STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165351	A. Building B. Wing	07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Griswold Rehabilitation & Health Care Center	106 Harrison St Griswold, IA 51535

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on interview, document review, and policy review the facility failed to ensure one resident of five residents (Resident (R) 1) reviewed for abuse was free from employee-to-resident abuse. As reported by R1 and Certified Nursing Assistant (CNA) CNA1, CNA2 slapped R1's hand away and moved her roughly causing her to hit her arm on the wall. The failure of the facility to recognize that abuse occurred and respond appropriately to protect R1 and other residents from abuse and failure to ensure the accused was immediately barred from providing resident care and work at the facility resulted in an Immediate Jeopardy for the potential of all facility residents to be vulnerable to abuse. This facility reported a census of 35. Findings include: Review of the facility policy titled Abuse, Prevention and Prohibition Policy, reviewed November 2021, revealed Resident abuse must be reported immediately to the Administrator. The facility Administrator will ensure a thorough investigation of alleged violations of individual rights and document appropriate action . If a person was identified in the allegation of abuse, that person will not be allowed access to the facility while the investigation was in progress . Implement steps to prevent further potential abuse . Complete a thorough investigation. The facility will immediately remove any alleged perpetrator from any further contact with any resident . When an employee is the alleged perpetrator of abuse or neglect, that employee shall immediately be barred from any further contact with residents through suspension, pending the outcome of the facility investigation, prosecution or disciplinary action against the employee. Review of an undated "Face Sheet" located in R1's electronic medical record (EMR) under the "Profile" tab indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE]. Review of the MDS (Minimum Data Set) for R1 revealed an Assessment Reference Date (ARD) of 04/05/22 documented a Brief Interview for Mental Status (BIMS) revealed a score of 15 out of 15, which indicated intact cognition. During an interview on 07/11/22 at 2:40 PM, R1 remembered and recounted an event a couple of months ago when a Certified Nursing Assistant (CNA) was assisting her into the sit-to-stand lift used to get her to the bathroom. R1 recalled the CNA slapped her hand away and R1 did not want that to happen again. R1 remembered also hitting her arm on the wall or door frame when being moved by the CNA into the bathroom. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the Progress Notes tab in the EMR for R1 dated 05/11/22 at 12:10 AM, documented as a late entry This nurse requested by Administrator to assess [R1's] left elbow. This was done to check for pain and bruising. No pain noted by [R1]. Will continue to monitor. During an interview on 07/12/22 at 2:41 PM, CNA1 recalled the event with R1 when CNA2 slapped R1's hand out of the way while CNA2 was putting the support strap around R1 for support saying, let me do my job. CNA1 observed CNA2 was visibly upset or mad and began roughly pushing the lift with R1 towards the bathroom, hitting her arm on the wall. CNA1 recalled she stepped in telling CNA2 she would finish working with R1 and CNA2 left the room. During a subsequent interview on 07/12/22 at 3:55 PM, CNA1 verbalized notifying the Administrator at about 8:30 PM on the night of the incident. CNA1 remembered the incident occurred about 8:00 PM when R1 was getting ready for bed and CNA2 finished her shift after the event of slapping R1, and her shift ended at 10:00 PM. CNA1 confirmed reporting the incident of the slap to the Administrator by text message and to the charge nurse (an agency nurse) the evening of the event. CNA1 stated she also reported the event to the ADON the next day. Review of the investigation of the accusation of abuse for R1, provided by the facility, revealed a written statement dated 05/09/22 by CNA1, documented at the time of the incident, R1 whispered to CNA1 to get her [CNA2] out of my room, I don't want her in here. CNA2 could not be reached for an interview. Review of the investigation for R1 provided by the facility revealed a statement by CNA2, dated 05/09/22, CNA2 apologized for hitting R1's arm on the wall and did not admit to the slap while placing R1 in the lift. During an interview on 07/12/22 at 3:57 PM, the Administrator explained she was at home when she received notification of the incident with CNA2. The Administrator thought the time was about 9:34 PM, and came into the facility about an hour later. The Administrator recalled that when she arrived CNA2 had already completed her shift and had left for the night. Review of the timecard for CNA2 provided by the facility revealed CNA2 reported to the facility after the alleged abuse and worked on 05/13/22 from 1:50 PM to 2:30 PM. During an interview on 07/12/22 at 3:57 PM, the Administrator explained, when she was informed CNA2 was working on 05/13/22, she spoke to CNA2 explaining the need to not work until the investigation was complete. CNA2 then left the facility. During an interview on 07/12/22 at 3:18 PM, the Social Services Director (SSD) recounted completing a grievance report on 05/10/22, the day after the event with CNA2, with R1 by personally interviewing R1. The SSD described R1 as distraught by the event describing what occurred when CNA2 slapped her and motioned with her hand to demonstrate how the slap happened. Review of the Final Report, investigation section with no date, submitted by the Administrator, revealed The CNA witness was interviewed, and a written statement obtained. Employee Investigation Questionnaire was taken by Administrator and signed accordingly by other staff working that day. Resident and Agency Aide [CNA2] were separated after incident and assessment completed. No injuries noted. