| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525730 | A. Building<br>B. Wing | 03/23/2023 |

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| Ignite Medical Resort Oak Creek | 2700 Honadel Boulevard<br>Oak Creek, WI 53154 |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>21855<br><br>Based on record review and interview, the facility did not ensure a resident's emergency contact was notified of significant changes in their status. This was discovered with 1(R22) of 3 residents reviewed with a change in condition. R22 was readmitted from the hospital, along with 5 new pressure injuries, their emergency contact was not notified. Findings include:<br><br>Surveyor reviewed the facility's policy and procedure on Notification of Family/ DPOA(Durable Power of Attorney) dated July 2020. The Procedure includes: changes of condition, including but not limited to: new skin injuries and re-hospitalization s.<br><br>1.) R22 medical record was reviewed by Surveyor. R22 is their own person and has designated Emergency Contacts in their medical record. The Progress Note on 2/14/23 at 9:34 AM indicates R22 had a change in condition. R22 Emergency Contact was notified the facility is sending R22 to the hospital. R22 medical record did not indicate R22 had any pressure injuries at the time of transfer. The Progress Note on 2/23/23 ay 7:31 PM indicates R22 returned to the facility from the hospital. There is no indication R22 Emergency Contact was notified of their return to the facility, nor R22 indicating they did not want their Emergency Contact updated. The Progress Note on 2/23/23 at 11:40 PM indicates R22 has skin integrity concerns that include: front neck surgical site, left buttock stage 3 wound per hospital report, right buttock stage 3 wound per hospital report, right knee (blank), right heel (blank). There is no documentation R22 Emergency Contact was updated on these skin areas, nor R22 was aware.<br><br>On 2/24/23 at 10:33 AM R22 had a comprehensive skin assessment completed by DON-B (Director of Nurses). The following was assessed:<br><br>*Right heel unstageable pressure injury measuring 5.5 cm by 7.0 cm; 80% necrotic and 20% pink pale non-granulating; moderate serosanguineous drainage.<br><br>* Right posterior knee stage 2 pressure injury measuring 0.8 cm by 8.00 cm; 100 % pale pink non-granulating; scant serosanguineous drainage.<br><br>* Right outer leg deep tissue injury measuring 18.0 cm by 1.4 cm; 100% deep maroon.<br><br>* Sacrum stage 2 pressure injury measuring 7 cm by 6 cm; 100 % pale pink non-granulating; scant serous drainage.<br><br>(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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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | * Left Lower Leg Back deep tissue injury measuring 6 cm by 1 cm; 100% deep maroon.<br><br>R22 medical record does not include documentation that R22 was aware of wound status and their Emergency Contact was notified of the new wounds.<br><br>On 3/8/23 at 2:15 PM Surveyor spoke with R22 Emergency Contact. They were not aware of R22 pressure injury status.<br><br>On 3/9/23 at 9:16 AM Surveyor spoke with LPN-G (Licensed Practical Nurse) who documented R22 return from the hospital and initial skin notation. LPN-G did not notify R22 Emergency Contact about R22 return or skin concerns.<br><br>On 3/13/23 at 3:12 PM at the Facility Exit Meeting Surveyor shared the concerns with R22 notification. DON-B was not available at this time. |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40533<br><br>Based on interview and record review the facility did not ensure 2 (R12 & R63) of 8 residents reviewed for grievances had their grievances fully investigated or followed up on by the facility to ensure resolution of the concern.<br><br>R12's family submitted multiple grievances to the facility that were not fully investigated and/or had no resolution.<br><br>Findings include:<br><br>Surveyor reviewed facility's Grievances policy with a date of [DATE]. Documented was:<br><br>Grievance Guideline<br><br>Purpose: To provide a process to voice grievances (such as those about treatment, care, management of funds, lost clothing, or violation of rights) and respond with prompt efforts to resolve while keeping the resident and / or resident representative appropriately apprised of progress toward resolution .<br><br>Grievances<br><br>The Grievance Official will initiate the appropriate notification and investigation processes per individual circumstance and facility guidelines. The investigation will consist of at least the following:<br><br>- A review of the completed complaint report<br><br>- An interview with the person or persons reporting the grievance<br><br>- Interviews with any witnesses to the concern<br><br>- A review of the medical record if indicated<br><br>- A search of resident room (with resident permission)<br><br>- Interview with staff members having contact with the resident during the relevant periods or shifts of the alleged incident<br><br>- Interview with the resident roommate, family members and visitors<br><br>- Completion of a root cause analysis of all circumstances surrounding the concern As necessary, the Grievance Official and facility leadership will take immediate action to prevent further potential continuations of any additional and like resident concerns while the grievance is being investigated.<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | RESOLUTION<br><br>The Grievance Official will complete a response to the resident and / or resident representative which includes:<br><br>- Date of grievance<br><br>- Summary of grievance<br><br>- Investigation steps<br><br>- Findings<br><br>- Resolution outcome and actions taken with date decision was determined .<br><br>R12 was admitted to the facility [DATE] with diagnoses that included Unspecified Dementia without Behavioral Disturbances, Encounter for Surgical Aftercare Following Surgery on the Digestive System and Adult Failure to Thrive. R12 had designated her Power of Attorney (POA)-KK to help speak for R12.<br><br>On [DATE] POA-KK sent 13 Grievances to the facility via email.<br><br>Documented Grievance with a date of [DATE] by POA-KK was:<br><br>I arrived at Ignite to see (R12). I saw the [Registered Nurse (RN)-II)] when I was in the front foyer . I stopped him and informed him that (R12's) roommate, [R63], had some concerns and I would like someone to please speak to her. I stated that one of her issues was that she did not have a clock in her room and would like one. I also informed him that she told me that she has not had her glasses since shortly after arriving at the facility and I had a left a message for the other [Assistant Chief Nursing Officer (ACNO)-D], earlier in the week, but, did not receive a response. I was informed that he would take care of it by contacting maintenance and it would be addressed the following day, on Monday. He stated he would speak to [ACNO-D] about [R63] not having her glasses. I arrived to (R12's) room shortly after this exchange and found her laying in a sopping wet diaper with no pants on and the sheet and chuck completely saturated. I went immediately to the nursing station where there were several staff members and asked who (R12's) aid (sic) was for the day.