STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	03/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St Kerrville, TX 78028

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 - Some	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** 43889 Based on observation, interview, and record review the facility failed to ensure all residents were free from abuse for 2 of 6 residents (Residents #1 and #5) reviewed for abuse in that: The facility staff failed to implement adequate interventions to ensure Resident #1 did not enter other resident rooms, which caused him to be abused by Resident #2 and Resident #3. Eventually, Resident #1 was pushed by Resident #3 and Resident #1 broke his right hip and his left index finger. Resident #1 was no longer independent after breaking his hip. The facility failed to implement adequate interventions to ensure Resident #5 felt safe at the facility after he was pushed by resident #3. This failure resulted in identification of an Immediate Jeopardy (IJ) on 3/17/23. While the IJ was removed on 3/19/23, the facility remained out of compliance level of actual harm with a scope identified as isolated until interventions were put in place to ensure residents were free from abuse. This failure could place residents at risk for abuse from other residents. The findings were: Record review of Resident #1's face sheet, dated 3/15/23, revealed Resident #1 was originally admitted to the facility on [DATE] with diagnoses of unspecified dementia [a general term for impaired ability to remember, think, or make decisions], unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, pain, unspecified, and hypocalcemia (History of) [low levels of calcium in the blood.] Record review of Resident #1's Quarterly MDS, dated [DATE], revealed Resident #1 did not have a BIMS score because Resident #1 was rarely/never understood. Record review of Resident #1's care plan, obtained 3/15/23, revealed the following: (continued on next page)

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.

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

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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 - Some	- Problem last updated 11/2/22: Behavior problem related to: Dementia AEB [As Evidenced By:] Roams into others rooms. This problem area had the following goal: Will have behavior identified so that staff may intervene quickly with listed interventions, daily, through next review date. One of the interventions was last updated on 11/2/22 read: Intervene as needed to protect the rights and safety of others. Approach and speak in a calm manner. Divert attention. Remove from situation and take to another location as needed. - Problem last updated 1/18/23: Resident resides in secure unit and is at risk for injury from wandering in an unsafe environment R/T [related to] impaired safety awareness. Resident is at risk for injury from others while residing in secure unit D/T [due to] altered cognition. This problem area had the following goal: Dignity will be maintained and resident will wander about unit without occurrence of any injury over the next quarter. One of the interventions last updated on 1/18/23 was: Keep environment free from possible hazards. This problem area also had the following goal dated 1/18/23: Activities director to monitor/discuss activity preference. This problem area also had the following goal dated 1/18/23: Allow resident to choose activities inside and outside that don't pose a safety risk. Record review of activities documentation from 2/1/23 to 3/14/23 revealed Resident #1 had outside activity, which was outside (walk), as early as 2/2/23. Other activities that took place outside of the locked unit, like bingo were seen documented as early as 2/6/23 and a coffee social on 2/15/23. Record review of Resident #2's face sheet, dated 3/15/23, revealed Resident #2 was originally admitted to the facility on [DATE] with diagnosis of dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance, depression, unspecified, Type 2 diabetes mellitus without complications, and unspecified dementia with behavioral disturbance. Further record review of this document revealed Resident #2 was discharged on [DATE]. Record review of Resident #2's Discharge MDS, dated [DATE], revealed Resident #2 had a BIMS score of 3, signifying severe cognitive impairment. Record review of Resident #2's care plan, obtained 3/15/23, revealed the following: - Problem last updated 11/17/22: [Resident #2] is territorial of room/personal belongings r/t: Dementia with Behaviors. This problem area had the following goal: Will have behavior identified so that staff may intervene quickly with listed interventions, daily, through next review date. This problem area had the following intervention dated 11/3/22: Intervene as needed to protect the rights and safety of others. Approach and speak in a calm manner. Divert attention. Remove from situation and take to another location as needed. - Problem area last updated 1/4/23: Behavior problem related to: Dementia with behaviors AEB: Physical and Verbal aggression towards others. This problem area had the following goal: Will have behavior identified so that staff may intervene