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the Final Report, summary section, with no date, submitted by the Administrator, revealed The allegation of abuse cannot be substantiated. However, there are ongoing Customer Service issues as reported by residents and staff with complaints of rushing, lack of patience and lack of communication. Agency Aide [CNA2] has been educated several times to slow down, be patient and to communicate with residents while providing cares with little to no change. For this reason, Agency Aide [CNA2] has been asked to not return to facility. During an interview on 07/12/22 at 3:57 PM, the Administrator explained the conclusion the investigation was unsubstantiated for abuse was based on the behaviors of CNA2 moving too quickly when doing things and did not do it to abuse R1. If CNA2 had slowed down, then when she pushed the arm of R1 it would not have felt like a slap and concluded the contact between CNA2 and R1 was a push not a slap. The Administrator also confirmed the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) both thought it was not abuse and therefore CNA2 could continue working through the agency at the facility. During an interview on 07/12/22 at 4:22 PM, the DON remembered the event between CNA2 and R1 and explained it as a personality conflict between the two. The DON interpreted the slap as a push away of R1's hand and not a slap. When asked about the process when there was an abuse allegation, stated the process as who to notify within two hours, assess the resident, obtain witness reports, and failed to communicate part of the process was to immediately remove the accused abuser from the facility as soon as the allegation of abuse was made. On 07/13/22 at 5:30 PM, the Administrator and the Regional [NAME] President of Operations (RVP) were informed of the failure to recognize employee-to-resident abuse occurred, constituted an immediate jeopardy at F600-L: Abuse: employee-to-resident abuse occurred. The Facility Staff removed the Immediate Jeopardy on 07/14/22 at 5:45 PM through the following actions: A. Educated staff on Abuse prevention, abuse policies and procedures B. Administrator and DON were in-serviced on Abuse Policy including investigating and identifying abuse. C. Abuse allegations for last 12 months were reviewed for compliance with Abuse Policy. Administrator will conduct rounding audit of abuse policy and procedures for 4 weeks by interviewing residents. The scope lowered from a L to a D at the time of the survey, after ensuring the facility staff were educated on policies and audits were implemented.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 39540 Based on interview, document review, and policy review, the facility failed to implement the abuse policy for three residents out of three residents (Resident (R) 1, 25, and 134) reviewed for abuse. Specifically, the facility failed to follow the abuse procedure to remove the accused abuser after the abuse was reported to the abuse coordinator, report timely when abuse was observed/suspected, and complete a thorough abuse investigation to include interviewing the accused abuser. The failures to implement abuse policies to identify abuse, protect resident from alleged perpetrators, and fully investigate abuse constituted an Immediate Jeopardy. The facility reported a census of 35. Findings include: Review of the facility policy titled Abuse, Prevention and Prohibition Policy, reviewed [DATE], revealed [The facility will] complete a thorough investigation . The facility will immediately remove any alleged perpetrator from any further contact with any resident . When an employee is the alleged perpetrator of abuse or neglect, that employee shall immediately be barred from any further contact with residents through suspension, pending the outcome of the facility investigation, prosecution or disciplinary action against the employee. "Facility staff shall be trained on the Abuse Prohibition Program during orientation, annually and ongoing during educational sessions." Further review of the policy revealed "the alleged staff member will be advised of the allegation and encouraged to assist in completing a statement relevant to the facts." 1. Review of an undated "Face Sheet" located in R1's electronic medical record (EMR) under the "Profile" tab indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE]. Review of the MDS [Minimal Data Set] R1 revealed an Assessment Reference Date (ARD) of [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated intact cognition. During an interview on [DATE] at 2:40 PM, R1 remembered and recounted an event a couple of months ago when a Certified Nursing Assistant (CNA) was assisting her into the sit-to-stand lift used to get her to the bathroom. R1 recalled the CNA slapped her hand away and R1 did not want that to happen again. R1 remembered also hitting her arm on the wall or door frame when being moved into the bathroom. Review of the Progress Notes tab in the EMR for R1 dated [DATE] at 12:10 AM, documented as a late entry This nurse requested by Administrator to assess [R1's] left elbow. This was done to check for pain and bruising. No pain noted by [R1]. Will continue to monitor. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 2:41 PM, CNA1 recalled the event with R1 when CNA2 slapped R1's hand out of the way while CNA2 was putting the support strap around R1 for support saying, let me do my job. CNA1 recalled CNA2 was visibly upset or mad and began roughly pushing the lift with R1 towards the bathroom, hitting her arm on the wall. CNA1 recounted telling CNA2 she (CNA1) would finish working with R1 and CNA2 left the room. Review of the investigation of the accusation of abuse for R1, provided by the facility, revealed a written statement dated [DATE] by CNA1, documented at the time of the incident, R1 whispered to CNA1 to get her [CNA2] out of my room, I don't want her in here. Review of the investigation for R1 provided by the facility revealed a statement by CNA2, dated [DATE], CNA2 apologized for hitting R1's arm on the wall and did not admit to the slap while placing R1 in the lift. During an interview on [DATE] at 3:55 PM, CNA1 verbalized notifying the Administrator at about 8:30 PM, remembering the incident occurred about 8:00 PM when the resident was getting ready for bed. CNA1 recalled CNA2 finished her shift after the event of slapping R1, and her shift ended at 10:00 PM. CNA1 confirmed reporting the incident of the slap to the Administrator by text message and to the charge nurse (agency nurse) the evening of the event and reported to the ADON the next day. CNA2 was not available for interview. During an interview on [DATE] at 3:57 PM, the Administrator explained she was at home when she received notification of the incident with CNA2. The Administrator thought the time was about 9:34 PM, and came into the facility about an hour later. The Administrator recalled that when she arrived CNA2 had already completed her shift and had left for the night. Review of the timecard for CNA2 provided by the facility revealed CNA2 reported to the facility after the alleged abuse and worked on [DATE] from 1:50 PM to 2:30 PM. During an interview on [DATE] at 3:57 PM, the Administrator explained when she was informed CNA2 was working on [DATE], she spoke to CNA2 explaining the need to not work until the investigation was complete. CNA2 then left the facility. Review of the Final Report investigation section with no date, submitted by the Administrator, revealed The CNA witness was interviewed, and a written statement obtained. Employee Investigation Questionnaire was taken by Administrator and signed accordingly by other staff working that day. Resident and Agency Aide [CNA2] were separated after incident and assessment completed. No injuries noted. The investigation in the Final Report lacked documentation action was taken to remove the alleged abuser from the facility after the abuse allegation. Review of the Final Report summary section, with no date, submitted by the Administrator, revealed The allegation of abuse cannot be substantiated. However, there are ongoing Customer (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Service issues as reported by residents and staff with complaints of rushing, lack of patience and lack of communication. Agency Aide [CNA2] has been educated several times to slow down, be patient and to communicate with residents while providing cares with little to no change. For this reason, Agency Aide [CNA2] has been asked to not return to facility. The summary of the Final Report failed to conclude abuse had occurred. During an interview on [DATE] at 3:57 PM, the Administrator explained the conclusion the investigation was unsubstantiated for abuse was based on the behaviors of CNA2 moving too quickly when doing things and did not do it to abuse R1, if CNA2 had slowed down then when she pushed the arm of R1 it would not have felt like a slap and concluded the contact between CNA2 and R1 was a push not a slap. The Administrator also confirmed the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) both thought it was not abuse and therefore CNA2 could continue working through the agency at the facility. During an interview on [DATE] at 4:22 PM, the DON remembered the event between CNA2 and R1 and explained it as a personality conflict between the two. The DON interpreted the slap as a push away of R1's hand and not a slap. When asked about the process when there was an abuse allegation, stated the process as who to notify within two hours, assess the resident, obtain witness reports, and failed to communicate part of the process was to immediately remove the accused abuser from the facility as soon as the allegation of abuse was made. 2. Review of R25's quarterly MDS, with an ARD of [DATE] located in the "MDS" tab of the EMR, revealed R25 was admitted on [DATE], was severely cognitively impaired, had a diagnosis of Alzheimer's disease, and required extensive to total assistance with activities of daily living. Review of R25's [DATE] "Care Plan" located in the EMR under the "Care Plan" tab revealed "The resident has Amputation of right lower extremity amputation [RLE]." On [DATE] at 12:00 PM, R25 was observed sitting in his wheelchair with a RLE. R25 did not respond to questions he was asked. Review of the facility's investigation report, dated [DATE], revealed that Certified Nurse Aide (CNA) 3 alleged R25 was physically and verbally abused by CNA4. CNA3 reported CNA4 grabbed R25's arm and yelled at R25. R25 did not sustain