<br><br>[Certified Nursing Assistant (CNA)-Q] indicated it was her. I asked her if she could please come with me to (R12's) room. Upon showing her the condition I found (R12) in, she stated that it was the student's fault. I know that there had previously been students in the unit during the week (not that I or (R12) was told about it), but, I did not know that they were there on the weekend. I was in the process of cleaning (R12) up by changing the bedding, her clothing, washing her, and putting a clean diaper on her - not once did she offer to help me.<br><br>Investigation Summary Page<br><br>Staff Investigating Grievance: [RN-II]<br><br>Title: Supervisor<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Via cellphone<br><br>Investigation Summary (Attach Documentation as Needed):<br><br>[R12's] [POA-KK] approached me [with] concerns on roommates clock [and] glasses]. I put a clock in the room from an empty room [and] left [social services] a message regarding her glasses. I believe [social services] may contact [eye doctors]. She stated (R12) was soaking wet. I talked to [CNA-Q] who stated she never said that. [Students] were not even scheduled on the weekend.<br><br>Via cell phone interview with [RN-II]<br><br>[Signed by Director of Nursing (DON)-B] [DATE]<br><br>Grievance Follow-Up Page<br><br>Staff Member Following up: [CNA-Q]<br><br>Title: CNA<br><br>Date: [DATE]<br><br>She never came and got me. I had went (sic) in there 45 min prior to daughter even being there and changed her. She never showed me (R12) being soaked.<br><br>[Signed by CNA-Q]<br><br>[Signed by DON-B]<br><br>Surveyor noted there was no interview with the person reporting the grievance, no interview with other staff members having contact with the resident during the relevant periods or shifts of the alleged incident, no interview with the resident's roommate, no completion of a root cause analysis of all circumstances surrounding the concern, no resolution or response to the resident representative which included date of grievance, summary of grievance, investigation steps, findings, and no resolution outcome and actions taken with date decision was determined.<br><br>Documented Grievance with a date of [DATE] by POA-KK was:<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | My (family member) . was at the facility from 3:15PM until 4:30PM. At 6:30PM I received a call from (R12) who was very upset that she was sopping wet and was told by her aid (did not know who it was) that she would be back to change her after she came in her room and shut the call light off. I informed (R12) she should hit the call light again and we would wait and see if someone came back in. An aid came into the room while I was on the phone with (R12) and was arguing with her that she wasn't wet as she had just been changed. (R12) repeatedly told her that her bed and pajama bottoms were wet and she would like to be changed. She was told repeatedly that she wasn't wet. I arrived at the facility 20 minutes later 6:50PM and found (R12's) diaper, pajama bottoms, and sheet (no chuck) was wet. The diaper that was on her was too large and due to this reason, it leaked everywhere. The aid happened to be outside the room with the cart and I asked her if she was the person speaking to (R12) 20 minutes earlier and she said, yes, her name is [CNA-LL]. I informed her that (R12) was in fact wet and so was her pajamas and sheet as the diaper that was on her was way too large. She stated, well don't tell me I didn't do my job, because I just changed her. I responded to her that I never said she didn't, just that she was wet now and so was everything else. I began changing (R12's) bedding and her, and was not asked if I needed help .<br><br>[DATE]: When I arrived I found her pajamas saturated with urine laying on a clean blanket on her chair - she had no pants on.<br><br>RESIDENT GRIEVANCE FORM<br><br>DATE: ,d+[DATE]<br><br>RESIDENT: [R12] .<br><br>NAME OF PERSON FILING GRIEVANCE: [POA-KK]<br><br>STATEMENT OF GRIEVANCE (Explanation of incident to include dates, times and witnesses as applicable):<br><br>CNA - went into the room [at] least every two hours to [check and change]. [At] no time was she soaked or the linen being dirty.<br><br>INVESTIGATED BY: [Signed by DON-B]<br><br>DATE OF RESOLUTION: [DATE]<br><br>SUMMARY OF RESOLUTION: unable to substantiate<br><br>ADMINISTRATOR'S SIGNATURE: [Signed by DON-B]<br><br>DATE: [DATE]<br><br>Documented Grievance with a date of [DATE] by POA-KK was:<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | I was at the facility from 4:00PM until 6:30PM. I fed her, toileted her, cleaned her dentures, combed her hair, washed her, and put a clean diaper on her. At 8:30PM I received a call from her crying and apologizing, stating she didn't know what to do. She had been waiting for a bed pan since 7:30PM and no one had come. She couldn't help it and had a bowel movement in her diaper and was sorry. I directed her to hit the call button while she was on the phone with me. Someone came in almost immediately, (R12) attempted to tell her she needed help and had been waiting an hour but, she shut off her call button and left the room stating she would be back. I told (R12) to hit the button again. She came back into the room, went directly to shut the call light off and I told (R12) to tell her I wanted to speak with her. Due to her dementia (R12) sometimes states that I am her mother, she stated to the aid, my mother wants to talk to you I could hear her laughing at her and stated, YOUR MOTHER wants to talk to me? Hahahahhaha. My mother responded, yes, my mother. She got on the phone and I asked her whom I was speaking to, she said [CNA-O]. I stated that (R12) had waited over an hour for a bed pan and seeing as no one responded to her call light she defecated in her diaper and was now sitting in crap and had been for quite some time. She responded to me, well, (R12) isn't the only person here. I stated, you did not just say that to me did you [CNA-O]? I continued, you are going to say that to me when (R12) has been sitting in shit for an hour and calling me crying? I told her I was aware that (R12) is not the only resident there, and I know this as I am there a minimum of five days a week. I asked her if she wanted me to come there and she asked me what would I come there for and I stated, to do your job. I stated that the time it was taking her to argue with me on the phone about doing her job, she could have already changed her. I asked her directly if she would please help (R12) and change her diaper, I stated that I would pay her. She said then said she would take care of it. I thanked her and asked her to tell (R12) I would call her back in 15 minutes. I called back about 10 minutes later and [CNA-O] was just leaving the room. (R12) thanked her and her response was, YEP.<br><br>RESIDENT GRIEVANCE FORM<br><br>DATE: ,d+[DATE]<br><br>RESIDENT: [R12] .