quickly with listed interventions, daily, through next review date. This problem area had the following interventions dated 1/4/23: Intervene as needed to protect the rights and safety of others. Approach and speak in a calm manner. Divert attention. Remove from situation and take to another location as needed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review Resident #3's face sheet, dated 3/15/23, revealed Resident #3 was admitted to the facility on [DATE] with diagnosis of other lack of coordination, unspecified dementia, unspecified severity, with other behavioral disturbance, anxiety disorder, unspecified, unspecified psychosis not due to a substance of known physiological condition, and persistent mood [affective] disorder [a persistent and usually fluctuating disorders of mood which can last for many years that involve considerable distress and disability], unspecified. Record review of Resident #3's 5-day MDS, dated [DATE], revealed Resident #3 had a BIMS score of 9, signifying moderate cognitive impairment. Record review of Resident #3's care plan, obtained 3/15/23, revealed the following: - Problem dated 3/10/23: Behavior problem related to: Dementia AEB: Physical Aggression/Verbal aggression. This problem area had the following goal: Will have behavior identified so that staff may intervene quickly with listed interventions, daily through next review date. This problem area had the following interventions dated 3/10/23: intervene as needed to protect the rights and safety of others. Approach and speak in a calm manner. Divert attention. Remove from situation and take to another location as needed. Record review of Resident #5's face sheet, dated 3/15/23, revealed Resident #5 was admitted to the facility on [DATE] with diagnoses of Alzheimer's Disease [a progressive disease that affects memory and other important mental functions], unspecified, other abnormalities of gait and mobility, other lack of coordination, weakness, other malaise, and muscle wasting and atrophy not elsewhere classified, unspecified site. Record review of Resident #1's incident report, dated 2/15/23 and written by LVN E, revealed the following: Brief Description of Incident: hit by another resident [Resident #2] in the head Description of injury: laceration [cut] over left eye . At 2:25 pm this nurse heard loud voices coming from . another resident's room, this resident [Resident #1] came out of the room, this nurse asked the other resident [Resident #2] what was the problem, the other resident [Resident #2] stated that he [Resident #2] hit this [sic] because he repeatedly told him [Resident #1] to get out of his [Resident #2's] room but he [Resident #1] refused. [sic] Record review of Resident #2's nursing progress note, dated 2/15/23 and written by LVN E, revealed the following: this nurse heard loud voices coming from this resident's [Resident #2's] room, another resident [Resident #1] . came out of the room, this nurse asked the resident [Resident #2] what was the problem, resident [Resident #2] stated he hit the other [Resident #1] because he [Resident #2] repeatedly told him [Resident #1] to get out of his [Resident #2's] room but he refused. Record review of Resident #1's incident report, dated 3/9/23 and written by LVN F, revealed the following: Patient went into another patient room when the Aggressor Punched other patient in the nose . Nurse was notified by CNA Patient was seen walking up and down hall with Excessive bleeding coming down from nose and another patient verbalized to her he came into his room and 'he got what he deserved.' Record review of Resident #2's nursing progress note, dated 3/9/23 and written by LVN F, revealed the following: Nurse was notified by CNA Patient admitted to hitting another patient in the nose verbalized He got what he deserved because he walked into his room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #2's electronic health record revealed no 30-day discharge notice dated prior to his discharge on 3/10/23. Record review of Resident #5's nursing progress note, dated 3/11/23 at 10:31 a.m. and written by LVN F, revealed the following: Patient requested to [NAME] [sic] to nurse out in 'secret' He feels unsafe around another resident and would like for him to leave him alone. Nurse spoken [sic] to other resident and separated the two nurse will continue to monitor patients. Record review of Resident #5's nursing progress note, dated 3/11/23 and written at 10:31 a.m. by LVN F, revealed Rm changed to 116B. Record review of Resident #3's nursing progress note, dated 3/11/23 at 10:42 a.m. and written by LVN F, revealed the following: Patient seen trying to shove roommate into his room. When asked patient to please leave other patient alone he does not want to be in the room he shouted, 'I didn't touch him, I don't have blood on my hands.' Nurse talked to patient about keeping his hands to himself and patient understood. Record review of Resident #3's nursing progress note, dated 3/11/23 at 4:06 p.m. and written by LVN F, revealed the following: Patient arguing and yelling at other patients in the hall, Nurse instructed patient to sit at nurse station for 1:1 Observation. For behavior problems. Record review of Resident #1's incident report, dated 3/12/23 and written by LVN C, revealed the following: Brief description of incident: wandered to another resident room, pushed to the floor by another resident [Resident #3] . 