any injuries as a result. The date of the occurrence was [DATE] and the date and time of notification was [DATE] at 2:10 PM. The investigation did not include documentation of why CNA3 reported the allegation of abuse four days after the alleged occurrence, or any retraining CNA3 received to correct the problem of delayed abuse reporting. Additionally, the investigation did not include a witness statement from CNA4. Review of CNA3's witness statement, dated [DATE], revealed during care on [DATE] CNA4 grabbed R25's arm and yelled in his face, saying she was going to "beat his ass." CNA3 did not include in his statement why he did not immediately report the abuse allegations. Review of a progress note dated [DATE], in R25's EMR under the "Progress Notes" tab revealed a "skin assessment completed. no apparent injuries noted. resident acting per his norm [normal]." (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	3. Review of R134's admission MDS, with an ARD of [DATE] located in the "MDS" tab of the electronic medical record (EMR), revealed R134 was admitted on [DATE], had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating R134 was cognitively intact, required extensive to total assistance with activities of daily living, and was receiving hospice care. Review of R134's [DATE] care plan' located in the EMR under the "Care Plan" tab revealed "The resident wishes to remain in the facility. Hospice of the [company name]." Review of the facility's investigation report, dated [DATE], revealed that CNA3 alleged R134 was physically and verbally abused by CNA4. CNA3 reported CNA4 pushed R134 into the wall and got in R134's face yelling at him. R134 did not sustain any injuries as a result. The date of occurrence was [DATE] and the date of notification was [DATE]. The investigation did not include documentation of why CNA3 reported the allegation of abuse four days after the alleged occurrence, or any retraining CNA3 received to correct the problem of delayed abuse reporting. Additionally, the investigation did not include a witness statement from CNA4. The report revealed "Summary: Resident was on hospice, not related to incident, and has since passed away." Review of CNA3's witness statement, dated [DATE], revealed on [DATE] at 9:15 PM ".when we [CNA3 and CNA4] got him [R134] into bed we were going to change his brief. He [R134] wouldn't roll towards the wall for us so she [CNA4] shoved him [R134] into the wall and started yelling at him. [R134's initials] pushed her [CNA4] away and she got in his face asking him if he hit his wife like that and if he wanted to be hit back. [R134] grabbed my arm and seemed like he was in a lot of pain so I told CNA4 to just change him and stop yelling at him." CNA3 did not include in his statement why he did not immediately report the alleged abuse. Review of the progress note dated [DATE], in R134's EMR under the "Progress Notes" tab revealed that R134 was found to have expired on [DATE] at 11:46 PM. On [DATE] at 5:00 PM, DON stated she was aware of the delay of CNA3 reporting two abuse allegations but was not sure if CNA3 was asked about it. The DON stated the Assistant Director of Nursing (ADON) handled it and the ADON was currently out of the country. On [DATE] at 8:45 AM, the Administrator was interviewed concerning their abuse investigation and following their abuse policy. In response to why CNA3 waited four days to report the abuse and why he did not report it immediately as per their policy; the Administrator stated they did ask CNA3 why he waited four days to report the abuse and he told them he did not know he was supposed to, stating he was a new CNA and the information he received from the facility was so overwhelming. The Administrator went on to say she did not know why her staff did not document CNA3's response to their questions about his delayed reporting. The Administrator stated CNA3 was re-trained on the abuse reporting policy but did not know why this was not documented in the investigation or any other location. Regarding a lack of a statement from CNA4 about the allegations against her per their abuse policy, the Administrator stated she made multiple calls to the agency to contact CNA4. Again, she did not know why their efforts were not documented in the investigation or any other location. On [DATE] at 2:51 PM, an attempt was made to interview CNA3 via phone. He did not answer or return the call. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 4:40 PM, CNA4 denied the allegations of abuse against her. CNA4 stated all she was told was that she was not allowed to return to the facility due to allegations of abuse against her. The agency she worked for informed her of this. CNA4 stated no one asked her for her side. Review of CNA3's personal file revealed a "General Orientation Checklist" that included "Resident Abuse and Reporting Procedures" in which CNA3 signed on [DATE] as an acknowledgment of his understanding. Review of CNA4's personal paperwork revealed no documentation of CNA4 was asked to assist in completing a statement relevant to the facts. On [DATE] at 5:30 PM, the Administrator and the Regional [NAME] President of Operations (RVP) were informed that the failure to implement the abuse policy and remove the abuser once abuse was reported, report abuse timely, and complete the investigation to include all those involved, constituted an immediate jeopardy at F607-L: Develop/Implement Abuse Policies. The Facility Staff removed the Immediate Jeopardy on [DATE] at 5:45 PM through the following actions: A. Staff were educated on abuse policies and procedures. Contract staff members and any new orientees will also be educated. B. Administrator and DON were in-serviced on abuse policy including a proper investigation and procedures during investigations. C. Abuse allegations over last 12 months were audited. D. Administrator will conduct rounding audits by interviewing residents and staff across all shifts for four weeks. E. Interviewable residents were interviewed about abuse. F. Regional Nurse will review abuse files for completion and compliance to ensure policy and procedures is followed when abuse is reported. The scope lowered from an L to an E at the time of the survey, after ensuring the facility initiated education and audits.