requiring "Set-up help only"

Toilet use "Extensive assistance" requiring "One -person physical assist"

Personal Hygiene "Extensive assistance"

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requiring "One-person physical assist"

Bathing "Total dependence"

Review of the physicians' orders revealed:
08/21/21 "Please sign signing sheet in residents' room each time care is rendered ..."

Observation of resident's room was conducted on 06/24/22 at approximately 12:30 PM, the surveyor did not observe a sign in sheet for ADL care.

During a face-to-face interview conducted on 06/24/22 at approximately 1:00 PM, Employee #3 (Assistant Director of Nursing) when asked by the surveyor where was the sign in sheet for staff to fill in after care is rendered? Employee #3 stated "I cannot find it at the bedside."

11. The facility staff failed to provide comprehensive and person-centered care that is in accordance with professional standards by placing 2 incontinent briefs on Resident #85.

Review of a Facility Reported Incident (FRI) received by DOH (Department of Health) on 06/17/22, concerning Resident #85, documented "...During incontinent /perineal care at 4:00 pm by the assigned CMA [CNA] staff , writer was notified of a new open area ..."

Resident #85 was admitted to the facility on 09/18/18, with multiple diagnoses that included the following: Other Schizophrenia, Constipation Unspecified, Edema, and Alzheimer's Disease Unspecified.

An Observation was conducted on 06/27/22 at 4:15 PM, Resident #85 was observed in bed and

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was non-interviewable. Resident was observed wearing two incontinent briefs.

Review of the Quarterly Minimum Data Set (MDS) dated 04/11/22, revealed that facility staff coded the following:
Section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) summary score "99" indicating resident unable to complete the interview.
Section G (Functional Status): Toilet Use "Extensive assistance" required "One-person physical assist"
Personal hygiene "Extensive assistance" required "One-person physical"

Section H (Bladder and Bowel): "Has a trial of a toileting program been attempted on admission/entry or reentry since urinary incontinence was noted in this facility?" "No"
Urinary Continence "Always incontinent"
Bowel continence "Frequently incontinent"

During a face-to-face interview conducted on 06/27/22 at 4:20 PM, Employee #21 (Unit Manager 3rd floor) acknowledged the finding and stated "That's not our practice."
12. Facility staff failed to administer Resident #54 supplemental oxygen as ordered.

Resident #54 was re-admitted to the facility on 01/08/21 with diagnoses including, Pneumonia, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), and Dependence on Supplemental Oxygen.

During an observation on 06/23/22 at 12:12 PM, Resident #54 was awake, resting comfortably,

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with non-labored breathing. The resident was receiving supplemental humidified oxygen via nasal cannula at a rate of 5 liters per minute.

A Quarterly Minimum Data Set (MDS) dated 04/25/22 showed in Section C (Cognitive Patterns) that facility staff documented the resident as having a Brief Interview for Mental Status summary score (BIMS) of "00," indicating that the resident had severely impaired cognition. In Section G (Functional Status), facility staff documented that Resident #54 required extensive assistance with one person physical assistance for bed mobility and was totally dependent and required assistance from one staff person for transfers. ADD O2 section.

Review of Resident #54's medical record revealed:

05/20/22 [Physician's Order] directed, "O2 (oxygen) at 2 L(liters)/min(minute) for SOB (shortness of breath) or respiratory distress."

05/22/22 [Care Plan] Focus area: [Resident # 54] has diagnosis of COPD exacerbation, acute bronchopneumonia; Interventions: ...Give nebulizer treatments and oxygen therapy as ordered."

A review of Resident 54's Vital Signs Report documented the following oxygen saturation levels from 06/23/22: at 2:06 AM, 98% on room air; 5:24 AM, 98% on room air; 10:42 AM, 97% on oxygen via nasal cannula.

During a face-to-face interview on 06/23/22 at approximately 12:15 PM, Employee #33 (Unit

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Manager 2nd Floor) acknowledged that Resident #54 was receiving 5 liters of oxygen per minute. The employee then stated, "Oh, the oxygen level is too high," and the employee turned down the resident's oxygen rate to 2 liters oxygen.

13. Facility staff failed to administer Tramadol to Resident #256 in accordance with the physician's order.

Resident #256 was admitted to the facility on 06/10/2022 with diagnoses that included Osteoarthritis of Hip, Neuromuscular Dysfunction of Bladder and Clostridium Difficile.

According to the physician's order dated 06/12/2022 the resident is to receive Tramadol HCl (used to relieve moderate to moderately severe pain) 50 mg one tablet by mouth every 8 hours as needed for pain 6-10 in scale.

Review of the controlled drug administration record for Resident #256 showed she was to receive Tramadol 50 mg one tablet by mouth every 8 hours as needed for pain 6-10 in scale; and count received from the pharmacy was 30.

Review the physician's order directed, "Tramadol 50 mg take 1 tablet by mouth every 8 hours as needed for pain 6-10."

Review of the Medication Administration Record (MAR) showed that a facility staff nurse signed that she gave Resident #250 Tramadol on 06/13/22 at 17:07 however there was no pain level recorded; and on 06/16/22 at 11:12 facility staff recorded the resident's pain level as 5 of 10.

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F 684	Continued From page 121 The facility nurses signed that they removed the medication (Tramadol) and administered it to the resident on the following dates: 06/16/22 at 11:12 AM 1 tab was given - however the recorded pain level was 5 During a face-to-face interview on 06/27/22 at approximately 11:00 AM, Employee #2 reviewed the documents and acknowledged findings.	F 684		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, for five (5) of 67 sampled residents, facility staff failed to ensure that residents received care consistent with professional standards of practice for pressure ulcers as evidenced by failing to: perform weekly skin assessments for four (4) residents and first	F 686		

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F 686	Continued From page 122 observing facility acquired pressure ulcers for two (2) residents at an advanced stage. (Residents' #4, #56, #84, #138, and #257) The findings included: 1. Facility staff failed to perform weekly skin assessments for Resident #4. Resident #4 was admitted to the facility on 05/23/22 with multiple diagnoses that included: Pressure Ulcer Sacral Region Stage 4, Type 2 Diabetes Mellitus with Unspecified Complications, and Muscle Weakness. Review of the Admission Minimum Data Set (MDS) dated 05/27/22, revealed that the facility staff coded the following: Section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) Summary Score "02" indicating severely impaired cognition. Section G (Functional Status): Bed Mobility, "Extensive assistance" requiring "Two-person physical assist" Dressing, "Total dependence" requiring "One-person physical assist" Toilet Use, "Total dependence" requiring "Two-person physical assist" Personal hygiene, "Total dependence" requiring "One-person physical assist" Upper extremity and Lower extremity "Impairment on both sides" Section H (Bladder and Bowel): Indwelling Catheter Bowel Continence "Always Incontinent"	F 686	F686 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: The affected Resident #4 was reassessed from head to toe including skin reassessment on 08/17/22 by licensed nurse, no new skin issue observed. Resident suffered no negative outcome. Resident weekly skin assessment by licensed nurses is being completed and ongoing. The affected Resident #56 was reassessed from head to toe including skin assessment on 08/17/22 by licensed nurse, no new skin issue observed. Resident suffered no negative outcome. Resident weekly skin assessment by licensed nurses is being completed and ongoing. Resident#84 reassessed from head to toe including skin assessment on 08/17/22 by licensed nurse, no new skin issue observed. Resident suffered no negative outcome. Resident weekly skin assessment by licensed nurses is being completed and ongoing. Resident #138 reassessed from head to toe including skin assessment on 08/17/22 by licensed nurse, no new skin issue observed. Resident suffered no negative outcome. Resident weekly skin assessment by licensed nurses is being completed and ongoing. Resident #257 skin sweep observation sheet was implemented immediately. The licensed nurse completed head to toe reassessment including skin assessment on 08/17/22 no new skin issue observed. The licensed nurse completes and sign Resident weekly skin assessment by licensed nurses is being completed and skin sweep observation sheet ongoing. Resident suffered no negative outcome.	09/23/22

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F 686	Continued From page 123 Section M (Skin Conditions): The facility staff coded that resident has two (2) stage three pressure ulcers that were present on admission, one (1) unstageable pressure ulcer present on admission and moisture associated skin damage. Review of the physicians' orders revealed the following: 05/21/22 "Weekly skin assessment by licensed nurs ... day shift every fri (Friday)." 05/23/22 "Wound to right buttock: cleanse with normal saline apply medihoney and cover with dry dressing every day shift." 05/25/22 "Right Ischium Unstageable wound cleanse with normal saline, pat dry apply Medi honey and covered (sp) with bordered gauze daily. Every day shift. " Review of the care plan with a focus area of: "admitted with Pressure Ulcer to sacral unstageable wound to right buttock r/t (related to) immobility, incontinence, Stage 4 pressure to sacral" initiated on 05/24/22, included the following interventions: " ...Administer preventive treatment as ordered by physician. ..." Resident #4's medical record lacked documented evidence that facility staff conducted weekly skin assessments from 06/03/22 through 06/28/22, as ordered by the physician. During a face-to-face interview conducted on 06/28/22 at approximately 12:30 PM, Employee #3 (Assistant Director of Nursing) acknowledged the findings and stated, "They [Weekly Skin Assessments] were not done."	F 686	F686 IDENTIFICATION OF OTHERSWITH THE POTENTIAL TO BE AFFECTED: All the residents in the facility have the potential to be affected.	09/23/22

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F 686	Continued From page 124 2. Facility staff failed to ensure a licensed nurse performed ongoing skin assessments on Resident #56, subsequently the resident developed a pressure ulcer to his left heel that was first observed at a Stage 3. Resident #56 was readmitted to the facility on 08/30/19 with diagnoses that included Peripheral Vascular Disease, and Chronic Obstructive Pulmonary Disease. The physician's order dated 08/30/19 directed, "weekly skin assessment by licensed nurse every day shift every [Wednesday]" Review of the Admission Minimum Data Set (MDS) dated 04/06/22, revealed that the facility staff coded the following: Section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) Summary Score "04" indicating severely impaired cognition. Section G (Functional Status): "Extensive assistance" requiring "Two-person physical assist" for Bed mobility, Transfer, and Personal hygiene. Upper and lower extremity "Impairment both sides" Section M (Skin Conditions): The facility staff coded that resident has one (1) stage three pressure ulcer; the resident is at risk for pressure ulcers, is on a pressure reducing device for bed, receiving pressure ulcer care. The physician's order dated 02/17/21 directed,	F 686	F686 MEASURE TO PREVENT RECURRENCE: The facility Staff Developer/designee will provide education/ in-services to the facility licensed nurses to ensure residents receive care consistent with professional standards of practice and importance of completing skin assessments and implementing ongoing skin assessment as ordered by physician. This will be completed by 9/23/22. MONITORING CORRECTIVE ACTION: Assistant Director of Nursing (ADON)/Designee will conduct house wide audit to identify residents that are missing that facility licensed nurses failed to implement weekly skin assessment and documentation as ordered by the physician; and ensuring Residents receive care consistent with professional standards of practice. Any issue found during this audit will be addressed by 09/23/22 The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	09/23/22

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"Apply boot to left foot for pressure relief every shift."
Review of the Tissue Analytics form dated 05/25/21 revealed: location - left heel; wound status-healed; Etiology-Blister.

Review of the Skin Sweep/Shower sheets showed the following:

04/04/22 - Skin inspected and shows - was left blank (indicating the resident had no new open areas to his skin). The sheet was signed by the certified nurse aide and lacked a licensed nurse's signature indicating that she observed the resident's skin.