3/12/23 at 9:29 a.m This hour resident [Resident #1] sent out to ER to evaluate/tx [treat.] Pushed to floor by another resident [Resident #3.] Record review of Resident #3's nursing progress note, dated 3/12/23 and written by LVN C, revealed the following: This am [a.m., meaning morning,] Resident voiced 'I didn't do it. I have no blood on my hands' A commotion could be heard during resident smoke hour. This resident shouted, 'get outta my room'! Then a slapping noise. This writer check the hall another resident [Resident #1] on the floor. That resident [Resident #1] is unable to communicate the incident related to DX. Record review of Resident #1's hospital physician progress note, dated 3/13/23, revealed the following: Presents after was wondering about other patients room, was pushed, fall, subsequent inability to stand up, brought to the ED [Emergency Department] which showed nondisplaced fracture of right femoral neck [right broken hip] as well as fracture of [left] proximal second digit [broken index finger.] He is scheduled to have surgical correction his afternoon. Record review of Resident #1's hospital X-ray results, dated 3/13/23, revealed total right hip arthroplasty [hip replacement] without hardware complication. Record review of Resident #1's Physical Therapy Evaluation & Plan of Treatment, dated 3/15/23, revealed Resident #1 had the following short-term goals: -Patient able to perform sit <>[to] stand 3x [3 times] mod A [Moderate Assistance] to improve safety with transfers . PLOF [Prior Level of Function] (prior to onset) Independent. Baseline (3/15/23) dependent. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Patient able to stand with BUE [Bilateral Upper Extremities, meaning both arms] 1 minute min A [minimal assistance] to improve safety with transfers . PLOF (prior to onset) independent for most of the day. Baseline (3/15/23) unable limited by pain. Further record review of this same Physical Therapy Evaluation & Plan of Treatment, dated 3/15/23, revealed Resident #1 had the following long-term goals: -Patient able to perform supine [lying on bed face-up] <> [to] sit supervision to decrease caregiver assistance . PLOF (prior to onset) independent. Baseline (3/15/23) dependent. -Patient able to transfer bed <> [to] W/C [wheelchair] supervision to decrease caregiver assistance and risk for falls . PLOF (prior to onset) independent. Baseline (3/15/23) unable. Admit on stretcher to facility. Limited by pain. -Patient able to ambulate [walk] with FWW [four wheel walker] 150' [150 feet] with supervision to decrease risk for falls . PLOF (prior to onset) independent no device. Baseline (3/15/23) unable. Record review of Resident #1's Occupational Therapy Evaluation & Plan of Treatment, dated 3/15/23, revealed Resident #1 had the following short-term goals: -Patient will increase activity tolerance for functional activities of choice to 20 min in order to w/o [without] signs/symptoms of physical exertion increased participation with ADL tasks . PLOF Prior to onset) 20 min. Baseline (3/15/23) 30-60 seconds. -Patient will safely perform self feeding tasks with Set-up (A) with use of for initiation/termination of tasks in order to facilitate self esteem through increased independence with tasks . PLOF (prior to onset) S/U [set up.] Baseline (3/15/23) Min (A) [Minimal Assistance] -Patient will complete toilet/commode transfers with Modified Independence for clothing management with recognition of safety hazards . PLOF (prior to onset) MI [Modified Independence.] Baseline: Max (A) [Max Assistance]. Further record review of this same Occupational Therapy Evaluation & Plan of Treatment, dated 3/15/23, revealed Resident #1 had the following long-term goals: -Patient will complete hygiene and grooming tasks while standing at sink with Modified Independence for initiate/termination of tasks with recognition of safety hazards in order to facilitate ability to live in environment with least amount of supervision and assistance . PLOF (prior to onset) Modified Independence. Baseline (3/15/23) Max (A). -Patient will safely perform toileting tasks using grab bars with Modified Independence for clothing management with recognition of safety hazards . PLOF (prior to onset) MI. Baseline (3/15/23) Max (A). -Patient will safely and efficiently perform LB [Lower Body] Dressing with Modified Independence with use of for initiation/termination of tasks in order to be able to return to prior level of living . PLOF (prior to onset) MI. Baseline (3/15/23) Max (A) (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Daily Schedule, dated 3/12/23, revealed the facility had 1 LVN, 1 CMA, and 1 CNA on 3/12/23. A second CNA was seen noted for the locked unit, but the second CNA's name scratched out and moved to another unit. Record review of the facility's current staff roster, provided on 3/15/23, revealed the facility had 17 CNAs, 11 Nurse Aides, 4 CMAs, 9 LVNs, and 1 RN. Including the non-clinical staff, the facility had 65 total employees. Record review of the facility's uploaded files