<br><br>NAME OF PERSON FILING GRIEVANCE: [POA-KK]<br><br>STATEMENT OF GRIEVANCE (Explanation of incident to include dates, times and witnesses as applicable):<br><br>Writer spoke at length [with] CNA via telephone who stated all allegations were untrue. See statement<br><br>INVESTIGATED BY: [Signed by DON-B]<br><br>DATE OF RESOLUTION: [DATE]<br><br>SUMMARY OF RESOLUTION: unable to substantiate<br><br>ADMINISTRATOR'S SIGNATURE: [Signed by DON-B]<br><br>DATE: [DATE]<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Employee Statements<br><br>Per CNA she did not laugh [at] [POA-KK], she did not state [R12] isn't the only one here. [R12] was never sitting in [feces], I [check and changed] her every two hours [and] went into her room multiple times to see if she needed anything. [POA-KK] was very rude [and] aggressive to staff per norm [and] was making false allegations that were not true.<br><br>Signature: via telephone with [CNA-O]<br><br>[DATE] [Signed by DON-B]<br><br>Documented Grievance with a date of [DATE] by POA-KK was:<br><br>I arrived at the facility at 4:00PM. Upon entering the room, I observed that the room was in complete disarray. I found her lunch tray sitting on her desk (at 4:00) next to items used for toileting. Her tray table was completely filthy as something was spilled on it and there was garbage that needed to be thrown in the trash.<br><br>She did not have any water or anything else to drink available to her. I am unclear as to how another human being would think that putting toileting items next food items would be OK. No one could even take 3 minutes to clean up what was spilled and throw some garbage away? I took the tray out to the dining room and proceeded to clean up the mess.<br><br>RESIDENT GRIEVANCE FORM<br><br>DATE: ,d+[DATE]<br><br>RESIDENT: [R12] .<br><br>NAME OF PERSON FILING GRIEVANCE: [POA-KK]<br><br>STATEMENT OF GRIEVANCE (Explanation of incident to include dates, times and witnesses as applicable):<br><br>See statement.<br><br>Per CNA she gave resident her bottled water [and] the room wasn't a mess [because] she always straightens the room up.<br><br>INVESTIGATED BY: [Signed by DON-B]<br><br>DATE OF RESOLUTION: [DATE]<br><br>SUMMARY OF RESOLUTION: unable to substantiate<br><br>ADMINISTRATOR'S SIGNATURE: [Signed by DON-B]<br><br>DATE: [DATE]<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Employee Statements<br><br>[R12] will ask for bottled water out of her fridge [and] will not accept water from the facility. On the 9th I did give her a water bottle. Patient tends to call daughter [and] not put her light on. The room was cleaned [and] there wasn't a mess.<br><br>Signature: [signed by CNA-Q]<br><br>Documented Grievance with a date of [DATE] by POA-KK was:<br><br>I arrived at the facility around 3:30. (R12) was complaining of pain and informed me that she believed she had told the aid about it. I checked her and she did not have any pain patches on her knees or upper right arm, she was begging for Tylenol. I went and got the nurse and questioned (again) whether or not she was receiving a daily regimen of Tylenol as previously discussed with the [Hospice Nurse]. My understanding was that when we met in December . the decision was made to place her on a daily regimen of Tylenol, apparently this did not occur. The nurse I spoke to was unable to provide me with a direct answer as to whether or not this was ordered. She was given two Tylenol and I was given three pain patches that I put on her.<br><br>RESIDENT GRIEVANCE FORM<br><br>DATE: ,d+[DATE]<br><br>RESIDENT: [R12] .<br><br>NAME OF PERSON FILING GRIEVANCE: [POA-KK]<br><br>STATEMENT OF GRIEVANCE (Explanation of incident to include dates, times and witnesses as applicable):<br><br>Patches were put on.<br><br>Tylenol is scheduled [and] was administered.<br><br>INVESTIGATED BY: [Signed by DON-B]<br><br>DATE OF RESOLUTION: [DATE]<br><br>SUMMARY OF RESOLUTION: unable to substantiate see [Medication Administration Record (MAR)]<br><br>ADMINISTRATOR'S SIGNATURE: [Signed by DON-B]<br><br>DATE: [DATE]<br><br>[MAR was attached but unable to determine time medications administered]<br><br>Employee Statements<br><br>(continued on next page) |

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|---|---|
| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | I gave resident her patches [and] scheduled as ordered. See MAR.<br><br>Signature: via telephone [DATE]<br><br>[signed by DON-B]<br><br>Documented Grievance with a date of [DATE] by POA-KK was:<br><br>I arrived at the facility at 2:00PM. (R12) was completely wet from urine and so was her clothing and bedding. It was clear that she had not been provided any care this day regarding her clothes being changed or even her diaper being checked/changed. I completed a full bed change, washed her, put clean clothes/diaper on her. I cleaned her dentures and brushed her hair. These two things are never done, ever. I continued to clean the room for both her and her roommate, disinfecting tables, door handles, remotes, etc. I have repeatedly informed all the staff that work with her (when I am there) that she has dementia.<br><br>She does not know if she is wet or not, or even if she has to use the bathroom.<br><br>Someone could ask her if she is wet and she will not know. I have requested repeatedly that they not ask her, but, rather check her. It doesn't make sense that staff would rather wait until she is completely sopping wet with urine and then everything needs to be changed, versus, physically checking her and then changing her if needed. I have also informed staff that she will sometimes hit the button for assistance and when staff come to attend to her, she will not remember what she needed. Sometimes, she does not even remember that she hit the call button. Staff need to be aware, that someone with dementia, especially her very short-term memory loss, is not going to remember what they need. Instead of asking her, maybe they could actually take two minutes and check her and talk to her to see if she will remember what she needed? Why is her condition not being relayed to staff that are working with her? These issues, along with all the other ones could be addressed by adequate communication, which appears to be non-existent in the facility.<br><br>RESIDENT GRIEVANCE FORM<br><br>DATE: ,d+[DATE]<br><br>RESIDENT: [R12] .<br><br>NAME OF PERSON FILING GRIEVANCE: [POA-KK]<br><br>STATEMENT OF GRIEVANCE (Explanation of incident to include dates, times and witnesses as applicable):<br><br>See attached.<br><br>INVESTIGATED BY: [Signed by Nursing Home Administrator (NHA)-A]<br><br>DATE OF RESOLUTION: [DATE]<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | SUMMARY OF RESOLUTION: unable to substantiate. Aide stated she checked on guest frequently and changed her when wet.<br><br>ADMINISTRATOR'S SIGNATURE: [Signed by NHA-A]<br><br>DATE: [DATE]<br><br>Employee Statements<br><br>Checked on patient and changed frequently. She was not saturated. I do not remember the exact time. I changed her but I charted it at [1:51 PM].