04/07/22 - Skin inspected and shows - was left blank (indicating the resident had no new open areas to his skin). The sheet was signed by the certified nurse aide and the licensed nurse indicating the licensed nurse observed the resident's skin.

04/11/22- Skin inspected and shows - was left blank (indicating the resident had no new open areas to his skin). The sheet was signed by the certified nurse aide and lacked a licensed nurse's signature indicating that a licensed nurse had not observed the resident's skin.

04/14/22- Skin inspected and shows - was left blank (indicating the resident had no new open areas to his skin). The sheet was not signed by the certified nurse aide, however the licensed nurse signed indicating that she observed the resident's skin.

04/18/22 -Skin inspected and shows - was left blank (indicating the resident had no new open

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areas to his skin). The sheet was signed by the certified nurse aide and lacked a licensed nurse's signature indicating that a licensed nurse had not observed the resident's skin.

Review of the skin assessment dated 04/19/22 revealed ... "Reopened left heel, cleanse with normal saline, pat dry and apply medi honey and cover with dry dressing ..."

Review of the Tissue Analytics form dated 04/19/22, revealed: "location - left heel; Date wound acquired- 04/18/2022; granulation - 60%, slough-40%, Depth 0.10 centimeter; wound status- reopened; Etiology-pressure stage 3 ..."

The physician's order dated 04/19/22 directed, "Wound to left heel (Reopened): Cleanse with normal saline, pat dry and apply medi honey and cover with dry dressing ..."

Although the Tissue Analytics form documented that the pressure ulcer on the left heal re-opened on 04/18/22, there is no documented evidence in the medical record of treatment orders until 04/19/22.

During a face-to-face interview with Employee #41 (Wound Nurse) on 06/21/22 at 1:09 PM she stated, "He [Resident #56] has bunions and is prone to blisters. The left heel was a DTI (Deep Tissue Injury) and is now a stage 3 (Pressure ulcer), it is clean."

There was no evidence that a licensed nurse performed ongoing assessments of Resident #56's left heel, subsequently his left heal wound reopened and was observed on 04/18/22, as a Stage 3 pressure ulcer.

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During an interview with Employee #2 (Director of Nursing) on 06/27/22 at 10:46 AM, she reviewed the documents and made no comment.

3. Facility staff failed to perform weekly skin assessment for Resident #84.

Review of a Facility Reported incident (FRI) received by DOH (Department of Health) on 09/20/21, concerning Resident #84 documented " ...A complete head to toe assessment done Multiple scars to left upper back and sacral area. Redness to perineal /sacral, area ..."

Resident #84 was admitted to the facility on 05/20/21, with multiple diagnoses that included: Type 2 Diabetes Mellitus Without Complications, Hemiplegia and Hemiparesis following Cerebral Infarction.

Review of the Quarterly Minimum Data Set (MDS) dated 02/18/22, revealed that facility staff coded the following:

Section C (Cognitive Patterns): "Should a Brief Interview for Mental Status be Conducted? "No" indicating resident was not assessed.

Section G (Functional Status): Bed Mobility, "Extensive assistance" requiring "One-person physical assist"

Transfer, "Extensive assistance" requiring "Two-person physical assist"

Toilet use, "Extensive assistance" requiring "One-person physical assist"

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Personal hygiene, "Extensive assistance" requiring "One-person physical assist"

Bathing "Total dependence"

Upper extremity "Impairment on one side"

Lower extremity "Impairment on one side"

Section M (Skin Conditions): Facility staff coded resident as being at risk of developing pressure ulcers/injuries and as having one (1) unstageable pressure ulcer that was not present on admission.

Review of the physician's orders revealed the following: 04/06/22, "Weekly skin assessments by licensed nurse. ... day shift every Wed (Wednesday) ..."

Review of the care plan with a focus area of "[Resident #84] has potential impairment to skin integrity r/t (related to) fragile skin. ..." initiated date of 05/23/22, had the following interventions "Treatment to be done per MD order, ..."

The medical record lacked documented evidence that weekly skin assessments were completed on the following dates: 04/06/22 to 4/19/22, 04/21/22 to 05/03/22 and 05/05/22 to 06/21/22.

During a face-to-face interview conducted on 06/23/22 at 3:00 PM, Employee #33 (unit Manager 2nd floor) acknowledged the findings and stated "A nurse goes and checks the skin and whatever they see they document."

4. Facility staff failed to perform weekly skin assessment for Resident #138.

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Resident #138 was admitted to the facility on 08/20/21with multiple diagnoses that included, Chronic Respiratory Failure with Hypoxia, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Pressure Ulcer of Sacral Region Stage 3, Muscle Weakness and Unspecified Abnormalities of Gait and Mobility.

Review of the Quarterly Minimum Data Set (MDS) dated 05/17/22 revealed that facility staff coded the following:
Section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) summary score "15" indicating intact cognition.
Section G (Functional Status): Bed mobility "Limited assistance" requiring "One-person physical assist"
Transfer "Limited assistance" requiring "One-person physical assist"
Toilet use "Limited assistance" requiring "One-person physical assist"
Personal hygiene "Extensive assistance" requiring "One-person physical assist"
Bathing "Total dependence"
Mobility devices "Wheelchair"
Section M (Skin Conditions): Facility staff coded the resident as having one (1) stage three pressure ulcer

Review of the physicians' orders revealed the following: 08/20/21, directed, "Weekly skin assessment by licensed nurse... day shift on Tue (Tuesday)"

Review of the care plan with a focus area of "[Resident #138] was admitted with stage 3 ulcer to sacral r/t (related to) fragile skin, decreased mobility ..." date initiated of 08/21/21, had the

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following interventions " ...Treatment to be done per order"

The medical record lacked any documented evidence that the facility staff did weekly skin assessments for Resident # 138 from 05/07/22 through 05/30/22.

During a face-to-face interview conducted on 06/27/22 at 10:30 AM, Employee #3 (Assistant Director of Nursing) was asked if weekly skin assessments were performed in May 2022 for the resident and where were they located? Employee #3 acknowledged the findings and made no further comment.

5. Facility staff failed to ensure Resident #257 received care consistent with professional standards of practice to prevent the development of a pressure ulcer (Stage 3).

Resident #257 was admitted to facility on 11/19/21 with diagnoses that included: Acute Osteomyelitis of Left Ankle and Foot, Type 2 Diabetes Mellitus with Foot Ulcer and Peripheral Vascular Disease.

Review of Resident #257's medical record revealed the following:

04/06/22 at 10:09 AM [Skin/Wound Note] "Resident ... re-admitted on 04/06/22 with left foot diabetic ulcer, absence of left toe, right lateral foot necrotic tissue measured 2.95cm (centimeter) X 1.71cm, left second toe open area 1.80ccm X 1.29cm, right great toe necrotic tissue 0.83cm x 1.62cm ..."

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Review of physician's orders revealed the following:

04/06/22 "Weekly skin assessment by licensed nurse...day shift every Wed (Wednesday)"

04/06/22 "Apply moisturizing lotion daily for skin lubrication every day shift"

Care Plan updated on 04/13/22 " [Resident #257] has potential for pressure ulcer development r/t (related to) decreased mobility, fragile skin and incontinence ... Monitor/document/report PRN any changes in skin status ... Skin assessment weekly and as needed by licensed nurse ..."

Care Plan updated on 04/13/22 [Resident #257] has an ADL (activities of daily living) self-care performance deficit r/t generalized weakness ... totally dependent on staff to provide bath/shower twice weekly and as necessary ... requires skin inspection. Observe for redness, open areas, scratches, cuts, bruises and report changes ..."

06/01/22 [Weekly Skin Assessment] " ...Describe skin impairment: none ..." indicating the nurse did not observe any skin integrity concerns for Resident #257.

A Quarterly MDS dated 06/03/22 where facility staff coded: moderately impaired cognition, no rejection of care, extensive assistance one person physical assist for bed mobility and personal hygiene, impairment on both sides for lower extremities, always incontinent for bowel and bladder, 2 unstageable pressure ulcers that were present upon admission/entry or reentry and diabetic foot ulcers.

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06/06/22 at 2:51 PM [Situation, Background, Assessment, Request] "Situation: Observe wound on coccyx... During incontinent care at 2:45 pm, writer was notified by CNA (Certified Nurse Aide) staff assigned to resident of an opening area ... on coccyx which measure L=0.87cm X W= 0.55cm. Moderate drainage noted from sites ..."

06/06/22 at 2:51 PM [Skin Observation Tool] " ...Coccyx wound 0.87cm 0.55cm ..."

06/07/22 at 10:40 AM [Skin/Wound Note] " ... Comprehensive skin and wound evaluation ... sacrum stage 3 pressure ulcer ..."

06/10/22 at 1:02 PM [Wound/Pressure Ulcer Note] " ... Pressure ulcer/Stage 3 sacrum length 0.87 cm width 0.55 cm depth 0.1 cm ... in house acquired ..."

Review of the form "Unit 3 Resident Bath/Shower List" (not dated) provided to the surveyor on 06/23/22 showed that Resident #257 was on the schedule for a bath/shower every Monday and Thursday.

During a face-to-face interview on 06/23/22 at 11:05 AM, Employee #12 (Registered Nurse) stated, "Skin sweep assessments are done on scheduled shower days. A skin sweep form is completed by the CNA and nurse. If there's no sheet, then it [skin sweep assessment] wasn't done."

Review of Resident #257's medical record lacked documented evidence that a "Skin Sweep Observation Sheet" was completed on 06/02/22 (Thursday), which is Resident #257's scheduled

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F 686	Continued From page 133 bath/shower day. Review of the CNA documentation showed that Resident #257 received a bed bath (BB) every day from 06/02/22 to 06/05/22. Review of the Treatment Administration Record (TAR) showed that facility staff initialed in the area that directed, "Apply moisturizing lotion daily for skin lubrication every day shift" from 06/02/22 to 06/05/22 (4 days) indicating that the task was completed. The evidence showed that for a period of 4 days (06/02/22 to 06/05/22), the facility's nursing staff failed to document and report any changes in Resident #257's skin. Subsequently, Resident #257 was observed with a Stage 3 pressure ulcer on his sacrum on 06/06/22. During a face-to-face interview on 06/23/22 at 11:39 AM, Employee #13 (Educator) acknowledged the finding and stated, "Resident's should not be found with wounds at advanced stages (Stage 3). The CNA's and nurses know to document and report any changes to the skin. Nursing staff have been educated on documenting on the Skin Sweep Sheet on shower days. If the resident refuses the bath, shower or the skin sweep, it should be documented on the form and in a [nurse's] note."	F 686		
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	F 688		

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F 688	Continued From page 134 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, record review and staff interview for three (3) out of 67 sampled residents, facility staff failed to ensure residents with limited range of motion received the appropriate services to maintain or improve range of motion. Facility staff failed to show evidence that restorative nursing services were provided and failed to ensure that a resident received prescribed orthotics and multi-podus boots as ordered by the physician to prevent worsening contracture. (Residents' #32, #95, and #102) The findings include: Review of the policy "Restorative Nursing Care" revised 02/22 documented, "Restorative nursing is offered to all residents who have completed skilled OT (Occupational Therapy) or PT (Physical Therapy) services ... Our facility has an active program of restorative nursing which is developed and coordinated through the resident's care plan ...Restorative nursing care is performed for those residents who require such service ...	F 688	CORRECTIVE ACTION TO THE AFFECTED RESIDENT: The facility cannot retroactively correct this deficiency. The affected Resident #32 was assessed from head to toe on 08/17/22 by Unit Manager/Designee, Resident#32 clinically stable Resident #32 did not suffer any negative outcome. The affected Resident #95 was assessed from head to toe on 08/17/22 by Unit Manager/Designee, Resident #95 is clinically stable.Resident #95 currently on Occupation Therapy started 08/11/22. Resident #95 did not suffer any negative outcome.	09/23/22