from TULIP for Intake #411419 (which was the incident involving Resident #1 and Resident #2 on 3/9/23), revealed the following in-services conducted on the following dates: -On 3/9/23, the facility educated 14 staff members on Falls and Unmanageable Residents. -On 3/9/23, the facility also educated 22 staff members on Prevention of Abuse and Neglect. However, of the 22 staff members, 2 staff members signed their names twice for a total of 20 staff members. Of these now 20 staff members, 14 were the same staff members educated on Falls and Unmanageable residents. Only 6 new staff members received this education. -On 3/13/23, the facility also educated 13 staff members on Abuse Reporting. -On 3/13/23, the facility also educated 13 staff members on Managing Fall Risk. The 13 staff members on this in-service were the same 13 staff members who were educated on Abuse Reporting. During an observation and interview on 3/15/23 at 1:11 p.m., Resident #1 was seen in bed, awake, alert, and fully-dressed. CO H was at Resident #1's bedside and CO H stated Resident #1 may not be able to answer questions due to his diagnosis of dementia. An interview was attempted with Resident #1. When asked if he had any issues with other residents, Resident #1 answered, yes, but he did not elaborate on his answer when this surveyor prompted Resident #1 to elaborate. CO H stated Resident #1 was attacked 3 times last week and stated Resident #1's last attack was on Sunday, 3/12/23. CO H stated she received a call from CO J and they both went to a local emergency department. CO H stated, the story they told [CO J] is that the nurse was out on the patio and she heard someone yell 'get out of here.' She [the nurse] went to investigate and [Resident #1] was on the floor. And that's when the hip was broken . They [the facility] promised me they were going to keep [Resident #1 and Resident #2] separate and keep [Resident #1] safe. During an interview on 3/15/23 at 3:11 p.m., NA G stated if [Resident #3] sees anyone walking by, he'll try to pick a fight. Usually Resident #5 is afraid of Resident #3. In a follow-up interview on 3/15/23 at 3:20 p.m., NA G stated she had heard [Resident #2] had struck [Resident #1.] NA G stated Resident #2 was no longer in the facility. During an interview on 3/17/23 at 9:21 a.m., Resident #5 stated he did not feel safe in the facility. Resident #5 stated the other residents make him feel unsafe and have hurt him before. Resident #5 did not provide the names of the other residents who had hurt him. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 3/17/23 at 9:22 a.m., LVN C stated she ensured the safety of residents in the facility's locked unit by frequently monitoring the residents. LVN C stated she currently had 2 CNAs, but she was supposed to have a 3rd CNA that was supposed to come in later. When asked how they ensured Resident #1's safety, LVN C stated frequent re-direction all the time . to the best of our ability educate the residents that it's not intentional on his part to invade their space. LVN C stated [Resident #2] could go for a good amount of time [without being aggressive] and then slowly start to show the signs and then explode. When asked how they managed Resident #2's aggressive behavior, LVN C stated they spoke with [Resident #2] firmly. LVN C stated after Resident #2 struck Resident #1 they had temporarily moved Resident #1 to the women's side until lunch the next day, 3/10/23, after Resident #2 was discharged . LVN C stated only new interventions she was aware of for [Resident #1] was to consider alternative placement but it was difficult to find alternative placement for Resident #1 due to his wandering. Continuing the interview on 3/17/23 at 9:22 a.m., LVN C stated Resident #3's aggressive behavior was new for Resident #3. LVN C stated she believed Resident #3 may be mimicking Resident #2's aggressive behavior. LVN C stated, [Resident #3] somehow got attached to him and he was always calling out for [Resident #2.] And I found that extremely odd because [Resident #3] was becoming dependent on [Resident #2.] [Resident #3] felt safe around him. LVN C stated prior to 3/12/23, Resident #3 was approaching other residents with the intent to push them over, but when [Resident #3] was aware he was being watched by the facility staff, he would leave the other residents alone. LVN C confirmed she was working on 3/12/23, the day Resident #3 pushed Resident #1. LVN C stated, We were short [a staff member] that day. I remember because I had to take them out to smoke because usually a CNA would do it. So to keep the [other residents] calm I went and initiated the smoke [smoke break.] So I let them [the residents] out and then it happened. LVN C stated after Resident #3 pushed over Resident #1 and caused Resident #1 to break his hip they made sure [Resident #3] stayed away from the others. During an interview on 3/17/23 at 10:48 a.m., LVN I stated he was currently the primary nurse for Resident #1. LVN I stated Resident #1 was currently on physical therapy and occupational therapy, which was new for Resident #1. LVN I stated Resident #1 could previously walk independently and currently cannot bear weight on his broken hip. During an interview on 3/17/23 at 12:28 