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on interview, observation, and record review the facility failed to ensure all alleged abuse was reported to the administrator or his/her designated representative immediately for two of two residents reviewed for reporting of abuse (Residents (R) 25 and 134). The delay in reporting abuse could place all 34 residents at risk for abuse. Findings include: Review of the facility's abuse policy, revised 11/2018, revealed The facility employee or agent, who becomes aware of abuse or neglect . shall immediately report the matter to the facility Administrator or his/her designated representative in the Administrators absence." 1. Review of R25's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) date of 06/01/22 located in the MDS tab of the electronic medical record (EMR), revealed R25 was admitted on [DATE], was severely cognitively impaired, had a diagnosis of Alzheimer's disease, and required extensive to total assistance with activities of daily living. Review of R25's 12/27/21Care Plan located in the EMR under the Care Plan tab revealed The resident has Amputation of right lower extremity amputation [RLE]. Review of the facility's investigation report, dated 04/12/22, revealed that certified nurse aide (CNA) 3 alleged R25 was physically and verbally abused by CNA4. CNA3 reported CNA4 grabbed resident's arm and yelled at the resident. R25 did not sustain any injuries as a result. The date of occurrence was 04/08/22 and the date and time of notification was 04/12/22 at 2:10 PM. The investigation did not include documentation of why CNA3 reported the allegation of abuse four days after the alleged occurrence. Review of CNA3's witness statement, dated 04/12/22, revealed during care on 04/08/22 CNA4 grabbed R25's arm and yelled in his face, saying she was going to beat his ass. CNA3 did not include in his statement why he waited four days to report the alleged abuse. On 07/11/22 at 12:00 PM, R25 was observed sitting in his wheelchair with a RLE. R25 did not respond to questions he was asked. 2. Review of R134's admission MDS, with an ARD date of 01/28/22 located in the MDS tab of the EMR, revealed R134 was admitted on [DATE], had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating R134 had intact cognitive abilities, required extensive to total assistance with activities of daily living, and was receiving hospice care. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigation report, dated 04/12/22, revealed that CNA3 alleged R134 was physically and verbally abused by CNA4. CNA3 reported CNA4 pushed R134 into the wall and got in R134's face, yelling at him. R134 did not sustain any injuries as a result. The date of occurrence was 04/08/22 and the date of notification was 04/12/22. The investigation did not include documentation of why CNA3 reported the allegation of abuse four days after the alleged occurrence. The report revealed Summary: Resident was on hospice, not related to incident, and has since passed away. Review of CNA 3's witness statement, dated 04/12/22, revealed on 04/08/22 at 9:15 PM when we [CNA3 and CNA4] got him [R134] into bed we were going to change his brief. He [R134] wouldn't roll toward the wall for us so she [CNA4] shoved him [R134] into the wall and started yelling at him. [Resident's initials] R134 pushed her [CNA4] away and she got in his face asking him if he hit his wife like that and if he wanted to be hit back. R134 grabbed my arm and seemed like he was in a lot of pain so I told CNA4 to just change him and stop yelling at him . CNA3 did not include in his statement why he was four days late in reporting the alleged abuse. On 07/12/22 at 5:00 PM, DON stated she was aware of the delay of CNA3 reporting but was not sure if CNA3 was asked about it. She stated the Assistant Director of Nursing (ADON) handled it and the ADON was currently out of the country. On 07/14/22 at 8:45 AM, the Administrator stated they did ask CNA3 why he waited four days to report the abuse and he told them he did not know he was supposed to. The Administrator recalled CNA3 told them he was a new CNA and the information he received from the facility was so overwhelming. The Administrator went on to say she did not know why her staff did not document CNA3's response to their questions about his delayed reporting. Review of CNA 3's personal file revealed a General Orientation Checklist that included Resident Abuse and Reporting Procedures in which CNA3 signed on 04/04/22 as an acknowledgment of his understanding.