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F 688	Continued From page 135 initiate point click care list for each resident placed on program ..." 1. Facility staff failed to ensure Resident #32 received appropriate services and assistance to maintain mobility evidenced by failure to provide restorative nursing services as ordered by the physician. Resident #32 was admitted to the facility on 03/27/20 with multiple diagnoses that included: Muscle Weakness, Cerebral Infarc and Alzheimer's Disease. Review of Resident #32's medical record revealed the following: A Quarterly Minimum Data Set (MDS) dated 05/13/22 where staff coded: moderately impaired cognition, extensive assistance with two persons physical assist for bed mobility, transfers, toilet use and personal hygiene, range of motion impairment on both lower extremities, wheelchair mobility device and received occupational therapy (OT) services from 04/11/22 to 05/13/22. 05/13/22 [Occupational Therapy Discharge Summary] "... Discharge Status and Recommendations: RNP (Restorative Nursing Program) ...to facilitate maintaining current level of performance and in order to prevent decline, development of and instruction in the following RNPs has been completed with the IDT (interdisciplinary team): ROM (range of motion) active..." 05/13/22 [Physician's Order] "D/c (discharge) from OT services as highest functional level achieved. Pt (patient) to start on RNP for	F 688	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents in restorative therapy in the facility have potential to be affected.	09/23/22

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F 688	Continued From page 136 3-5x/week to maintain function." Review of the "Restorative Nursing Program" document provided to the surveyor on 06/21/22 at 9:20 AM, did not list Resident #32 as receiving RNP. During a face-to-face interview on 06/21/22 at 9:26 AM, Employee #10 (Rehab Manager) stated, "[Resident #32] had no issues or complaints when we saw him during the latest round of OT. He (Resident #32) participated and made consistent progress. He was d/c to restorative nursing. Education was provided to the nursing staff on the techniques and ROM to provide." Review of Resident #32's medical record on 06/21/22 showed no documented evidence that restorative nursing services were being provided since discharge from OT, approximately 6 weeks (05/13/22 to 06/21/22). During a face-to-face interview on 06/21/22 at 10:38 AM, Employee #2 (Assistant Director of Nursing (ADON)/RNP Program Manager) acknowledged the finding and stated, "It was an oversight on my part." 2. Facility staff failed to ensure Resident #95 received appropriate services, and assistance to maintain mobility evidenced by failure to apply the resident's prescribed rehabilitative equipment (right hand splint). During an observation on 06/14/22 at 10:31 AM, Resident #95 was observed in bed with a sign at the head of her bed that directed " ...Apply right hand splint for 6-8 hours daily ..." At the time of this observation, a right hand splint was noted	F 688	F688 MEASURES TO PREVENT RECURRENCE: The facility Staff Developer/ Designee will provide an education/ in-service to facility nursing staff. The education will explain the importance of ensuring that residents with limited range of motion received appropriate treatment and services to prevent further decrease in range of motion by 9/23/22. MONITORING CORRECTIVE ACTION: The facility ADON/Designee will complete house wide review/audit of all facility residents to identify potential residents with limited range of motion that the facility's staff failed to ensure received appropriate treatment and services to prevent further decrease in range of motion weekly times 4, then, monthly times 3 months. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	09/23/22

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above the bed in a clear, plastic bag.

During a face-to-face interview conducted at the time of the observation, Employee #9 (Certified Nurse Aide) stated, "The therapist or the restorative aide applies and removes the splint."

During observations on 06/21/22 at 12:16 PM and 06/24/22 at 3:54 PM, Resident #95 was noted to not be wearing the right hand splint. At each observation, the right hand splint was observed at the head of her bed, in a clear, plastic bag.

Resident #95 was admitted to the facility on 11/16/18 with multiple diagnoses that included: Muscle Weakness, Cerebral Vascular Disease, Type 2 Diabetes Mellitus and Hypertension.

Review of Resident #95's medical record revealed the following:

06/02/21 [Physician's Order] "Right resting hand splint"

04/12/22 [Revised Care Plan] "[Resident #95] on restorative nursing for PROM (passive range of motion) to bilateral extremities ... right resting hand splint for 6-8hrs to prevent right hand contractures... Restorative staff will assist with daily exercises as per order ..."

A Quarterly MDS dated 05/31/2022 showed facility staff coded the Resident #95 as severe cognitive impaired, totally dependent on staff with two persons physical assist for bed mobility, toilet use and personal hygiene; range of motion impairment on both sides for upper and lower extremities and received OT services from 04/19/22 to 05/31/22.

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F 688	Continued From page 138 06/01/22 [Occupational Therapy Discharge Summary] "... Discharge recommendations: RNP... to facilitate patient maintaining current level of performance and in order to prevent decline, development of and instruction in the following RNPs has been completed with the IDT: bed mobility and R (right) H (hand) splint or brace care..." Review of the "Restorative Nursing Program" document provided to the surveyor on 06/21/22 at 9:20 AM, did not list Resident #95 as receiving RNP for the right hand resting hand splint. Review of Resident #95's medical record showed no documented evidence to show that facility staff was applying the right hand splint as specified by the physician's order and care plan. During a face-to-face interview conducted on 06/24/22 at approximately 4:00 PM, Employee #2 acknowledged the findings and made no comments. 3) Facility staff failed to show evidence that restorative nursing services were provided and ensure that the Resident #102, received prescribed orthotics and multi-podus boots as ordered by the physician to maintain or improve range of motion. Resident #102 was admitted to the facility on 07/30/20, with multiple diagnoses that included the following: Adult Failure to Thrive, Pressure Ulcer of Sacral Region, Stage 3, Contracture Unspecified Joint, Contracture Right Knee, Contracture Left Knee, Moderate Protein Calorie Malnutrition and Muscle Weakness.	F 688		09/23/22

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Review of the Quarterly Minimum Data Set (MDS) dated 06/02/22, revealed facility staff coded the following:

Section C (Cognitive Patterns): Brief Interview for Mental Status Summary Score "15" indicating intact cognition.

Section E (Behavior): Rejection of Care -Presence & Frequency "0" Behavior not exhibited

Section G (Functional Status): Bed mobility "Extensive Assistance" requiring "Two-person physical assist"

Transfer "extensive assistance" requiring "Two-person physical assist"

Dressing "Extensive assistance" requiring "Two-person physical assist"

Eating "Supervision" requiring "Set-up help only"

Toilet use "Extensive assistance" requiring "One -person physical assist"

Personal Hygiene "Extensive assistance" requiring "One-person physical assist"

Balance during transitions and walking Surface to surface transfer "Not steady only able to stabilize with staff assistance"
Upper extremity "no impairment"
Lower extremity "Impairment on both sides"

Section K (Swallowing/Nutritional status): Swallowing Disorder "None of the above"

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Section O (Special Treatments, Procedures, and programs): Physical Therapy start date was coded "05/27/2022" no end date was coded. The number of minutes in physical therapy was coded "0168" minutes

Review of the physicians' orders revealed the following:

10/08/20 "Out-of Bed to wheelchair by nursing as tolerated to improve interaction with environment"

11/23/21 "LE (Left Extremity) orthotics: R (Right) knee extensor brace and B/L ankle multi-podus boots to be worn up to 6 hours or to patients' tolerance with skin assessments completed pre and post use D/C (Discontinue) use if patient reports pain or changes in skin integrity occur."

04/03/22 "Discontinue OT as patient has achieved highest practical level in ADL's and functional mobility. Patient will start RNP (Restorative Nurisng Program) 5-6x/week for 15 minutes"

Review of the care plan with a focus area of "[Resident #102] has alteration in musculoskeletal status r/t (related to) contracture of the bilateral knees." date revised 06/02/2022 had the following interventions: "Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance."

Review of a document titled "Physical Therapy progress report" in the section titled "Summary /Justification to continue service dated signed 06/21/22 at 3:04 PM showed, "Reason to continue services : Continue PT (physical

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F 688	Continued From page 141	F 688		

therapy) services are necessary in order to evaluate need for assistive device, develop and instruct in RNP (restorative nursing program) ...promote safety awareness, enhance rehab potential, increase coordination , improve dynamic balance, increase functional activity tolerance, increase LE (lower extremity) ROM (range of motion) and strength ..."

Review of the document titled "Documentation survey report v2" from June 1, 2022, through June 23, 2022, documents care provided to residents revealed in the section titled Intervention/task showed resident did not receive restorative nursing for active range of motion of bilateral lower extremity on the following dates:
06/01/22
06/02/22
06/06/22
06/07/22
06/16/22
06/17/22
06/20/22
06/23/22
In the section that documents resident receiving restorative nursing for bed mobility getting out of bed and transferred to wheelchair for 4 hours showed this task was not done on the following days:
06/01/22
06/02/22
06/06/22
06/07/22
06/16/22
06/17/22
06/20/22
06/23/22
In the section that documents "Resident on Restorative Nursing for splinting to right knee with

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F 688	Continued From page 142 knee brace and multi pods boot. Don after morning care and Duff at bedtime ..." showed that this task was not performed on the following days: 06/01/22 06/02/22 06/03/22 06/06/22 06/07/22 06/16/22 06/17/22 06/20/22 06/23/22 For all the above-mentioned sections facility staff either left the space blank or documented "NA" which means "Not Applicable" according to the documentation. A face-to-face interview was conducted on 06/24/22, at 2:40 PM with Employee #3 (Assistant Director of Nursing) he stated "The restorative aide does the restorative nursing program and applies the orthotics, I know we have some challenges sometimes they assist the unit" The surveyor went on to question Employee #3 about what the "NA" meant in the documentation, and he stated it meant "Not available and it was done in error" Employee #3 acknowledged the findings	F 688	F689 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT The facility cannot retroactively correct this deficient practice. Resident#124 did not returned to the facility from Leave Of Absence . Resident #124 was discharged from the facility on 07/1/2022. Resident #135 was assessed from head to toe done by a licensed nurse on 11/20/21 post fall medicated for complaint of pain. X-ray ordered for complaint of to the right hip on 11/20/21, result of X-ray was negative for fracture and no acute changes noted. Resident #135 was reassessed from head to toe on 08/17/22 by the licensed nurse Resident did not suffered any negative outcome.. Resident #35 was assessed from head to toe on 05/20/22 by the licensed nurse post fall . No complaint of pain or apparent injury sustained. The resident is now provided with adequate supervision when leaving and returning from dialysis. Resident #35 was reassessed from head to toe on 08/17/22 by the licensed nurse Resident did not suffered any negative outcome. Education was immediately provided to the assigned staff with regards to providing proper assistance during care transfer.	09/29/22
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		

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F 689	Continued From page 143 §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 record review and staff interviews, facility staff failed to ensure that three (3) of 67 sampled residents received adequate monitoring and supervision to prevent avoidable accidents as evidenced by the following occurrences: one resident that left the facility without staff knowledge; one resident who fell out of her wheelchair while being escorted back into the facility; and one resident who fell after receiving assistance from one staff person during a transfer. (Residents' #124, #135, #35). The findings included: Review of the policy "Leave of Absence (LOA) for Residents" revised on 05/22 documented, "...For all authorized leave of absence ... Time, date, destination, responsible party, expected return and any special instruction must be documented on LOA form ... residents who go on LOA, must return back to facility prior to midnight ... Progress note must be completed stating the timeline of event in the resident medical record." Review of the policy, "Mobility and Falls ..." revised 05/22 documented, "... It is the policy of [Facility Name] to provide a safe environment for our residents. The facility falls prevention initiative will provide strategies ...to decrease the number of falls ... Procedure and Implementation ...communicate patients fall risk status to caregivers. Develop individualized plan of care ..." 1. Facility staff failed to follow its LOA policy for	F 689		09/23/22

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F 689	Continued From page 144	F 689	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED. All the residents in the facility have the potential to be affected.	09/23/22

Resident #124, who left the facility without staff knowledge on 06/13/22 at approximately 10:30 AM.