<br><br>Signature: [signed by CNA-MM]<br><br>Documented Grievance with a date of [DATE] by POA-KK was:<br><br>My [family member] was at the facility from 3:15PM to 4:30PM. He indicated that he cleaned (R12's) room and fed her due to the food in the facility being inedible about 80% of the time. The food that arrives for residents is always late and the times are sporadic. More often than not, it is not what is indicated on the menu. I recognize that in some cases adjustments need to be made based on what is available, but, every meal this occurs? I have attempted to contact the kitchen on numerous occasions to request a soup/sandwich to substitute for a meal. I have attempted to call two hours previous to the meal being served (whenever that may be) as I have been directed to do. I have never gotten a response. No one answers the phone and messages go unanswered. On this day, [family member] went to wash a dish in the sink in the dining room and observed [another resident] (on the floor that we have both been accustomed to seeing/talking to) who was sitting in his wheel chair with a puddle of urine dripping from him. [Family member] stated that he went to the nurse's station and reported it to staff. About a half hour later he went to leave, and [resident] was sitting in the same place in the same condition. He said there was an aid sitting at a table with another resident and he proceeded to point the mess out to her, and she just stared at him. He then asked her if she was going to address it as it was not very sanitary and she got up and walked away.<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | At 6:45PM (R12) called me and told me she was wet and needed to be changed, I directed her to hit the call button. I waited on the phone with her to ensure someone came in to attend to her. An aid entered the room and proceeded to turn off the call light and told her she would be right back, I heard her say this. We waited 15 minutes and I directed her to hit the call button again, as I realize that shift change occurs at 7:00PM. 7:15PM no response. 7:30PM no response. 7:45PM no response. 8:00PM no response. I arrived at the facility at 8:20PM and observed that there were no less than 10 lights on RED, there was no staff anywhere. I proceeded to start a full bed change as everything was sopping wet with urine. A staff person was then outside the door and I went to talk to her as I was in the process of doing your employees' job. I was told that no one showed up for work and she was assisting the residents even though she was a med passer. I told her I would take care of (R12) if she could assist her roommate with being changed and getting ready for bed. I completed a full bed change, changed her pajamas, and put a clean diaper on her. Part of the problem is that the diaper someone had put on her was the wrong size (way too big - tan, she wears the blue size) so, urine had leaked everywhere. I proceeded to get the women water and snacks and left after 9:00PM. I worked 10 hours this day and arrived at the facility in my pajamas to care for my mother. Is this OK? Is this normal? Are you not being paid to care for her, because I'm not. Maybe you should consider putting me on the payroll to compensate me for doing your staffs job? After 9 months of my mother being in the facility, I am continuing to question why you are running 12 hour shifts for employees, when clearly, this is not working. Your staff is overwhelmed and they are exhausted after 8 hours, they can't do it. It appears that this is why you cannot retain staff. There are CNA's that are awesome and are doing this work because they care, but, you continue to place unrealistic demands on them that they cannot meet.<br><br>RESIDENT GRIEVANCE FORM<br><br>DATE: ,d+[DATE]<br><br>RESIDENT: [R12] .<br><br>NAME OF PERSON FILING GRIEVANCE: [POA-KK]<br><br>STATEMENT OF GRIEVANCE (Explanation of incident to include dates, times and witnesses as applicable):<br><br>See statement from CNA who stated she did assist residents [with] cares [and] never made the comment to daughter that she was the only CNA there.<br><br>INVESTIGATED BY: [Signed by DON-B]<br><br>DATE OF RESOLUTION: [DATE]<br><br>SUMMARY OF RESOLUTION:<br><br>See summary<br><br>ADMINISTRATOR'S SIGNATURE: [Signed by NHA-A]<br><br>DATE: [DATE]<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Employee Statements<br><br>Per [CNA-RR] she assisted [resident] about 15 min after family member made her aware of his incontinence. I never told [POA-KK] that I was the only person there. I also did change and assist her, I can't remember the time but I had help from the nurse [and] another CNA. [POA-KK] was rude [and] made [accusations] that I shut her light off but that's because I went to get a new brief.<br><br>Signature: via telephone [CNA-MM]<br><br>[DATE]<br><br>Employee Statements<br><br>Educated staff on answering phone. I also spread (sic) break times so someone will always be in kitchen to answer the phone.<br><br>Signature: [Signed by RN-II]<br><br>Documented Grievance with a date of [DATE] by POA-KK was:<br><br>4:00PM Quarterly Meeting with [Social Worker (SW)-NN], (R12), and myself .<br><br>During the meeting I was very emotional as I attempted to relay how the lack of care my mother receives on an almost daily basis is affecting my life. I cried several times in discussing how I just want the best for her, and just want the individuals who are responsible for her care to do their job, so, I don't have to.<br><br>[SW-NN] appeared very empathetic, however, as I talked about the lack of communication from staff and how this is a large part of the problem, I was not reassured in anyway that anything would change. She stated that she recognized that there are a lot of issues related to staffing, food service, and overall daily operations within the facility. We discussed the progression of (R12's) disease and I requested, again, that staff be made aware of her condition and that they not enter her room and ask her what she needs, but, rather physically check her to ensure she is clean and her diaper is changed. She informed me that she would address this by requesting that she be placed on a two-hour round, where someone would come in and change her every two hours. I informed her that I recognize that there are going to be issues in any facility, but, I wanted to work with staff in any way I could to ensure that the last days (R12) has on the face of the planet will be of comfort and assurance, not chaos.<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | After our meeting, I asked [SW-NN] if she would be willing to meet with me and (R12's) roommate, [R63], she said she would. I had previously spoke with [R63] regarding ongoing issues she is having, and how she doesn't really have anyone to advocate for her. Her [brother] has his hands full, as he is elderly, and there are other family members who are also having severe medical issues that he attends to. Even though he is her POA, he is not really available to address her everyday needs. She did contact him several weeks before this to ask him to borrow her some money, because she does not have access to her money (her wallet is in her apartment). [Brother] came and visited her a few weeks ago and brought her $100. I had started purchasing her some snacks and soda prior to this, but, informed her that I was not in a position to continue to do this for her. I shopped for her on several occasions buying her what she wanted and ensuring her money was accounted for. I also contacted [Dietary] and informed her what she likes to eat and requested changes be made regarding what she was being served, starting with a bowl of oatmeal daily. I had also informed the weekend [RN-II] that she was requesting a clock in her room as she did not know what time it was. My [family member] went and purchased her a battery for her watch so, she at least had that.