p.m., the DOR stated Resident #1 was currently on physical therapy and occupational therapy for his broken right hip. The DOR stated Resident #1 never required therapy before because he was ambulatory [able to walk] without any device and was independent with ADLs prior to his broken hip. The DOR stated Resident #1 was currently bed-bound at this point. He was independent, but now he's dependent. During an interview on 3/17/23 at 1:34 p.m., the Director of Marketing LVN stated his current role at the facility was a Nurse Manager due to the fact the facility did not have a DON and ADON. The Director of Marketing LVN stated the facility ensured the safety of residents in the locked unit by frequent monitoring. The Director of Marketing LVN stated if 2 residents had a physical altercation the staff would ensure the altercation doesn't happen again by monitoring continuously. When asked about the incident involving Resident #1 and Resident #2 on 2/15/23, the Director of Marketing stated he could not recall much about the incident as that was around the time he began to become more involved in nurse management. The Director of Marketing LVN stated after the incident we did our frequent monitoring and then our redirection and then provided activities on the unit. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 3/17/23 at 3:05 p.m., the Administrator stated he had been the Administrator at the facility since early February 2023 and was currently the abuse coordinator. The Administrator stated they ensured the safety of residents in their locked unit by supervision and increased activities. The Administrator stated he did not recall if the facility had implemented any interventions for the locked unit after the incident involving Resident #1 and Resident #2 on 2/15/23. The Administrator stated he was not too familiar with Resident #2 beyond the incident between Resident #1 and Resident #2 on 3/9/23. The Administrator stated he was not aware of any new interventions for Resident #2 prior to 3/9/23. The Administrator stated he was aware the facility had attempted to discharge Resident #2 before 3/9/23 but with no success. The Administrator stated aside from in-servicing, the facility did not make any major changes after the incident between Resident #1 and Resident #2 on 3/9/23. Continuing the interview on 3/17/23 at 3:05 p.m., the Administrator stated he heard Resident #3 became aggressive towards Resident #5 prior to Resident #3 pushing over Resident #1 on 3/12/23. The Administrator stated on 3/12/23 he was notified of the incident between Resident #3 and Resident #1 and he came on-site the same day to conduct safe surveys with other residents. When asked if there were any interventions in place to ensure Resident #1's safety, the Administrator stated, just the 15-minute check thing that we've done. I'll tell you what the problem is, it's the size of the hall . Most everyone has dementia and some of those guys get into people's personal space and some people don't like it. And [Resident #1] does that. He'll enter people's personal space and these guys-they have dementia too and I assume they don't like it. The Administrator stated he was unsure if there were any considerations to place Resident #1 in another facility. When asked if he felt the facility had done everything they could to ensure Resident #1's safety, the Administrator stated, I don't think I could have done anything to make that not happen. An updated education for the facility's incident report on 3/12/23 was requested at this time. In a follow-up interview on 3/17/23 at 5:47 p.m., the Marketing Director LVN stated the facility's education on 3/9/23 carried over to the incident on 3/12/23. During an interview on 3/18/23 at 10:45 a.m. with the Administrator, this surveyor requested for a copy of a 30-day discharge for Resident #2, if one was available. In a follow-up interview on 3/18/23 at 11:03 a.m., LVN C stated she was aware Resident #3 attempted to push Resident #5 before and heard Resident #3 raised a fist at Resident #5. LVN C stated Resident #5 felt unsafe around Resident #3 and wanted to change rooms. In a follow-up interview on 3/18/23 at 11:15 a.m. with CO H, CO H stated, [Resident #1] walks and always has. That honestly is my biggest concern . He used to sit up by himself and stand and now he can't do that . Something that he's never done before that's really concerned me is that I went to move his hair out of his eyes and he flinched. And that broke my heart. He knows I'd never lay a hand on him . He sleeps a lot more. He never used to sleep during the day. He was always up and walking. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	03/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St Kerrville, TX 78028