Review of Facility Reported Incident (FRI) dated 06/13/22 documented, "At about 17:10 pm (5:10 PM), writer was informed by the on-coming shift supervisor that [Resident #124] is not in her room while she did her wellness check and routine rounds on the unit. Report received from the nurse (evening shift supervisor) that resident left the facility on LOA at about 10:36a.m. Writers notify the MPD (Metropolitan Police Department) via 911 at 08:40pm ...The police officer exited the building and returned at 09:35p.m ...The DOH (Department of Health) and Ombudsman were notified ..."

Resident #124 was admitted to the facility on 04/21/21 with diagnoses that included: Difficulty Walking, Hypothyroidism, Hypertension, Anemia and Dysphagia.

During a tour of room 129 on 06/14/22 at approximately 11:20 AM, Resident #124 was not in the room. The bed was made, no personal effects were noted at the bedside or in the bedside drawer and no clothes were noted in the closet- just 4 (four) empty hangers.

Review of Resident #124's medical record revealed the following:
05/07/21 [Physician's Order] "May be up as ad lib or as needed ... LOA (leave of absence) with meds"

05/07/21 [Physician's Order] "Check every 1 hour to confirm that the resident is physically in the facility. Indicate "HW" for Hallway, "DR" for Dining

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F 689	Continued From page 145 Room, "RM" for Room, "OF" for Out of Facility, "SC" for Smoking Patio, and "IB" for In-bed ..." A Quarterly Minimum Data Set (MDS) dated 05/14/22 showed facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 15, indicating intact cognition, no potential for psychosis, no verbal or physical behavioral symptoms directed towards others, no refusal of care, independent for locomotion on and off the unit, no impairment in range of motion and no active discharge planning for the resident to return to the community. June 2022 [Medication Administration Record (MAR)]: facility staff initialed to indicate that Resident #124 received all her scheduled 9:00 AM medications on 06/13/22. June 2022 [Treatment Administration Record (TAR)]: facility staff documented "3", meaning "absent from home" from 06/13/22 at 11:00 AM to 06/13/22 at 5:00 PM in the area that directed, "check every 1 hour to confirm that the resident is physically in the facility." Review of the "24 Hour Report" on 06/14/22 revealed that facility staff did not document that Resident #124 had left LOA on 06/13/22. Review of the Unit 1 sign in/out log on 06/14/22 lacked documented evidence that Resident #124 signed out to leaving the facility. 06/13/22 at 9:28 PM [Nurses Note] "At about 17:10pm, writer was informed by the on-coming shift supervisor that [Resident #124] is not in her room while she did her wellness check and routine rounds on the unit. Report received from	F 689	MEASURE TO PREVENT RECURRENCE: Staff Developer/Designee will provide education/in-service to all facility staff on the importance of following the facility policy on Leave of Absence (LOA) and ensuring documentation of resident that left on LOA by 09/23/22. Staff Developer/Designee will provide education/in-service to the facility Nursing licensed nurses and Nursing Assistants on how to provide proper transfer assistance to residents. This will be completed by 09/23/22. The facility Staff Developer/Designee will provide education/ in-service to all the facility staff on importance of ensuring resident receive adequate monitoring and supervision to prevent avoidable accidents and potential elopement by 09/23/22.	09/23/22

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F 689	Continued From page 146 the nurse [Nurse Supervisor] that resident left the facility on LOA at about 10:36a.m. Writer review the resident's chart to get her contact number but resident had no contact number nor emergency contact in her records... Writer notify [Physician's Name] ... and the APS was called ... Writer notify MPD ..." 06/13/22 at 11:16 PM [Situation Background Assessment Request (SBAR)] "Situation: 17:10 (5:10 PM), writer observed that resident was not in her room during dinner ... At 15:00 (3:00 PM) during start of shift, writer received report that resident left the facility on LOA at 10:30am ... During routine check at 17:10 (5:10 PM), writer observed that resident was not in her room ... Resident is self R/P with no contact nor emergency contact on her chart ...Writer notified MPD ... arrived at 08:45p.m, reviewed resident's information ...Officer said resident is not considered a missing person at this time base on her cognitive status, resident has no restriction not to leave the facility ..." Review of the progress notes showed a nurses note that was created on 06/14/22 at 7:41 AM with an effective date of 06/13/22 at 3:36 AM that documented, "Late Entry ... Resident is alert and oriented x3, received sitting up in bed this am. Tolerated all due medications this am with no concerns noted. Resident left the facility on LOA at 10:30 am in stable condition. She is self RP (resident representative)..." During a face-to-face interview on 06/14/22 at 11:30 AM, Employee #7 (Unit 1 Nurse Manager) stated, "I was not aware that the resident (Resident #124) was going anywhere. She did not have any scheduled appointments." Employee #7	F 689	MONITORING CORRECTIVE ACTION: The facility Assistant Director of Nursing/Designee will conduct house wide audit of all residents that goes on Leave of Absence (LOA) to ensure that the facility LOA policy is followed by staff and documentation is accurate. The facility Assistant Director of Nursing/Designee will conduct house wide audit/Review of all residents requiring two - person assistance with transfer to ensure that facility staff provide adequate assistance. This audit will be completed weekly times 4, then, monthly times 3 months. The facility Assistant Director of Nursing/Designee will conduct house wide audit of all residents to ensure that residents received adequate monitoring and supervision to prevent avoidable accidents weekly times 4, then, monthly times 3 months. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	09/23/22

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further stated, "Anytime a resident leaves the facility whether for a medical appointment or LOA, it should be documented on the 24 hour report book and in a progress note in PCC (point click care)."

During a face-to-face interview on 06/14/22 at 2:57 PM with Employeess #17 (Security Officer) and #18 (Security Supervisor), Employee #17 stated that she let Resident #124 out of the building by pushing a button (this button opens and closes the sliding door at the front entrance). Employee #17 further stated, "She (Resident #124) did not sign out. She appeared to be a visitor. I only know of one caucasian resident here. It was my first time seeing her (Resident #124)."

Security footage was not unavailable for review at the time of the interview. Employee #18 stated, "The cameras are set up for 24 hour delete. I saw the video and she [Resident #124] had a black tote bag. She walked out the front door, through the parking lot to Southern Avenue."

During a telephone interview on 06/15/22 at 9:59 AM, Employee #5 (Assigned Registered Nurse on 06/13/22 day shift), stated that during medication administration at approximately 10:15 AM, Resident #124 mentioned to her that she was going to leave the facility to take care of something. Employee #5 further stated, "I did not know that the resident had left the facility or even the time. When I finished my shift at 3:30 PM, I did not know she had left. It was not until I received a call from the evening shift nursing supervisor while on my way home from work asking about Resident #124's where abouts that I was made aware. The supervisor asked me when

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the last time I saw her (Resident #124) was and I told her when I gave her medications in the morning (approximatley 10:15 AM). The resident doesn't get any scheduled afternoon medications."

The evidence showed that facility staff failed to follow its policy for residents going on LOA. As a result, Resident #124 left the facility on 06/13/22 at approximately 10:30 AM without staff knowledge.

During a face-to-face interview with Employees #1 (Administrator) and #2 (Director of Nursing) on 06/15/22 at 11:08 AM, they both acknowledged the finding.

It should be noted that as of 06/29/22 (16 days after leaving), Resident #124 did not return to the facility nor was she ever located.

2. Facility staff failed to provide Resident #135 with adequate assistance of two persons for transfers which resulted in a fall.

Resident #135 was admitted to the facility on 07/28/21 with diagnoses that included: Lack of Coordination and Muscle Weakness.

A FRI received on 11/22/21 documented, "... At 11am ... CNA (Certified Nurse Aide) gave her shower, took her to her room, try to assist her in bed, resident's legs gave up, and the CNA help lower her on the floor and call for the writer. Upon entering resident's room, resident was observed on the floor in a sitting position beside her bed; CNA explained what had happened to the writer. Upon assessment resident complained pain to her right leg, but no visible injury noted, no

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headache, no drainage from ears, nose, eyes, no redness, resident was assisted to her bed and made comfortable ..."

Review of Resident #135's medical record revealed the following:

07/28/21 [Physician's Order] "Fall precaution every shift"

7/28/21 [Physician's Order] "Low bed for safety every shift"

10/27/21 [Quarterly Fall Risk Assessment/Evaluation] "...Moderate Risk..."

A Quarterly Minimum Date Set (MDS) dated 11/01/21 showed that facility staff coded the following: A brief Interview for Mental Status (BIMS) summary score of 08, indicating moderately impaired cognition, no refusal of care, extensive assistance with two persons physical assist for transfers, impairment on one side for lower extremities and no falls since admission, reentry or prior assessment.

11/20/21 at 11:10 AM [Nurses Note] "Report received from assigned nurse around 11:44 am that resident was eased on by floor by assigned CNA during transfer from chair to bed. Met resident in bed alert and oriented x 3. Able to move all extremities, c/o (complained of) pain to right lower extremity, pain med (medication) administered by assigned nurse and effective. NP (Nurse Practitioner) in facility, reassess resident and gave new order for x-ray to right lower extremity ..."

11/20/21 [Physician's Order] "x-ray- Right hip c/o

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(complained of) pain one time..."

11/20/21 at 3:26 PM [Nurses Note] "Writer ask resident what had happened, she stated that as the assign CNA was trying to assist her in bed, her legs gave up and she help lower her on the floor."

11/21/21 at 4:59 PM [Nurse Practitioner Note] "...review X-ray results done last night...No acute changes ... negative for fracture..."

Care Plan created on 07/29/21 "[Resident #135] has ADL (activities of daily living) self-care performance deficit r/t (related to) impaired balance ... The resident has requires (2) staff participation with transfers."

During a telephone interview on 06/24/22 at 12:35 PM, Employee #23 (assigned CNA on date of fall) stated, "I was transferring the resident from the shower chair to the bed when her legs gave out. I called the nurse to come in and she helped me get her (Resident #135) back in bed. I always transferred her by myself, I was not aware that she needed 2 people for transfers."

The evidence showed that facility staff failed to provide Resident #135 with adequate assistance of two persons for transfers.

During a face-to-face interview conducted on 06/24/22 at 12:37 PM, Employee #7 (Unit 1 Nurse Manager) acknowledged the finding and stated, "She (Resident #135) should've had two people assisting her."

3. Facility staff failed to provide adequate supervision for Resident #35, who sustained a fall from fell wheelchair while being asssited by staff.

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Resident #35 was re-admitted to the facility on 03/15/22 with diagnoses including Dependence on Renal Dialysis, Personal History of Transient Ischemic Attack (TIA), and Cerebral Infarct without Residual Deficits.

A Quarterly Minimum Data Set (MDS) dated 04/11/22 showed in Section C (Cognitive Patterns) that facility staff documented the resident as having a Brief Interview For Mental Status summary score (BIMS) of "15," indicating intact cognition. Section G (Functional Status), facility staff documented that Resident #35 used a wheelchair for mobility, required extensive assistance with one person physical assistance for transfers, and required supervision for setup for locomotion on and off the unit.