<br><br>I pointed out to [SW-NN], that [R63] had on a band indicating NO CPR and [R63] had informed me that she did not agree to this and neither did her [brother]. This was extremely concerning giving the implications of what could have happened. [SW-NN] checked her computer and determined that the band was put on in error, she removed it right there. [R63] informed [SW-NN] that she had no issues with me speaking for her and I proceeded to tell her that the woman cannot see. She appeared confused and asked me what I was talking about. I stated that when she arrived at the facility she had glasses (they were red) and then they disappeared. She has not had glasses in 3 months and she cannot see without them. Can you imagine that? You are dependent on other people for everything and you can't even see, because your glasses are gone. [SW-NN] stated that there is an optometrist that comes into the facility and she could help her with this. The smile on the woman's face was priceless! The thought of being able to see people and watch TV again was overwhelming to her. We discussed her bed, and the fact that she is extremely uncomfortable on the air mattress and she requested to get a regular bed. I also informed her that she has no clothes and I had brought her two quilts due to always being cold (they have yet to be washed, this was three weeks ago. I gave her one of (R12's) nightgowns, that she absolutely loves, and we were told that [SW-NN] would look for clothes for her. I informed her that I contacted [R63's], [Case Manager], to see if she would be willing to contact [R63's] landlord to arrange going into her apartment and getting her some of her things including, clothing/slippers, glasses, dentures, etc. [R63] said she trusts [Case Manager] as she has worked with her for 8 years. I did not get a call back from [Case Manager] when I called and left a message, so, [SW-NN] stated she would follow up on this as well.<br><br>The only thing that came as a result of this conversation, is that there was a clock hung in her room. No update on getting a new bed, still no glasses, no clothes, dirty blanket I brought her, nothing. Do you think this is acceptable? She is a human being and does not deserve to be treated this way. Why? Why is this happening to individuals that have been placed in your care? Would this be acceptable for your mother, your father, your sister, your brother, your aunt, your uncle, your loved one - is this acceptable?<br><br>Grievance Follow-Up Page<br><br>Staff Member Following up: [Director of Care Transitions (DCT)-E]<br><br>Title: DCT<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Date [DATE]<br><br>Resolution Communicated To: POA of roommate<br><br>Summary: [DCT-E] [follow up (f/u)] with POA of roommate accordingly [and] onsite [services] referred as needed.<br><br>[Social services] has been in contact [with] appropriate members of other resident's family.<br><br>Social Services Director Signature: [Signed by DCT-E]<br><br>General Manager Signature: [Signed by NHA-A]<br><br>Surveyor noted there was no interview with the person reporting the grievance, no interview with other staff members having contact with the resident during the relevant periods or shifts of the alleged incident, no interview with the residents roommate, no completion of a root cause analysis of all circumstances surrounding the concern, no resolution or response to the resident representative which included date of grievance, summary of grievance, investigation steps, findings, and no resolution outcome and actions taken with date decision was determined.<br><br>Documented Grievance with a date of [DATE] by POA-KK was:<br><br>Before leaving the facility on [DATE] I changed (R12), cleaned her room, had snacks available for her, and water and soda in her fridge. I wrote on a dry erase board that I have in her room, that, I would be out of town on Friday and Saturday, so, she would remember I would not be coming on these days. On Friday morning, I was in an accident in which my truck and trailer were totaled.<br><br>We were driving up North to go fishing and hit ice. My [family member] and I were lucky we were not injured or killed. I called (R12) to tell her what happened and informed her we were fine and we were still going to go on our trip. I informed her that I would call her or she could call me throughout the weekend and everything was fine. I mention this, as you can imagine, having something like that happen, in which I, or [family member], could have been severely injured or killed is extremely stressful.<br><br>At approximately 4:00PM I received a call from (R12) and she was hysterical.<br><br>She said she wasn't sure what was going on, but, someone had come into her room and placed her microwave and toaster on the floor. She informed me that she attempted to ask the man why he was doing this and he simply stated, it's direction from the big boss. I attempted to calm her down and tell her it was OK, I would figure out what the issue was and would call her back.<br><br>I contacted [DOCT-E], regarding the matter and left a message. She called me right back, and I informed her I was extremely confused about what was going on. I asked her why someone would do this to my mom.<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | She stated, we aren't doing anything to your mom. I stated, let me choose my words wisely, why did someone not speak to me if this was a problem and instead, this was done without my knowledge when I was not there, clearly upsetting my mom? I stated, the microwave and toaster have been in her room for 5 months, and there has never been any issues and no one has ever said anything to me about it. I previously contacted the state and was informed that there are no regulations regarding having these items in her room, so, what is the issue? She stated, it is a safety issue. I stated, if this is the case, why could you not wait to talk to me about it directly, and instead you do this when clearly the staff knew I would not be there due to what I wrote on the dry erase board. She stated, we don't have time to wait for everyone . I hung up the phone as I will no longer listen to her speaking to me, in her condescending way.<br><br>Wait for me? I am there five days a week and she is aware of this, but, nothing was said by her or any other staff member about this until I take a weekend off?