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on interview, document review, and policy review, the facility failed to implement the abuse policy for three residents of five residents (Resident (R) 1, 15, 28) reviewed for abuse. Specifically, the facility failed to remove the accused abuser after the abuse was reported to the abuse coordinator, placing the other residents at risk for abuse. Additionally, the facility failed to recognize resident-to-resident interactions as potential abuse and take appropriate action to protect the residents from future abuse. The facility's failure to recognize that abuse occurred and respond appropriately to protect other residents from abuse resulted in an Immediate Jeopardy for the potential of other residents to be vulnerable to abuse. The facility reported a census of 35. Findings include: Review of the facility policy titled Abuse, Prevention and Prohibition Policy, reviewed 2021, revealed Resident abuse must be reported immediately to the Administrator. The facility Administrator will ensure a thorough investigation of alleged violations of individual rights and document appropriate action . If a person was identified in the allegation of abuse, that person will not be allowed access to the facility while the investigation was in progress . Implement steps to prevent further potential abuse . Complete a thorough investigation. The facility will immediately remove any alleged perpetrator from any further contact with any resident . When an employee is the alleged perpetrator of abuse or neglect, that employee shall immediately be barred from any further contact with residents through suspension, pending the outcome of the facility investigation, prosecution, or disciplinary action against the employee . When another resident is the alleged perpetrator of the abuse, a licensed professional shall immediately evaluate the resident's physical and mental status, care plan, monitor behaviors and notify the physician for a determination regarding treatment and/or discharge options. 1. Review of an undated "Face Sheet" located in R1's electronic medical record (EMR) under the "Profile" tab indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE]. Review of the admission MDS [Minimum Data Set] for R1 revealed an Assessment Reference Date (ARD) of 04/05/22 documented a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. During an interview on 07/11/22 at 2:40 PM, R1 remembered and recounted the event a couple of months ago when a Certified Nursing Assistant (CNA) was assisting her into the sit-to-stand lift used to get her to the bathroom. R1 recalled the CNA slapped her hand away and R1 did not want that to happen again. R1 also remembered hitting her arm on the wall or door frame when being moved into the bathroom. During an interview on 07/12/22 at 2:41 PM, CNA1 recalled the event with R1 when CNA2 slapped R1's hand out of the way while CNA2 was putting the support strap around R1 for support saying, let me do my job. CNA1 observed CNA2 was visibly upset or mad and began roughly pushing the lift with R1 towards the bathroom, hitting her arm on the wall. CNA1 recalled telling CNA2 she (CNA1) would finish working with R1 and CNA2 left the room. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the investigation of the accusation of abuse for R1, provided by the facility, revealed a written statement dated 05/09/22 by CNA1, documented at the time of the incident, R1 whispered to "CNA1 to get her [CNA2] out of my room, I don't want her in here. During an interview on 07/12/22 at 3:55 PM, CNA1 verbalized notifying the Administrator at about 8:30 PM the night of the incident, remembering the incident occurred about 8:00 PM when the resident was getting ready for bed. CNA1 recalled CNA2 finished her shift after the event of slapping R1, and her shift ended at 10:00 PM. CNA1 confirmed reporting the incident of the slap to the Administrator by text message and to the charge nurse the evening of the event and reported the incident to the Assistant Director of Nursing (ADON) the next day. During an interview on 07/12/22 at 3:57 PM, the Administrator explained she was at home when received notification of allegations against CNA2. The Administrator thought the time was about 9:34 PM, and she came into the facility about an hour late and discovered CNA2 had already completed her shift and had left for the night. Review of the timecard for CNA2 provided by the facility revealed CNA2 reported to the facility after the alleged abuse and worked on 05/13/22 from 1:50 PM to 2:30 PM. During an interview on 07/12/22 at 3:57 PM, the Administrator explained when she was informed CNA2 was working on 05/13/22, the Administrator spoke to CNA2 explaining the need to not work until the investigation was complete. CNA2 then left the facility. Review of the Final Report investigation section with no date, submitted by the Administrator, revealed The CNA witness was interviewed, and a written statement obtained. Employee Investigation Questionnaire was taken by Administrator and signed accordingly by other staff working that day. Resident and Agency Aide [CNA2] were separated after incident and assessment completed. No injuries noted. The investigation in the Final Report lacked documentation action was taken to remove the alleged abuser from the facility after the abuse allegation. Review of the Final Report summary section, with no date, submitted by the Administrator, revealed The allegation of abuse cannot be substantiated. However, there are ongoing Customer Service issues as reported by residents and staff with complaints of rushing, lack of patience and lack of communication. Agency Aide [CNA2] has been educated several times to slow down, be patient and to communicate with residents while providing cares with little to no change. For this reason, Agency Aide [CNA2] has been asked to not return to facility. The summary of the Final Report failed to conclude abuse had occurred. During an interview on 07/12/22 at 3:57 PM, the Administrator explained the conclusion the investigation was unsubstantiated for abuse was based on the behaviors of CNA2 moving too quickly when doing things and did not do it to abuse R1, If CNA2 had slowed down then when she pushed the arm of R1 it would not have felt like a slap and concluded the contact between CNA2 and R1 was a push not a slap. The Administrator also confirmed the Director of Nursing (DON) and the ADON both thought it was not abuse and therefore CNA2 could have continued working through the agency at the facility. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 07/12/22 at 4:22 PM, the DON remembered the event between CNA2 and R1 and explained it as a personality conflict between the two. The DON interpreted the slap as a push away of R1's hand and not a slap. When asked about the process when there was an abuse allegation, stated the process as who to notify within two hours, assess the resident, obtain witness reports, and failed to communicate part of the process was to immediately remove the accused abuser from the facility as soon as the allegation of abuse was made. 2. Review of an undated "Face Sheet" located in R15's EMR under the "Profile" tab indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE]. Review of the Care Plan tab for R15 in the EMR revealed a focus initiated on 11/17/21 for the resident has mood problem Disease Process (Dementia). Interventions documented resident moods: Mood #1 Although fully clothed, resident was observed touching himself in his peri area. resident was easily redirected. Date Initiated: 11/17/2021, Revision on: 11/19/2021. Mood #2 Resident has been having inappropriate conversations with female residents. Date Initiated: 11/17/2021, Revision on: 11/17/2021. Mood #3 kissing female residents. Date Initiated: 01/02/2022. The Care Plan lacked documentation of updated interventions for mood behaviors. Review of the Progress Notes tab for R15 in the EMR revealed on 03/19/22 at 2:10 PM, revealed Resident [R15] came out of his bedroom without a brief and without his pants pulled up in front of a female resident. When staff redirected him, he just laughed at them. This was an alert note. Resident wasn't being inappropriate. Resident was redirected. Advised DON. No further action needed. During an interview on 07/13/22 at 1:50 PM, the DON explained the progress note for [R15] dated 03/19/22 was not abuse, the resident just got up [out of bed] on his own, was in the hallway and was not inappropriate with another resident. [R15] usually does not get out of bed by himself, did so on this day and this incident was not about the other resident. Review of the Progress Note tab for R15 in the EMR revealed on 07/04/22 at 2:59 PM, This nurse was informed by the activities aide that resident was noted walking near residents and staff and made them feel uncomfortable. Resident was educated and redirected to the couch and asked to watch TV. This nurse informed ADON about resident behavior. Review of the Progress Note tab for R15 in the EMR revealed on 07/05/22 at 10:28 AM, revealed other resident complained about [R15's] behavior making them [feel] uncomfortable. addressed with DON. During an interview on 07/15/22 at 11:01 AM, the Administrator confirmed the documentation in the progress note for R15 dated 07/04-05/22 was abuse and reportable and the DON/ADON did not inform the Administrator and therefore the incident was not reported or investigated. 3. Review of an undated "Face Sheet" located in R28's EMR under the "Profile" tab indicated the resident was admitted to the facility on [DATE]. Review of the MDS (Annual Minimum Data Set) tab in the EMR for R28 revealed an Assessment Reference Date (ARD) of 06/15/22 documented a Brief Interview for Mental Status (BIMS) revealed a score of 15 out of 15, indicating intact cognition. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 07/15/22 at 10:17 AM, R28 expressed feeling scared when R15 approached her. R28 recalled one day R15 was going on and on and raising his voice and R28 thought R15 was going to hit her. R28 stated she chooses to avoid R15 yet R15 follows and stares at R28 and she does not like that and has told him lots of times to not do that. R28 explained she had filed a grievance about R15 about how he follows her, taking deep breaths and then looks at his crotch. He has done that six times and it frightened R28 because she thought he was going to be aggressive. During an interview on 07/15/22 at 11:01 AM, the Administrator explained R28 had submitted a grievance about R15. The incident in the grievance occurred on 07/09/22, the form completed on 07/11/22 when they were informed of the incident, and the investigation was initiated on 07/12/22. The investigation was still ongoing during the recertification survey. On 07/13/22 at 5:30 PM, the Administrator and the Regional [NAME] President of Operations (RVP) were informed of the failure to recognize abuse occurred, constituted an immediate jeopardy at F610-L: Investigate/Prevent/Correct Alleged Violation. The Facility Staff removed the Immediate Jeopardy on 07/14/22 at 5:45 PM through the following actions: A. Staff were educated on abuse policies and procedures. Contract staff members and any new orientees will also be educated. B. Administrator and DON were in-serviced on abuse policy including a proper investigation and procedures during investigations. C. Abuse allegations over last 12 months were audited. D. Interviewable residents were interviewed about abuse. The scope lowered from a L to a E at the time of the survey, after ensuring the facility educations, interviews, and audits were conducted.