A review of Resident #35's medical record revealed:

05/20/22 at 5:00 PM [Nurses Notes]: "Resident returned ...at 1600 (4:00 PM) via wheelchair from dialysis. CNA (Certified Nurse's Assistant) informed writer, that she went to escort [the] resident from the transportation van back into the facility. CNA stated , that after [the] resident was taken from the van and she turned the wheelchair around to take [the] resident into the building, [the] resident slid out of her w/c (wheelchair) to the ground in a sitting position... Resident was assisted back into her w/c with 2-person assist and brought to the unit, Resident was assisted to bed and assessed no apparent injury noted..."

05/20/22 [Care Plan]: "...Focus: [Resident #35] slid out of the wheelchair in a sitting position on the floor ...Goal: Reduce falls..[Resident #35] will

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F 689	Continued From page 152 minimize[the] risk for falls ...Interventions: Provide assistance to transfer ..." Review of the facility's investagative resport revealed the following statements: 05/20/22 [Employee #35 -CNA] documented, "Resident went for dialysis treatment on 05/20/2022. Upon [return to the facility] escort notified Charge Nurse and writer [Employee #4/Registered Nurse] that resident slipped out of the wheelchair into a sitting position while transferring her into the facility..." 05/20/22 [Employee #36 - CNA] documented, "[Resident #35] was back from dialysis when another staff went to assist her on the wheelchair to the build[ing]. [Resident #35] slide off the wheelchair. I assisted to reposition [Resident #35] back in her wheelchair. Nurse was informed." During a face-to-face interview on 06/28/22 at 10:42 AM, Resident #35 reported, "I was coming back from dialysis before I fell. The van driver got me off the van. Three escorts were waiting at the curb when I got off. One of the escorts was pushing me back to building, talking to another escort when I slid out of the chair onto the ground. The escort was not paying attention. I wasn't hurt. Two escorts helped me get back into my chair, and one brought me back upstairs." During a face-to-face interview on 06/28/22 at 11:17 AM Employee #3, (Assistant Director of Nursing) acknowledged the finding.	F 689	F697 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: The facility cannot retroactively correct this deficiency. Resident #104 pain medication was administered immediately according to the parameters and physician orders after being notified and assigned licensed nurse was immediately educated on medication administration process and medication reconciliation process. Resident was reassessed head to toe on 8/17/22. Resident did not suffer any negative outcome. Resident #133 was immediately given pain medication per physician orders. This in ongoing. Licensed nurse was educated on proper administration of medication and accurate documentation. Resident was reassessed from head to toe on 08/17/22 by licensed nurse. Resident suffered no negative outcome.	09/23/22
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management.	F 697		

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F 697	Continued From page 153 The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, for two (2) of 67 sampled residents, facility staff failed to provide pain management in accordance with the physician's order. Residents' #104 and #133. The findings included: Review of the policy "Pain Management" revised 02/22, documented, "... The licensed nurse will... administer the order as indicated..." Review of the policy "Medication/Treatment Administration Record and Initials" revised 03/2022 documented, "... Prior to administration of medication and treatment, the licensed nurse assigned to the resident must check and validated the ten Rights of Medication which includes ... right assessment, right evaluation ... Licensed nurses will administer medication and treatment to residents following the physician orders..." 1. Facility staff failed to administer Resident #104's pain medication in accordance with the physician's order. Resident #104 was re-admitted to the facility on 05/05/22 with multiple diagnoses, including, Malignant Neoplasm of Prostate, Moderate Protein -Calorie Malnutrition, Acidosis, Vitamin D	F 697	F697 IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All the residents in the facility on pain management have the potential to be affected.	*09/23/22

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F 697	Continued From page 154 Deficiency, Pressure Ulcer of Sacral Region , Unstageable, and Pressure Ulcer of Left Buttock, Unstageable. Quarterly Minimum Data Set (MDS) dated 05/12/22 showed in Section C (Cognitive Patterns) that facility staff documented the resident as having a Brief Interview for Mental Status Summary Score (BIMS) of "15," indicating that the resident had intact cognition. In Section G (Functional Status), facility staff documented that Resident #104 required extensive assistance with one person physical assistance for bed mobility and eating, was totally dependent requiring one person physical assistance for transfers, dressing, toilet use and personal hygiene. In Section N (Medications) facility documented that resident received opioids for 3 days during the last 7 days or since admission/entry or reentry. A review of Resident #104's medical record revealed: On 06/20/22 at 6:00 PM the physician's order directed, "Percocet Tablet 5-325 mg (Oxycodone-Acetaminophen). Give 2 tablet(s) by mouth four times a day for pain 7-10." Medication Administration Record (MAR) for June 2022 revealed that the facility's licensed nursing staff marked that they administered Percocet Tablet 5-325 mg (Oxycodone-Acetaminophen), to Resident #104 from 06/21/22 to 06/24/22. Review of the June 2022 Pain Rating Report (Numeric Scale) documented: 06/20/22 - 5:44 AM- 4/10; 8:08 AM-0/10; 1:16 PM-0/10; 5:45 PM- 0/10	F 697	F697 MEASURE TO PREVENT RECURRENCE: The facility Staff Development and PharmScript Pharmacy Consultants will provide education to the facility licensed nurses to ensure that medication administration meet professional standard of practice, and ensuring that licensed nurses administer medications and treatments following physician orders by 9/23/22.	09/23/22

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F 697	Continued From page 155 06/21/22 - 12:55 AM-4/10, 1:55-0/10 AM, 6:11 AM-4/10, 2:15 PM-1/10, and 6:25 PM- 0/10 06/22/22 - 9:36 AM-0/10, 5:36 PM-0/10, and 11:51 PM- 0/10 06/23/22 - 1:58 AM-0/10; 6:07 AM-0/10, 10:59 AM-0/10; 12:14 PM-0/10, 5:23 PM-0/10 06/24/22 - 12:00 AM-6/10 and 6:00 AM 6/10 A review of Resident's #104's medical record revealed that from 06/21/22 to 06/24/22, facility staff failed to administered Percocet in accordance with the physician's order, which specified to administer the medication to the resident for a pain rating of 7-10. During a face-to-face interview on 06/20/22, Employee #3, Assistant Director of Nursing (ADON), after reviewing Resident #104's June 2022 MAR, acknowledged that the facility's licensed nursing staff administered Percocet to Resident#104 when the resident's pain rating was less than 7-10 and the employee offered no further comment. 2. Facility staff failed to administer Resident #133's narcotic pain medication as ordered by the physician. Resident #133 was admitted to the facility on 07/08/21 with diagnoses that included: Pain in Right Leg and Acute Kidney Failure. During a medication administration observation on 06/15/22 at 8:46 AM, Resident #133 stated that his pain level was "6" on a scale of 1 to 10. Employee #11 (Registered Nurse) then proceeded to administer Oxycodone (narcotic pain reliever) - APAP (Acetaminophen) 5-325 MG	F 697	F697 MONITORING CORRECTIVE ACTION: Assistant Director of Nursing (ADON)/Designee will conduct house wide audit to identify potential residents that facility licensed nurses failed to provide pain management in accordance with the Physician's order. weekly times 4, then, monthly times 3 months. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	09/23/22

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F 697	Continued From page 156 (milligram) 1 tablet by mouth to Resident #133. Review of Resident #133's medical record revealed the following: 05/27/22 [Physician's Order] "Fentanyl (narcotic pan reliever) Patch 72 Hour 25 MCG (micrograms)/HR (hour) Apply 1 patch transdermally one time a day every 3 day(s) for pain management and remove per schedule" 05/28/22 [Physician's Order] "Acetaminophen (pain reliever) Tablet 500 MG Give 2 tablet by mouth one time a day for Pain 30 minutes prior to wound care" 05/30/22 [Physician's Order] "Oxycodone-Acetaminophen Tablet 5-325 MG (Percocet) (Give 1 tablet by mouth two times a day for Pain [level of] 7-10..." A Significant Change Minimum Data Set (MDS) dated 06/06/22 showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 15, indicating that the resdeint had an intact cognitive response, received scheduled and PRN (as needed) pain medication and experienced pain occasionally. Care plan revised on 06/14/22 "[Resident #133] is on pain medication therapy (Percocet) r/t right leg pain ... Administer analgesic medications as ordered by physician. Review for pain medication efficacy ..." Review of the June 2022 Medication Administration Record (MAR) showed that facility staff administered Oxycodone-Acetaminophen Tablet 5-325 MG 1 tablet as followed:	F 697	F698 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: The facility cannot retroactively correct this deficiency. Resident #21's dialysis pressure dressing AV fistula site was immediately removed after being notified. Resident was reassessed from head to toe on 08/17/22 by licensed nurse. Resident suffered no negative outcome.	09/23/22

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F 697	Continued From page 157 06/01/22 at 9:00 AM and 6:00 PM - Pain level =5 06/02/22 at 9:00 AM and 6:00 PM Pain level =0 06/04/22 at 9:00 AM Pain level =6 and 06/04/22 at 6:00 PM Pain level= 4 06/05/22 at 9:00 AM and 6:00 PM Pain level =0 06/06/22 at 9:00 AM Pain level =2 and 06/06/22 at 6:00 PM Pain level= 0 06/07/22 at 9:00 AM and 6:00 PM Pain level =3 06/08/22 at 9:00 AM and 6:00 PM Pain level =0 06/09/22 at 9:00 AM and 6:00 PM Pain level =0 06/10/22 at 9:00 AM Pain level =2 and 06/10/22 at 6:00 PM Pain level= 0 06/11/22 at 9:00 AM and 6:00 PM Pain level =0 06/12/22 at 9:00 AM and 6:00 PM Pain level =0 06/13/22 at 9:00 AM and 6:00 PM Pain level =0 06/14/22 at 9:00 AM Pain level =2 and 06/14/22 at 6:00 PM Pain level= 0 06/15/22 at 9:00 AM Pain level =6 and 06/15/22 at 6:00 PM Pain level =0 06/16/22 at 9:00 AM Pain level =4 During a face-to-face interview conducted on 06/16/22 at 9:45 AM, Employee #10 acknowledged the finding and stated, "Sometimes when I ask, he (Resident #133) says "6" or something lower but I know it's not possible with what he has going on medically. He has a lot of wounds. I know the pain level he's saying is not possible." The evidence showed that facility staff failed to follow the physician's order for administering Resident #133's narcotic pain medication evidenced by licensed staff administering Percocet when the resident's pain level was less than 7 on the pain scale.	F 697	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED. All the residents on dialysis in the facility have the potential to be affected.	09/23/22
F 698 SS=D	Dialysis	F 698		

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F 698	Continued From page 158 CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview, for one (1) of 67 sampled residents, facility staff failed to remove the pressure dressing from Resident #21's arteriovenous (AV) Fistula site in accordance with the physician's order. The findings included: Resident #21 was admitted to the facility on 05/05/21 with diagnoses that included End Stage Renal Disease and Chronic Kidney Disease. A Quarterly Minimum Data Set (MDS) dated 05/09/22 showed in Section C (Cognitive Patterns) that facility staff documented the resident as having a Brief Interview For Mental Status Summary Score (BIMS) of "13," indicating intact cognition. Review of the physician's order dated 05/05/21 directed, "Remove pressure dressing on the left arm 6 hours post dialysis, [Monday, Wednesday, Friday] every evening shift..." During a face-to-face interview on 06/21/22 at 11:55 AM, Resident #21 stated, "My arm was bleeding this morning. I told [Employee #33]. She came in I showed her this sheet, the resident	F 698	F698 MEASURE TO PREVENT RECURRENCE: The facility Staff Developer will provide education/ in-services to the facility licensed nurses on the importance of implementing post dialysis care in accordance with the physician's order; which includes assessment and removal of pressure dressing from arteriovenous (AV) Fistula site post dialysis by 9/23/22. MONITORING CORRECTIVE ACTION: Assistant Director of Nursing (ADON)/Designee will conduct house wide audit of resident on dialysis to ensure that residents receive proper care of the pressure dressing from arteriovenous (AV) Fistula site post dialysis in accordance with the physician's order. Audit will be completed weekly times 4, then, monthly times 3 months. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	09/23/22