<br><br>You have no problem with me being a CNA, a Social Worker, a Maintenance worker, or a Housekeeper, but, this you have an issue with? What safety issue is there? I have yet to have anyone explain to me what potential harm this may cause to property or a person. I have read the Admission Packet and there is nothing in there specific to this, so, I am requesting in writing, as to whether or not I have your permission to keep the items in the room, unplugged, and they will only be used by me to feed (R12), because the facility appears to have issues in this area.<br><br>Do you really think that I want to drive myself insane everyday trying to figure out what I can feed her? If there are days when I am working and I am unable to bring her a home cooked meal, I have to have something there to give her. Being able to heat up some soup or give her some peanut butter toast, should not be a luxury. For whatever reason, that there is not a communal microwave available, unless I ask staff to heat something up, is an inconvenience to me and them. I would prefer that they assist the residents with their needs versus running around daily to heat up food for (R12) - it doesn't make sense. I am [AGE] years old, and I am quite versed in how to operate a microwave and a toaster.<br><br>Furthermore, if the food that was being given to her was adequate, I would not have to do this, which, trust me, would make my life so much easier. No fresh fruit, no salads, no soup (even though it's on the ticket daily), no snacks, no nothing. Do you like the tuna casserole that is being served to these people every other week? You should try it, if you haven't. Most of those residents who don't have anyone to advocate for them do not even get a soda, or c |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253<br><br>Based on record review and interview, the facility did not ensure residents were free from neglect or abuse for 7 (R47, R69, R70, R42, R27, R66, and R67) of 13 residents reviewed for abuse and neglect.<br><br>R47, R69, R70, R42, and R27 did not receive treatment and services when needed or in a timely manner from facility staff and called the police to intervene in order to get the care they needed.<br><br>R66 and R67 had a resident-to-resident altercation, and the incident was not investigated thoroughly to determine a root cause analysis in order to implement interventions to protect R66, R67, and other residents from future potential abuse.<br><br>Findings include:<br><br>The facility policy and procedure entitled Abuse Policy dated 11/2018 states: The facility Administrator will be designated as the facility Abuse Coordinator and is responsible for overseeing all components of the abuse policy.<br><br>Prevention: This facility will prohibit abuse, neglect, and mistreatment of residents. Resident care plans will be reassessed on a regular basis and any necessary changes will be implemented as needed. Resident behaviors will be monitored regularly for any changes and any aggressive behaviors that might lead to abuse will be assessed and any necessary interventions will be implemented. This facility will notify all residents of the Abuse Policy and will inform them that any concerns and/or allegations of abuse should be reported to facility administration without any fear of retaliation. Residents will also be notified regarding the facility grievance policy and 24-hour hotline. This facility will make every effort to identify residents who are at high risk for potential abuse of other residents. Facility staff will report immediately to facility administration any identified behaviors, injuries, bruises, and/or any concerns of potential abuse of residents.<br><br>Investigation: Any allegation of abuse must be reported immediately to the facility Director of Nursing and Administrator. The facility Administrator will initiate and complete a thorough investigation of the allegations and will gather and document all relevant information. Facility Administrator or designee will visit the resident and notify them that they are safe and that an investigation has been initiated. Immediate action will be taken to protect facility residents from further abuse. Two facility staff members will conduct an interview with the resident. The responsible party will be contacted and notified of the allegation. Interviews will be conducted and documented with any witnesses, staff, other residents, or visitors who potentially have any knowledge or information regarding the allegation. Interviews will be conducted with a sample of other residents residing on the same unit as the resident. Every staff member working on the specific unit that the resident resides who was working or present during the period of time of the allegation will be interviewed. A licensed nurse will assess the resident for signs of injury and notify the physician and responsible party of any findings. All interviews, statements, and/or information will be documented and collected by facility Administrator or designee.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Protection: . If another resident is identified in the allegation, a licensed staff member will complete an evaluation of the resident's status and condition and notify the physician to determine if any treatment is necessary. Facility Administrator or designee will assess all of the relevant information and determine whether or not a discharge from the facility is needed. The resident will be prohibited from having any contact with the resident alleging abuse while the investigation is completed. The facility Administrator or designee will determine if further action and/or intervention is needed upon completion of the investigation.<br><br>Definitions:<br><br>Abuse: the infliction of physical, sexual, or emotional injury or harm including financial exploitation by any person, firm, or corporation.<br><br>Neglect: the failure to provide services to an eligible adult by any person, firm, or corporation with a legal or contractual duty to do so, when such failure presents either an imminent danger to the health, safety, or welfare of the client or a substantial probability that death or serious physical harm would result.<br><br>1.) R47 was admitted to the facility on [DATE] with diagnoses of spinal stenosis, diabetes, pressure ulcer of the right hip, and pressure ulcer to the right buttock with Methicillin Susceptible Staphylococcus Aureus infection. R47's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated R47 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14. R47's Activities of Daily Living (ADL) Care Plan dated 7/6/2022 showed R47 needed assistance with all aspects of care.<br><br>On 1/10/2023 at 9:31 PM, R47 called 911 from the facility to report to the police there were no staff on the floor and R47 wanted to go to bed. The police Case Details Report stated R47 told the police officer R47 called 911 because R47 could not find a staff member to help R47 get to bed. The police officer located staff and advised them of R47's complaint.<br><br>Surveyor did not find any documentation in the facility or R47's medical record of R47 calling the police on 1/10/2023 or an investigation of why R47 felt the need to call the police.