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on interview and record review the facility failed to ensure staff documented complete skin assessments, monitored the effectiveness of treatments, and initiated timely treatment for one of four residents reviewed for skin conditions (Resident (R) 87) . This deficient practice had the potential to effect assessment and treatment for residents monitored for skin conditions. The facility reported a census of 34 residents. Findings include: Review of an undated "Face Sheet" located in R87's electronic medical record (EMR) under "Profile" tab indicated R87 admitted to the facility on [DATE] with diagnoses including candidiasis unspecified and candidiasis of the skin. Review of the admission Minimum Data Set (MDS) R87 with an Assessment Reference Date (ARD) of 04/14/22 documented a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated the resident showed moderate cognitive impairment. Review of the Misc tab in R87's EMR revealed a physician visit note dated 3/18/22, documented prior to admission. The note revealed R87 had problems with skin breakdown in the past and had been prescribed ketoconazole cream (an antifungal cream used to treat skin conditions) to apply to buttock area, peri area, and inner thighs twice daily. The note revealed R87 had a recent history of diarrhea due to antibiotic therapy which resulted in irritation of the buttock and peri area. Review of the Orders tab in the EMR for R87 revealed a physician's order dated 04/01/22 for ketoconazole cream 2 percent (%) Apply to buttock/peri/inner thighs topically every shift for skin integrity. Review of the Nursing Admission/Readmission Data Collection located under the Assessments tab for R87 in the EMR, dated 04/01/22, the section for skin integrity was blank. Review of the Assessments tab in the EMR for R87 revealed a Skin Check Weekly and PRN [as needed] dated 04/08/22 the Full Assessment was blank indicating a no skin impairment. Review of the Assessments tab in the EMR for R87 revealed a Skin Check Weekly and PRN dated 04/09/22 the Full Assessment documented for skin impairment description as yeasty looking rash under abdominal fold. Review of the Assessments tab in the EMR for R87 revealed a Skin Check Weekly and PRN dated 04/16/22 description Weekly Assessment documented a new issue of reddened left cheek and lacked documentation of skin impairment of rash under abdominal fold. Review of the Assessments tab in the EMR for R87 revealed a Skin Check Weekly and PRN dated 04/17/22 description Other Assessment documented an issue of reddened left cheek and lacked documentation of skin impairment of rash under abdominal fold. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Progress Notes tab for R87 in the EMR, dated 04/09/22 at 7:35 PM, documented when inspecting skin for injuries [after fall] resident has a rash under abdominal fold with a yeasty odor. Daughter states resident has a long [history] of yeast infections under all [skin] folds. Review of the Misc tab in the EMR for R87 revealed on 04/09/22 documentation to the physician concerning a rash under the abdominal folds with a yeasty odor, requesting treatment orders. Physician documented the response for Nystatin powder twice a day until clear signed and dated 04/11/22. Review of the Orders tab in the EMR for R87 revealed a physician's order dated 04/13 /22, four days after the abdominal rash was noted, for Nystatin powder to apply to abdominal folds topically every shift for yeast infection. Review of the Care Plan tab in the EMR for R87, revealed a focus for potential/actual impairment to skin integrity related to candidiasis initiated on 04/10/22 with interventions to administer treatments as ordered and monitor for effectiveness, avoid shearing while repositioning in bed, and pressure redistributing mattress on bed. The Care Plan lacked interventions for care of abdominal folds of skin. There was no documentation of how staff monitored for the effectiveness of treatment. During an interview on 07/14/22 at 2:15 PM, when questioned about the skin assessments and treatment of the excoriated areas on R87, the DON explained the staff could not be with the resident every time she went to the toilet to clean her to be sure the abdominal folds and peri area were dry, because the resident had the ability to take herself to the toilet independently. The DON verified the resident did wear adult briefs, but had no explanation for the lack of documentation of the skin irritations in the skin assessments that pertained to R87. Review of the emergency room Visit, located under the EMR Misc tab after a fall for R87, dated 04/19/21, documented in the chief complaint section noted a rash to [resident's] abdominal skin fold and groin. The physical exam section of the report documented Skin findings: Candidiasis infection to groin and abdominal pannus present. Review of the admission history and physical included in the emergency room Visit documentation, located under the EMR Misc tab, dated 04/19/22, revealed on arrival has a significant and painful looking candidal rash in her groin and skin folds. Under the Patient Active Problem List in the document candida dermatitis was listed as a current diagnosis dated 04/19/22.