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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 - Some	During an interview on 3/18/23 at 11:59 a.m., the Assistant Activities Director stated she conducted activities for the locked unit. The Assistant Activities Director stated she was told to do more activities with the men's locked unit, but added, I'm still making it work because she was trying to balance doing activities for the men and women's locked unit. When asked about any new changes to their activities schedule, the Assistant Activities Director stated the facility started having weekly outings on Thursdays since 3/2/23. The Assistant Activities Director stated off-unit activities had been implemented since October 2022. The Assistant Activities Director state the facility's off-unit activities included coffee socials on Tuesday, and bingo on Tuesdays and Thursdays. When asked about Resident #1, the Assistant Activities Director stated the resident liked to go for walks and she would take him to walk through the dining hall and outside at least 2 or 3 times per week for 30 minutes. During an interview and record review on 3/18/23 at 12:28 p.m., the Assistant Activities Director stated she was asked to pass to this surveyor a print-out of Resident #2'nursing and physician progress notes with highlighted portions indicating the facility's unsuccessful attempts to discharge Resident #2. No 30-day discharge notice was provided with this print-out and there was no documentation in the progress notes that indicated a 30-day discharge notice was provided. Record review of a facility policy titled, Preventing Resident Abuse, dated February 2014, revealed the following, Our facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures, training programs, systems, etc., to assist in preventing resident abuse . The facility's goal is to achieve and maintain an abuse-free environment. Record review of Resident #1's signed admission agreement, dated 10/19/23, revealed the following: Each Resident has the right to be free from verbal, sexual, mental and physical abuse, corporal punishment, and involuntary seclusion. The Administrator was notified of an IJ on 3/17/23 at 5:48 p.m. and was given a copy of the IJ Template and a Plan of Removal was requested. The Plan of Removal was accepted on 3/18/23 at 4:00 p.m. and included the following: Residents #2 is no longer in the facility. Resident # 1 and # 3 assessed by RN and support was provided as accepted, physician was notified of the alleged deficiency on 3/17/23. There were no new orders obtained. Affected residents' responsible parties were notified by Administrator of alleged deficiencies and plan of correction. Resident #3 was sent to psychiatric hospital for evaluation on 3/12/2023 and again on 3/17/2023 for evaluation and possible me [TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	03/19/2023

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43889 Based on observation, interview, and record review, the facility failed to 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 for 1 of 6 residents (Resident #6) reviewed for infection control in that: While performing incontinent care on Resident #6, Transportation CNA A did not perform hand hygiene between a glove change. This deficient practice could affect all residents and place them at risk for infection. The findings were: Record review of Resident #6's face sheet, dated 3/17/23, revealed Resident #6 was admitted to the facility on [DATE] with diagnoses of Type 2 Diabetes Mellitus without complications, Alzheimer's Disease [a progressive disease that affects memory and other important mental functions], unspecified, restlessness and agitation (history of), edema [swelling caused by excess fluid trapped in the body's tissues], unspecified, and hypokalemia [low potassium levels in the blood.] Record review of Resident #6's Quarterly MDS, dated [DATE], revealed Resident #6 had a BIMS score of 99, signifying Resident #6 was unable to complete the BIMS interview. Observation on 3/15/23 at 2:07 p.m. revealed, Transportation CNA A performed Resident #6's incontinent care. Transportation CNA A cleansed Resident #6's front and perineal area. Transportation CNA A removed her soiled gloves and put on one new, clean glove on one hand. Transportation CNA A paused and then stated, I should wash my hands between them [the glove change]. I'm going to pretend I have hand sanitizer on. It's in my pocket. Transportation CNA A put on another glove on her other hand and then proceeded to complete Resident #6's incontinent care. During an interview on 3/15/23 at 2:22 p.m., Transportation CNA A stated hand hygiene should be done before entering a patient's room, when removing gloves, and before putting on new gloves. Transportation CNA A stated I just forgot and I caught myself. If I didn't already have one glove on, I would have used it [hand sanitizer.] Transportation CNA A stated she had hand sanitizer in her pocket and showed the hand sanitizer to this surveyor. Transportation CNA A stated it was important to perform hand hygiene appropriately for cleanliness, don't want to spread germs, don't want to make anyone sick. Transportation CNA A stated she was last educated on hand hygiene in September 2022. Record review of Transportation CNA A's Handwashing Skills Checklist, dated 1/23/23, revealed Transportation CNA A was deemed competent in hand washing. This skills checklist did not cover when to perform hand hygiene, such as after removing gloves. Record review of a facility policy titled, Handwashing/Hand Hygiene, dated April 2012, revealed the following, use alcohol-based hand rub . for all the following situations: .after removing gloves.