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 2/22/2023 at 12:48 AM, R47 called 911 from the facility. The police Incident Report stated R47 called 911 due to not being cared for and not being able to reach facility staff. The Report stated the police officer attempted to ring the exterior intercom system due to the business being locked; no staff answered the call for several minutes. The police officer observed an employee walk past the front entrance and let the police officer into the building. The police officer informed the employee why the police were there, and the staff member escorted the police officer to R47's room. R47 told the police officer that R47 had been in the wheelchair from 1:00 PM that afternoon until the time the police officer arrived at approximately 12:50 AM. R47 told the police officer R47 had been trying to contact facility staff by calling on R47's phone but was unable to reach anyone. R47 told the police officer R47 tried to call the staff approximately 30-40 times with no results. R47 told the police officer R47 had back pain from sitting the wheelchair for an extended period of time and was sitting in a urine-soaked adult diaper. The police officer noted a strong smell of urine and feces while inside the room. The police officer noted a nurse was inside R47's room and had already moved R47 from the wheelchair to the bed when the police officer had arrived. The nurse, Licensed Practical Nurse (LPN)-G, was assisting R47 and LPN-G informed the police officer the facility was short staffed and that most of the staff had been on the other side of the facility attending to patients. LPN-G left the room after seeing to R47's needs. R47 told the police officer this was not the first time R47 had been treated that way since R47's arrival. R47 told the police officer R47 was supposed to have showers twice a week on Saturdays and Wednesdays but that does not routinely happen. The police officer asked R47 if a shower was missed on a particular day, does staff offer to give R47 a shower the next day. R47 answered R47 had to wait until the next scheduled shower day. R47 told the police that R47 had not yet received medication that was scheduled to be given at 11:00 PM. R47 told the police officer that LPN-G said LPN-G would be back with the medication. The police officer noted that no medications were given to R47 in the hour that the police officer was in the building. The police officer attempted to look for LPN-G prior to leaving the facility to follow up on the complaint and the medication but was unable to locate any staff within the facility. The police officer was unable to be let out of the facility due to it being secured and needing an employee to unlock the front door. In order for the police officer to exit the facility, the police officer had to use an emergency unlock button to open the door.<br><br>Surveyor reviewed medication administration times for R47 on 2/21/2023. R47 had seven medications scheduled at 8:00 PM. Those medications were administered at 10:43 PM, prior to the police officer's arrival.<br><br>Surveyor did not find any documentation in the facility or R47's medical record of R47 calling the police on 2/22/2023 or an investigation of why R47 felt the need to call the police.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 3/9/2023 at 3:19 PM, Surveyor asked LPN-G what LPN-G could recall of the police coming to the facility on [DATE] at 12:48 AM. LPN-G recalled they were short-staffed that night with only one Certified Nursing Assistant (CNA) on the unit and R47 was a Hoyer transfer so R47 could not be put back to bed with only one staff. LPN-G stated the on-call manager came in and assisted LPN-G to get R47 into bed. Surveyor asked LPN-G if R47 was incontinent at the time R47 was put to bed. LPN-G could not remember. Surveyor asked LPN-G if R47 had gotten medication that evening. LPN-G stated R47 had received medication before the police arrived. Surveyor asked LPN-G how long it normally takes nurses to pass medications on the unit. LPN-G stated it takes 3-4 hours to pass medications if there are two nurses working on the unit, but if there is only one nurse working, it can take six hours to pass medications. LPN-G recalled the CNA that was working on that unit had been pulled to help on another unit, so it was just LPN-G on the unit alone and that was why LPN-G had to wait for the on-call manager to come in to transfer R47 to bed. Surveyor asked LPN-G if anyone else was aware the police had been called to the facility. LPN-G did not know.<br><br>On 2/23/2023 at 9:52 PM, R47 called 911 from the facility. The police Case Details Report stated a 911 hang up call came from the facility and there was no answer on call back. Police Officer (PO)-OO reported speaking to R47 who stated R47 had been calling for an hour and a half for someone to come and lift R47 into bed from the wheelchair. Staff assisted R47 into bed once PO-OO had arrived.<br><br>In an interview on 3/8/2023 at 6:10 PM, Surveyor asked PO-OO about the events at the facility on 2/23/2023. PO-OO stated the police call center had received about four different 911 calls from the facility and R47 was the only person that stayed on the phone. R47 had called from the cell phone and said R47 had been trying to find medical personnel to assist R47 into bed from the wheelchair. PO-OO stated upon arriving at the facility, PO-OO was unable to enter through the front door as nobody would answer the intercom system to allow access to the building. PO-OO was able to enter through an emergency exit after knocking on the door and getting a nurse's attention. PO-OO stated the nurse advised PO-OO that the nurse and one CNA had been taking care of 38 different patients. PO-OO went to speak to R47 and found R47 had just been put into bed and a CNA was in the room assisting R47. PO-OO walked the different units to try and determine where the other 911 calls originated, and all staff advised PO-OO they were unaware of any other issues.<br><br>Surveyor did not find any documentation in the facility or R47's medical record of R47 calling the police on 2/23/2023 or an investigation of why R47 felt the need to call the police.<br><br>In an interview on 3/13/2023 at 9:35 AM, Surveyor asked LPN-QQ what LPN-QQ could recall on 2/23/2023 when the police responded to a 911 call placed by R47. LPN-QQ stated R47 wanted to go to bed, but they were short-staffed with only one nurse and one CNA on the unit. LPN-QQ stated they were not ignoring R47 or R47's needs, but R47 was a transfer with a mechanical lift and needed two staff members to transfer R47. LPN-QQ stated they responded to R47 when they had the time. Surveyor asked LPN-QQ if R47 was incontinent at the time R47 was transferred into bed. LPN-QQ could not remember. Surveyor asked LPN-QQ what staff do when 911 is called by a resident. LPN-QQ stated LPN-QQ would let the managers or supervisor know 911 was called.<br><br>2.) R69 was admitted to the facility on [DATE]. R69's admission Minimum Data Set (MDS) assessment dated [DATE] indicated R69 had moderate cognitive impairment with a Brief Interview of Mental Status (BIMS) score of 11. R69's Activities of Daily Living (ADL) Care Plan initiated 10/21/2022 indicated R69 needed assistance with all aspects of care.