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F 698	Continued From page 159 picked up a white flat sheet (bed linen) from her bed and showed the write the red spots on the sheet. She [Employee #33] put a dressing on it. The nurse did not remove the dressing last night (Monday 06/20/22) when I came from dialysis. [Employee #33] removed it this morning and when she did it started bleeding. That's when I called her back (into my room) and she put another dressing on my arm." At the time of this interview Resident #21 showed the writer a folded white sheet with red spots on it; and the resident pointed to a piece of white gauze that was secured by tape of over the AV Fistula site. Review of the Medication Administration Record dated 06/20/22, 3-11 shift, showed the nurse initialed in the designated location indicating that he/she removed the residents pressure dressing. Facility staff failed to remove Resident #21's pressure dressing in accordance with the physician's order. During a face-to-face interview on 06/21/22 at approximately 12:15 PM, Employee #33 acknowledged the findings.	F 698	F726 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: The facility cannot retroactively correct this deficiency. The affected Resident #133 immediately received pain medication according to professional standard of practice, parameters and according to the physician orders. Resident was reassessed from head to toe on 08/17/22 by licensed nurse. Resident suffered no negative outcome.	09/23/22
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services 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	F 726	Resident #257 skin assessment was immediately performed according to professional standards after being notified and as ordered by the physician. The skin sheet observation sheet is being used appropriately and is ongoing to ensure resident's skin is monitored. Resident was reassessed from head to toe on 08/17/22 by licensed nurse. No new skin issues were found and resident did not suffer any negative outcome.	

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F 726	Continued From page 160	F 726	F726	09/23/22

diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff interview, for two (2) of 67 sampled residents, facility staff failed to provide nursing and related services to assure resident safety as evidenced by failure to: (1) provide Resident #133 pain management that met professional standards of practice and (2) ensure Resident #257 received care consistent with professional standards of practice to prevent the development of a pressure ulcer (Stage 3).

The findings include:

Review of the policy "Pain Management" revised 02/22, documented, "... The licensed nurse will obtain order from the attending

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F 726	Continued From page 161 physician/designee for pain management and administer the order as indicated ..." Review of the policy "Clinical Documentation/Record" revised 02/2022 documented, " ... Clinical documentation is required to record pertinent facts, findings, and observations about the resident ..." Review of the policy "Medication/Treatment Administration Record and Initials" revised 03/2022 documented, "... Prior to administration of medication and treatment, the licensed nurse assigned to the resident must check and validated the ten Rights of Medication which includes ... right assessment, right evaluation ... Licensed nurses will administer medication and treatment to residents following the physician orders ..." 1. Facility staff failed to provide Resident #133 with pain management that met professional standards of practice. Resident #133 was admitted to the facility on 07/08/21 with diagnoses that included: Pain in Right Leg and Acute Kidney Failure. During a medication administration observation on 06/15/22 at 8:46 AM, Resident #133 stated that his pain level was "6" on a scale of 1 to 10. Employee #11 (Registered Nurse) then proceeded to administer Oxycodone (narcotic pain reliever) - APAP (Acetaminophen) 5-325 MG (milligram) 1 tablet by mouth to Resident #133. Review of Resident #133's medical record revealed the following:	F 726	F726 IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED. All the residents in the facility have the potential to be affected.	09/23/22

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F 726	Continued From page 162 05/27/22 [Physician's Order] "Fentanyl (narcotic pan reliever) Patch 72 Hour 25 MCG (micrograms)/HR (hour) Apply 1 patch transdermally one time a day every 3 day(s) for pain management and remove per schedule" 05/28/22 [Physician's Order] "Acetaminophen (pain reliever) Tablet 500 MG Give 2 tablet by mouth one time a day for Pain 30 minutes prior to wound care" 05/30/22 [Physician's Order] "Oxycodone-Acetaminophen Tablet 5-325 MG (Percocet) (Give 1 tablet by mouth two times a day for Pain [level of] 7-10..." A Significant Change Minimum Data Set (MDS) dated 06/06/22 showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 15, indicating that the resdeint had an intact cognitive response, received scheduled and PRN (as needed) pain medication and experienced pain occasionally. Care plan revised on 06/14/22 "[Resident #133] is on pain medication therapy (Percocet) r/t right leg pain ... Administer analgesic medications as ordered by physician. Review for pain medication efficacy ..." Review of the June 2022 Medication Administration Record (MAR) showed that facility staff administered Oxycodone-Acetaminophen Tablet 5-325 MG 1 tablet as followed: 06/01/22 at 9:00 AM and 6:00 PM - Pain level =5 06/02/22 at 9:00 AM and 6:00 PM Pain level =0 06/04/22 at 9:00 AM Pain level =6 and 06/04/22 at 6:00 PM Pain level= 4	F 726	MEASURE TO PREVENT RECURRENCE: The facility Staff Developer and PharmScript Pharmacy Consultants will provide education to the facility licensed nurses to ensure that medication administration meet professional standard of practice, by ensuring that licensed nurses administer medications and treatments following physician orders by 9/23/22. The facility Staff Developer will provide education/ in-services to the facility licensed nurses and nursing assistants to ensure residents receive care consistent with professional standards of practice to prevent development of wound by and ensuring skin sweep and documentation are done as scheduled and reporting any change in condition of the resident in a timely manner 9/23/22.	09/23/22

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F 726	Continued From page 163 06/05/22 at 9:00 AM and 6:00 PM Pain level =0 06/06/22 at 9:00 AM Pain level =2 and 06/06/22 at 6:00 PM Pain level= 0 06/07/22 at 9:00 AM and 6:00 PM Pain level =3 06/08/22 at 9:00 AM and 6:00 PM Pain level =0 06/09/22 at 9:00 AM and 6:00 PM Pain level =0 06/10/22 at 9:00 AM Pain level =2 and 06/10/22 at 6:00 PM Pain level= 0 06/11/22 at 9:00 AM and 6:00 PM Pain level =0 06/12/22 at 9:00 AM and 6:00 PM Pain level =0 06/13/22 at 9:00 AM and 6:00 PM Pain level =0 06/14/22 at 9:00 AM Pain level =2 and 06/14/22 at 6:00 PM Pain level= 0 06/15/22 at 9:00 AM Pain level =6 and 06/15/22 at 6:00 PM Pain level =0 06/16/22 at 9:00 AM Pain level =4 During a face-to-face interview conducted on 06/16/22 at 9:45 AM, Employee #10 acknowledged the finding and stated, "Sometimes when I ask, he (Resident #133) says "6" or something lower but I know it's not possible with what he has going on medically. He has a lot of wounds. I know the pain level he's saying is not possible." The evidence showed that facility staff failed to follow the physician's order for administering Resident #133's narcotic pain medication evidenced by licensed staff administering Percocet when the resident's pain level was less than 7 on the pain scale. 2. Facility staff failed to ensure Resident #257 received care consistent with professional standards of practice to prevent the development	F 726	MONITORING OF CORRECTIVE ACTION: Assistant Director of Nursing (ADON)/Designee will conduct house wide audit to identify residents with pain and ensure that facility licensed nurses provide pain management that meet professional standards of practice weekly times 4, then, monthly times 3 months. Assistant Director of Nursing (ADON)/Designee will conduct house wide audit of resident skin sweep and documentation to identify potential residents that facility staff failed to provide care consistent with professional standards of practice to prevent the development of wound. This will be conducted weekly times 4, then, monthly times 3 months. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	

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F 726	Continued From page 164	F 726		09/23/22

of a pressure ulcer (Stage 3).

Resident #257 was admitted to facility on 11/19/21 with diagnoses that included: Acute Osteomyelitis of Left Ankle and Foot, Type 2 Diabetes Mellitus with Foot Ulcer and Peripheral Vascular Disease.

Review of Resident #257's medical record revealed the following:

04/06/22 at 10:09?AM [Skin/Wound Note] "Resident is a 86 years old male re-admitted on 04/06/22 with left foot diabetic ulcer, absence of left toe, right lateral foot necrotic tissue measured 2.95cm (centimeter) X 1.71cm, left second toe open area 1.80ccm X 1.29cm, right great toe necrotic tissue 0.83cm x 1.62cm ..."
Physician's orders:

04/06/22 "Weekly skin assessment by licensed nurse. Document and notify MD (medical doctor)/NP (Nurse Practitioner) for abnormal findings every day shift every Wed (Wednesday)"

04/06/22 "Apply moisturizing lotion daily for skin lubrication every day shift"

Care Plan updated on 04/13/22 [Resident #257] has potential for pressure ulcer development r/t (related to) decreased mobility, fragile skin and incontinence ... Monitor/document/report PRN any changes in skin status ... Skin assessment weekly and as needed by licensed nurse ..."

Care Plan updated on 04/13/22 [Resident #257] has an ADL (activities of daily living) self-care performance deficit r/t generalized weakness ... totally dependent on staff to provide bath/shower

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F 726	Continued From page 165	F 726		

twice weekly and as necessary ... Provide sponge bath when a full bath or shower cannot be tolerated ... totally dependent on staff for repositioning and turning in bed and as necessary ... Reposition q 2 hours and as necessary to avoid injury ... requires skin inspection. Observe for redness, open areas, scratches, cuts, bruises and report changes ..."

06/01/22 [Weekly Skin Assessment] " ...Describe skin impairment: none ..."

A Quarterly MDS dated 06/03/22 where facility staff coded: moderately impaired cognition, no potential indicators of psychosis, no rejection of care, extensive assistance one person physical assist for bed mobility and personal hygiene, impairment on both sides for lower extremities, always incontinent for bowel and bladder, 2 unstageable pressure ulcers that were present upon admission/entry or reentry and diabetic foot ulcers.

06/06/22 at 2:51 PM [Situation Background Assessment Request] "Situation: Observe wound on coccyx... During incontinent care at 2:45 pm, writer was notified by CNA (Certified Nurse Aide) staff assigned to resident of an opening area ... on coccyx which measure L=0.87cm X W= 0.55cm. Moderate drainage noted from sites ..."

06/06/22 at 2:51 PM [Skin Observation Tool] "...Coccyx wound 0.87cm 0.55cm ..."

06/07/22 at 10:40 AM [Skin/Wound Note] " ... Comprehensive skin and wound evaluation ... sacrum stage 3 pressure ulcer ..."

06/10/22 at 1:02 PM [Wound/Pressure Ulcer

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F 726	Continued From page 166 Note] " ... Pressure ulcer/Stage 3 sacrum length 0.87 cm width 0.55 cm depth 0.1 cm ... in house acquired ..." Review of the form "Unit 3 Resident Bath/Shower List" (not dated) provided to the surveyor on 06/23/22 showed that Resident #257 was on the schedule for a bath/shower every Monday and Thursday. During a face-to-face interview on 06/23/22 at 11:05 AM, Employee #12 (Registered Nurse) stated, "Skin sweep assessments are done on scheduled shower days. A skin sweep form is completed by the CNA and nurse. If there's no sheet, then it (skin sweep assessment) wasn't done." Review of Resident #257's medical record lacked documented evidence that a "Skin Sweep Observation Sheet" was completed on 06/02/22 (Thursday), which is Resident #257's scheduled bath/shower day. Review of the CNA documentation showed that Resident #257 received a bed bath (BB) every day from 06/02/22 to 06/05/22. Review of the Treatment Administration Record (TAR) showed that facility staff initialed in the area that directed, "Apply moisturizing lotion daily for skin lubrication every day shift" from 06/02/22 to 06/05/22 (4 days) indicating that the task was completed. The evidence showed that for a period of 4 days (06/02/22 to 06/05/22), the facility's nursing staff failed to document and report any changes in Resident #257's skin. Subsequently, Resident	F 726	F755 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: The affected Resident#256 was reassessed from head to toe on 08/17/22 by licensed nurse. Resident suffered no negative outcome. Education was provided to facility nurses licensed on proper way of wasting of medications. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED. All the residents in the facility have the potential to be affected.	09/23/22

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F 726	Continued From page 167 #257 was observed with a Stage 3 pressure ulcer on his sacrum on 06/06/22. During a face-to-face interview on 06/23/22 at 11:39 AM, Employee #13 (Educator) acknowledged the finding and stated, "Resident's should not be found with wounds at advanced stages. The CNA's and nurses know to document and report any changes to the skin. Nursing staff have been educated on documenting on the Skin Sweep Sheet on shower days. If the resident refuses the bath, shower or the skin sweep, it should be documented on the form and in a [nurse's] note."	F 726	F755 . MEASURE TO PREVENT RECURRENCE: The facility Staff Developer will provide education/in-services to the facility licensed nurses on the importance of ensuring that the controlled medications were accurately recorded as given and accurately recorded wasted in the designated location; and accurately reconcile controlled medications by 9/23/22.	09/23/22
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in	F 755		

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F 755	Continued From page 168 the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, facility staff failed to ensure that the controlled medications were accurately recorded as given and accurately recorded wasted in the designated location; and accurately reconcile controlled medications for one (1) of three (3) sampled resident controlled drug records reviewed. Residents #256. The findings included: Resident #256 was admitted to the facility on 06/10/22 with diagnoses that included Osteoarthritis of Hip, Neuromuscular Dysfunction of Bladder and Clostridium Difficile. According to the physician's order dated 06/12/22 the resident is to receive Tramadol HCl (used to relieve moderate to moderately severe pain) 50 mg (milligram) one tablet by mouth every 8 hours as needed for pain 6-10 in scale. During an observation on 06/16/22 at 3:54 PM one (1) of two (2) Medication Carts on unit 3, there was one resident (Resident #256) with a physician's order that directed, "Tramadol 50 mg take 1 tablet by mouth every 8 hours as needed	F 755	F755 MONITORING OF CORRECTIVE ACTION: Assistant Director of Nursing (ADON)/Designee will conduct house wide audit to identify residents with controlled medication and ensure that facility licensed nurse accurately administer controlled medication, accurately record controlled medication, and unused controlled medication are disposed of in the designated location. This audit will be conducted weekly times 4, then, monthly times 3 months. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	09/23/22

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F 755	Continued From page 169 for pain 6-10." Review of the controlled drug administration record for Resident #250 showed the amount and count received from the pharmacy was 30. The blister packet of Tramadol was observed with 23 pills remaining, however, the controlled drug administration record showed, "amount remaining as 24" as of 06/16/22 at [no time recorded]. During a face-to-face interview on 06/16/22 at approximately 03:54 PM, Employee # 45 (Registered Nurse) stated, "I went to give the resident the medication by she refused. I wasted the medication with the nurse that I worked with during the night." Further review of the Controlled Drug Administration Record revealed the second nurse who witnessed the wasting of the Tramadol did not sign in the allotted space for witnessing on 06/16/22 at 1:00 AM. Also, the nurse failed to record the amount of medication wasted in the allotted space. The evidence showed that facility staff did not accurately record and reconcile the number of tramadol administered to Resident #256 and wasted on the controlled drug administration record for Resident #250. During a face-to-face interview on 06/16/22 at approximately 03:54 PM, Employee #12 (Registered Nurse) stated, "When I gave the pill today, I wrote the wrong number. I should have written '24' tablets remaining."	F 755		09/23/22
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed	F 803	F803 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: The affected Resident #102 was immediately provided with the menu and alternative menu after being notified and is ongoing so that resident can make food choices.. Resident reassessed was from head to toe on 08/17/22 by the licensed nurse. No negative outcomes noted. The affected Resident #82 was immediately provided with the menu and alternative menu after being notified and is ongoing so that resident can make food choices.. Resident reassessed was from head to toe on 08/17/22 by the licensed nurse. No negative outcomes noted.	

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F 803	Continued From page 170 CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interview for two (2) of 67 sampled residents, facility staff failed to provide menus to all the facilities residents so that they could make food choices and the facility's staff failed to update menus periodically and have them reviewed by the facilities dietician. (Residents' #102, and #82)	F 803	F803 IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED. All the residents in the facility have the potential to be affected .	09/23/22

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F 803	Continued From page 171 The findings include: 1. Resident #102 was admitted to the facility on 07/30/20, with multiple diagnoses that included the following: Adult Failure to Thrive, Pressure Ulcer of Sacral Region, Stage 3, Contracture Unspecified Joint, Contracture Right Knee, Contracture Left Knee, Moderate Protein Calorie Malnutrition and Muscle Weakness. Review of the Quarterly Minimum Data Set (MDS) dated 06/02/22, revealed facility staff coded the following: Section C (Cognitive Patterns): Brief Interview for Mental Status Summary Score "15" indicating intact cognition. Section E (Behavior): Rejection of Care -Presence & Frequency "0" Behavior not exhibited Section G (Functional Status): Bed mobility "Extensive Assistance" requiring "Two-person physical assist" Transfer "extensive assistance" requiring "Two-person physical assist" Dressing "Extensive assistance" requiring "Two-person physical assist" Eating "Supervision" requiring "Set-up help only" Toilet use "Extensive assistance" requiring "One -person physical assist" Personal Hygiene "Extensive assistance" requiring "One-person physical assist" Section K (Swallowing/Nutritional status): Swallowing Disorder "None of the above" Review of the Physicians orders revealed the following: 08/07/20 "Regular diet Regular texture, Thin	F 803	F803 periodically and have them reviewed by the facilities Dietitian/ Nutritionist by 9/29/22. MONITORING CORRECTIVE ACTION: The Director of Food and Nutrition Services/Designee will conduct house wide audit to to identify potential residents that facility staff failed to provide menus so that they could make food choices weekly times 4,then	09/23/22

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F 803	Continued From page 172 Liquids consistency (Double portion) per preference" Review of the care plan with a focus area of "(Resident #102) is at nutritional risk r/t (related to) Clinical DX (Diagnosis) Adult Failure to Thrive, Protein Calories Malnutrition, Type 1 Diabetes, Sickle Cell Trait, Calculus of Kidney, GERD, HTN (Hypertension) Requiring liberalized diet and oral nutritional supplements ..." initiated on 07/31/20,had multiple interventions including the following: "Continue providing education on importance of adherence to facility diet order/limiting food from outside facility. ... Food service staff to regularly check on resident's food preference changes. ..." An observation and face-to-face interview were conducted on 06/24/22 at approximately 1:00PM, Resident #102 stated "The food is terrible and there is not enough ...One time they gave me mac and cheese for a meat ...I can't get cold ice water" The surveyor asked the resident about the menu and if he raised these issues with staff? Resident 102 stated "I do not get a menu" A face-to-face interview was conducted on 06/24/22 at approximately 2:23 PM, Employee #30 (Registered Dietician) stated "He (Resident #102) complains he has been seen by the director of food services and she follows up. The surveyor asked the dietician where the menus are and how resident could get a meal replacement. The dietician then showed the surveyor a menu that was posted for the month of May 2022 (The current month at the time of survey was June 2022), on a bulletin board on a wall by the nursing station. The menu was noted to be in a small type of font and in area not assessable by all residents. Behind the menu	F 803	F812 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: No resident was affected by this deficient practice. Test tray of hot food was reassessed on 6/21/22. Food temperature was within the standard temperature range and Test tray is ongoing. The ceiling light located in a common area of the kitchen was replaced on 6/14/22. The wall behind the grease fryer was sealed on 6/14/22. The plate warmer was connected to power source immediately on 6/21/22 and is ongoing. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED. All the residents in the facility have the potential to be affected .	09/23/22

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F 803	Continued From page 173 was a form labeled "Next level Hospitality services That had food choices for breakfast lunch and dinner. Employee #30 stated the form was the alternative menu for residents. 2. Resident #82 was admitted to the facility on 06/13/17, with multiple diagnoses that included the following: Age-Related Nuclear Cataract, Bilateral, Vitamin B12 Deficiency Anemia Unspecified, Vitamin D Deficiency Unspecified, and Unspecified Dementia Without Behavioral Disturbance. Review of a complaint received by DOH (Department of Health) on 02/22/22 concerning Resident #82 documented " ...I have been providing my brother meals ...I would like to know when meals will resume being served ..." An observation and face-to-face interview were conducted on 06/22/22 at 10:18 AM with Resident #82, the surveyor observed resident in his room and noticed his breakfast tray appeared untouched and covered. The surveyor asked the resident if he had eaten and how was the food to which Resident # 82 stated "It was disgusting I can't eat those powered eggs" The surveyor asked the resident if he told staff to which Resident # 82 responded "That ain't going to do no good they don't send a menu ..." Review of the Annual Minimum Data Set (MDS) dated 06/02/22, revealed that facility staff coded the following: Section B (Hearing, Speech, and Vision) Vision "Impaired" Corrective Lenses "Yes" Section C (Cognitive Patterns) Brief Interview for	F 803	F812 Director of Maintenance /Designee will conduct house wide round/audit of common areas within the facility and the residents rooms to identify potential walls that wall are damaged with holes. Any issue found during this audit will be corrected by 9/29/22 Food and Nutrition Services Director /Designee will conduct rounds/audit in the kitchen to ensure the plate warmer is connected to electricity to help maintain	09/23/22

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F 803	Continued From page 174 Mental Status Summary Score "14" indicating intact cognition. Section G (Functional status) Eating "Independent" requiring "No set up or physical help from staff" Section K (Swallowing/Nutritional Status) Swallowing Disorder "None of the above" Review of the Physicians orders revealed the following: 06/01/22 "Regular diet Regular texture, Thin liquids consistency, Double Portion per residents request" Review of the care plan with a focus area of "(Resident #82 is at nutritional risk related to Dementia, Heart Failure, Major Depressive Disorder-requiring Regular diet and oral nutritional supplements ..." date revised 06/02/22, had interventions which included the following "Regular Diet, Regular texture, Thin Liquid Consistency, Feeding Ability Independent with tray set up ..." During a face-to-face interview conducted on 06/22/22 at 10:55 AM with Employee #33 (2nd Floor Unit Manager) "If they don't like the meal, they have to say something then we can give them something else" The surveyor asked if there is a menu where residents can make choices and how would a resident get a meal or item on the tray replaced. Employee #33 stated she would get the dietician to speak with the surveyor. During a face-to-face interview conducted on 06/22/22 at 12:07 PM with Employee #30 (Registered Dietitian) The surveyor asked how residents choose alternatives or replacements if they do not like a food item that is being served. Employee #30 stated she was not sure and that she would get the kitchen director.	F 803	F812 Food and Nutrition Services Director will ensure that that the kitchen staff members serve and distribute food in accordance with professional standards of practice for food services by 09/23/22. Dietician and Nutritionist will ensure that the food served to the residents are in accordance with professional standards of practice for food services. Any issues will be corrected by 9/23/22. Food and Nutrition Services Director will conduct food temperature test on the units to confirm that the food temperature of hot food is at 140 degrees per food service standards. Any issues found will be corrected by 9/23/22.	09/23/22

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F 803	Continued From page 175 During a face-to-face interview conducted 06/22/22 at approximately 12:15 PM with Employee #38 (Kitchen Director) "This (alternative menu) is always available it is on the wall right here." The form that Employee #38 said is an alternative menu is labeled "Next Level Hospitality services" The form was not easily accessible to the residents.	F 803	F812 The facility Staff Development will provide education/in-services to the maintenance staff on importance of : 1.maintaining and ensuring no ceiling light are cracked and loose around the facility. 2.maintaining and ensuring that the facility walls are not damaged with holes. by 9/23/22. MONITORING OF CORRECTIVE ACTION: Food and Nutrition Services Director/ Designee will conduct rounds in the kitchen to ensure that food is distributed in accordance with professional standards of practice; and will conduct test trays assessment to ensure that the residents get their food within the standard temperature weekly times 4,then monthly times 3 months. Director of Maintenance /Designee will conduct house wide round/audit of common areas within the facility and the residents rooms to ensure no ceiling light are cracked and loose weekly times 4, then monthly times 3 months.	09/23/22
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to prepare and serve foods under sanitary conditions as evidenced by food temperatures that tested under 135 degrees	F 812		

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F 812	Continued From page 176	F 812		09/29/22

fahrenheit (F) during a test tray assessment, a cracked and loose ceiling light in the main kitchen, a damaged wall behind the grease fryer, and staff failure to follow food quality standards of practice.

The findings include:

During a food test tray assessment on June 21, 2022, at approximately 2:00 PM, hot foods such as ham (117 degrees Fahrenheit), cabbage (105.7 degrees Fahrenheit), and mechanical ham (111.7 degrees Fahrenheit), tested below the minimum required temperature of 140 degrees Fahrenheit (F).

These observations were acknowledged by Employee #38 and/or Employee #42 during a face-to-face interview on June 21, 2022, at approximately 2:15 PM.

During a walkthrough of dietary services on June 14, 2022, at approximately 10:00 AM, the following were observed:

1. A ceiling light located in a common area of the kitchen was cracked and loose.

2. The wall behind the grease fryer was damaged with holes.

3. Staff failed to connect one (1) of one (1) plate warmer to help maintain hot food temperatures on the tray line on June 21, 2022, at approximately 12:45 PM. Subsequently, three (3) of four (4) hot food items tested below required temperatures during a test tray assessment on June 21, 2022, at approximately 2:00 PM.

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F 812	Continued From page 177 These observations were acknowledged by Employee #38 and/or Employee #42 during a face-to-face interview on June 27, 2022, at approximately 3:00 PM.	F 812	F880 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: Resident #38 was administered medication after being notified using parameters per physician orders and licensed nurse was education on proper administration of medications following infection prevention practices. Resident was reassessed was from head to toe on 08/17/22 by licensed nurse. Resident suffered no negative outcome Resident #66 was assessed and monitored closely x 3 days for signs and symptoms of Covid-19. by licensed nurses post exposure to an employee who was not vaccinated with Covid-19 vaccine, and was not wearing recommended face shield and N95 on 06/29/22. Resident #66 remained clinically stable without any symptoms of Covid-19. Resident suffered no negative outcome. Employee #6 was verbally educated on importance of the of wearing PPE and maintaining a minimum of 6 feet while working with resident or in the care area. Employee #6 was written up and suspended pending termination. Employee #6, resigned from suspension. Resident #406 was discharged on 7/21/22. Other resident belonging in the closet were removed, the closet was thoroughly cleaned on 06/16/2022. Resident suffered no negative outcome.	09/23/22
F 880 SS=D	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 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		

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F 880	Continued From page 178 (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. §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 observations, record reviews, staff and resident interviews, for three (3) of 67 sampled residents, failed to properly minimize or prevent the potential spread of infection as evidenced by	F 880	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have potential to be affected. MEASURE TO PREVENT RECURRENCE: The facility Staff Development will provide education/in-services to all facility staff infection control and prevention which include: Hand hygiene, Donning and doffing of Personal Protective Equipment (PPE), Maintaining social distancing of at least 6 feet while interacting with others. Importance of minimizing or prevent the potential spread infection (COVID-19) and other infectious diseases and the importance of proper cleaning and sanitizing resident rooms and shared equipment.	09/23/22

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F 880	Continued From page 179 not: performing hand hygiene prior to administering eye drops to Resident #38; wearing [unvaccinated staff] Personal Protective Equipment (PPE) when interacting with Resident #66 less than six (6) feet away; and thoroughly clean Resident #406's room prior to their admission. The findings included: 1. Facility staff failed properly minimize or prevent the potential spread of infection by not performing hand hygiene prior to administering eye drops to one (1) resident. "Wash hands before and after instilling eye drops to prevent cross infection and to remove drug residue from the hands." https://www.nursingtimes.net/archive/how-to-administer-eye-drops-and-ointments-26-09-2014/ Administering eyedrops ...Perform hand hygiene and put on clean gloves." https://journals.lww.com/nursing/Citation/2007/05000/Administering_eyedrops.14.aspx During a medication administration observation on 06/16/2022 at approximately 10:25 AM, Employee #46, (Licensed Practical Nurse) was administering Resident #38's oral medication to him using a plastic spoon. Employee #46 then gave the resident a cup of water to drink. Employee #46 then proceeded to instill the Refresh eye drops into the residents left and right eyes without first performing hand hygiene. At the time of the observation, Employee #46 acknowledged that she did not wash her hands or use hand sanitizer prior to instilling the drops into	F 880	MONITORING OF CORRECTIVE ACTION: Assistant Director of Nursing (ADON)/Designee will conduct house wide visual audit to identify resident on eye drops to ensure that the licensed nurse perform hand hygiene when administering eye drops. Audit will be done weekly times 4, then, monthly times 3 months. Unit Managers/Designee will conduct a visual audit of empty rooms on the units to identify potential resident rooms that are not clean and still contains belonging of previous residents. Director of Admissions/Designee will conduct house wide visual audit to admission ready empty rooms to identify potential rooms and closet that are not properly clean and still contain belonging of previous residents. Audits will be done weekly times 4, then, monthly times 3 months. The Assistant Director of Nursing (ADON)/Designee will conduct house wide visual audit to identify potential residents that employees failed to properly minimize or prevent the potential spread infection (COVID-19) by not properly wearing Personal Protective Equipment (PPE) when interacting with Resident less than six (6) feet away weekly times 4, then, monthly times 3 months. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	09/23/22

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F 880	Continued From page 180 the resident's eyes. 2. Facility's unvaccinated staff failed to properly minimize or prevent the potential spread infection (COVID-19) by not wearing Personal Protective Equipment (PPE) when interacting with Resident #66 less than six (6) feet away. Review of the facility's policy entitled, "COVID-19 Healthcare Staff Vaccination", instructed unvaccinated staff to wear a N95 mask and face shield in the facility and continue to follow infection prevention guidelines. On 06/29/22 at approximately 2:00 PM, Employee #6 (Social Worker) was observed in his office sitting at his desk talking to a resident who was approximately less than 2 feet away. The employee was not wearing a face shield or N95 mask. Resident #66 was observed wearing a face mask that was under his chin not covering his mouth or nose. Review of the facility's COVID-19 Staff Vaccination Status for Provider form showed Employee #6 (Social Worker) was not vaccinated for COVID-19. Review of Resident #66 medical record revealed the resident was admitted to the facility 08/08/15 with multiple diagnoses including Brady Cardia, Pacemaker, Hypertension, and Obesity. Continued review of the record showed the resident received Moderna (COVID-19) vaccinations on the following dates: 1st dose - 02/09/21, 2nd dose -03/08/21, and 1st Booster -	F 880		09/23/22

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F 880	Continued From page 181 02/08/22. During a face-to-face interview on 06/29/22 at approximately 2:10 PM, Employee #6 was not receptive to speaking with the surveyor. During a face-to-face interview with Employee #6 and Employee #2 (DON) on 06/29/22 at approximately 2:15 PM, Employee #6 stated that he did not have on a face shield or N95 because he only spoke with Resident #66 for a few minutes. When asked what was the facility's policy for wearing PPEs? The employee stated that he was to wear a face shield and N95 mask at all times. 3) Facility staff failed to properly minimize or prevent the potential spread of infection by not thoroughly cleaning Resident #406's room prior to their admission. Resident #406 was admitted to the facility on 06/10/22 with diagnoses including Cervical Stenosis of the Spinal Canal, Fracture of the Left Femur, Cervicalgia (neck pain), Lumbago (low back pain)[https://icd.codes/icd10cm/M542], and S/P (status post) accidental fall. Review of Resident #406's medical record revealed: 06/10/22 at 8:02 PM [Nurses Admission Note] documented, " ...admitted from [Local Hospital]... Resident is alert/oriented x 3, cooperative, able to make needs know(n) ...[Name of Physician] made aware of resident admission to the facility ..."	F 880		09/23/22

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F 880	Continued From page 182 During an observation and interview on 06/16/22 at approximately 9:20 AM, Resident #406 was resting in her bed. The resident reported that facility staff had not thoroughly cleaned her room before she was admitted, because another person's belongings (clothes) were hanging in her closet. The resident added that the facility staff was aware because the staff person who admitted her into the room opened the closet and saw clothing already hanging in the closet. During an observation on 06/16/22 at approximately 9:40 AM, the surveyor asked Employee #33, Unit Manager, to accompany her to Resident #406's room. With the resident's permission, the employee opened the Resident's closet and acknowledged that there were three bundles of clothing covered with white trash bags hanging in the resident's closet. The employee asked Resident #406 if the clothes were hers, and the resident replied, "No, I put my clothes in the dresser and nightstand." During a face-to-face interview on 06/16/22 at 9:44 AM, Employee #33 stated, " It is the housekeeping and nursing staff's responsibility to clean a room before a resident is admitted thoroughly. Housekeeping cleans and checks the room; when they find clothing, they usually let the nursing staff know." Employee #33 removed the three covered bundles of clothes from the resident's room.	F 880		09/23/22
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition.	F 908	F908 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT The dishwasher was repaired on June 22, 2022. No negative outcome observed.	

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F 908	Continued From page 183 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain essential equipment in safe condition as evidenced by one (1) of one (1) conveyor dishwasher that failed to automatically move peg racks filled with cups, dishes, silverware and/or food trays through the machine. The findings include: During observations in dietary services on June 21, 2022, at approximately 11:00 AM, one (1) of one (1) conveyor dishwasher failed to automatically move soiled items through the machine. to ensure proper wash, proper rinse, and proper final rinse of peg racks filled with cups, dishes, silverware and/or food trays. Consequently, the necessary parts were ordered, and the dishwasher was repaired on June 22, 2022. These observations were acknowledged by Employee #42 during a face-to-face interview on June 21, 2022, at approximately 2:15 PM.	F 908	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All facility essential equipment and patient care equipment have potential to be affected. MEASURE TO PREVENT RECURRENCE: The facility Staff Development will provide education/in-services to the facility maintenance staff and Kitchen staff on importance of maintaining essential and patient care equipment in safe condition. MONITORING OF CORRECTIVE ACTION: The Director of Maintenance/Designee will complete house wide audit of all facility essential and patient care equipment to identify potential equipment that is not maintained in a safe condition weekly times 4,then monthly times 3 months. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	09/23/22