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 12/4/2022 at 9:00 AM, R69 called 911 from the facility. The police Case Details Report stated R69 needed a monitor reattached, and the nurses were not helping R69. R69 told the police officer staff would not plug in a machine in R69's room and R69 was told it would have to wait until later. R69 could not say what the machine's function was. Staff came to R69's room and plugged the machine in.<br><br>Surveyor did not find any documentation in the facility or R69's medical record of R69 calling the police on 12/4/2022 or an investigation of why R69 felt the need to call the police.<br><br>In an interview on 3/13/2023 at 10:21 AM, Registered Nurse (RN)-SS was working on the unit with R69 on 12/4/2022. RN-SS did not recall R69 calling the police. RN-SS stated if RN-SS knew the police came to the facility, RN-SS would let management know. RN-SS stated the police do not necessarily talk to staff when they come in. RN-SS stated some residents call 911 all the time. RN-SS stated RN-SS has seen the police in a resident room and stopped in to ask if they needed something, but the police do not necessarily check in with the nurse. RN-SS stated the police have to check in at the front desk when they come in, but RN-SS did not know what the police tell the front desk for the reason of the visit.<br><br>3.) R70 was admitted to the facility on [DATE]. R70's admission Minimum Data Set (MDS) assessment dated [DATE] indicated R70 was cognitively intact with a Brief Interview of Mental Status (BIMS) score of 15. R70's Activities of Daily Living (ADL) Care Plan initiated on 12/14/2022 indicated R70 needed assistance with all aspects of care.<br><br>On 12/17/2022 at 7:31 AM, R70 called 911 from the facility. The police Case Details Report stated R70 claimed R70 was being abused, said no one was helping R70, R70 requested water two hours ago and had not received it, and no one was emptying the urine bottle. A nurse walked in at the end of the 911 call and stated R70's call light had just gone on. The police officer checked on R70 and a nurse was in the room with R70.<br><br>Surveyor did not find any documentation in the facility or R70's medical record of R70 calling the police on 12/17/2022 or an investigation of why R70 felt the need to call the police.<br><br>4.) R42 was admitted to the facility on [DATE]. R42's admission Minimum Data Set (MDS) assessment dated [DATE] indicated R42 was cognitively intact with a Brief Interview of Mental Status (BIMS) score of 13. R42's Activities of Daily Living (ADL) Care Plan initiated on 11/30/2022 indicated R42 needed assistance with all aspects of care.<br><br>On 12/17/2022 at 12:30 PM, R42 called 911 from the facility. The police Case Details Report stated R42 said the nurses have not come to R42's room to provide R42 with oxygen. The police officer reported contact was made with the facility staff who reported they were aware of the situation and would be taking care of the issue.<br><br>On 12/17/2022 at 1:24 PM in the progress notes, nursing charted an SBAR (Situation, Background, Assessment, Recommendation) due to R42 complaining of shortness of breath. R42's vital signs were blood pressure 126/77, pulse 86, temperature 97.3 degrees, and oxygenation 99% on room air. An order was received to send R42 to the hospital for evaluation and treatment. At 6:56 PM in the progress notes, nursing charted R42 was admitted to the hospital for shortness of breath. At 7:04 PM in the progress notes, nursing charted the hospital admitting diagnoses were COVID-19, respiratory distress, acute pulmonary edema, and to manage hemodialysis.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Surveyor did not find any documentation in the facility or R70's medical record of R42 calling the police on 12/17/2022 or an investigation of why R42 felt the need to call the police.<br><br>5.) R27 was admitted to the facility on [DATE]. R27's admission Minimum Data Set (MDS) assessment dated [DATE] indicated R27 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14. R27's Activities of Daily Living (ADL) Care Plan initiated on 11/25/2022 indicated R27 needed assistance with all aspects of care. R27's Manipulation Behavioral Problem Care Plan initiated on 12/24/2022 indicated R27 uses the call light after needs have been met, false accusations that staff are not assisting R27 and R27 feels threatened. Surveyor reviewed R27's progress notes and no documentation was found in R27's record of manipulative behaviors.<br><br>On 1/7/2023 at 1:14 AM, R27 called 911 from the facility. The police Case Details Report stated a 911 call was received when R27 was pushing phone buttons and then disconnecting. Police dispatch took an immediate second 911 call from R27 and R27 stated R27 was tangled in the phone cord, blankets, and boots. R27 did not need an ambulance but wanted someone to untangle R27 and bring R27 a glass of water. A phone call was placed to the facility to advise them of R27's request. The police officer confirmed there were no problems.<br><br>Surveyor did not find any documentation in the facility or R27's medical record of R27 calling the police on 1/7/2023 or an investigation of the circumstances of the police responding to a 911 call.<br><br>On 2/8/2023 at 5:27 PM, R27 called 911 from the facility. The police Case Details Report stated R27 felt R27 and others at the facility were being mistreated. While dispatch was on the phone with R27, a staff member came into R27's room and was yelling at R27 and telling R27 not to press the call light. R27 told the police officer R27 feared for his physical and mental safety. R27 told the police officer that R27 felt threatened by the staff's demeaning attitude and threatening looks. R27 told the police officer that R27 had not been hurt but does not feel comfortable and R27's complaints have not been heard. Staff told the police officer that a supervisor had spoken with R27 around 4:00 PM about R27's concerns and that R27 suffers from dementia.<br><br>On 2/8/2023 at 6:48 PM in the progress notes, LPN-FF charted R27 called 911 at approximately 6:00 PM while LPN-FF was taking a 15-minute break. LPN-FF got a report that R27 was stating R27 felt unsafe, and staff had been threatening him with our eyes. LPN-FF charted the police did not find any abuse in their investigation. LPN-FF talked with R27 about the concerns and reassured R27 that staff have R27's best interest and R27 should feel safe in the environment. LPN-FF talked to R27 and calmed R27 down. During the conversation, R27's roommate laughed at comments made and that upset R27. LPN-FF again reassured R27 that R27 was safe, and no one had physically harmed R27.<br><br>In an interview on 3/13/2023 at 10:26 AM, LPN-FF stated LPN-FF was on a 15-minute break on 2/8/2023 when R27 called the police. LPN-FF stated a Med Tech was working on the unit covering LPN-FF until LPN-FF came back from break. Surveyor asked LPN-FF if LPN-FF notified anyone that the police were in the building talking to R27. LPN-FF stated the nurse manager would be told and then it would be passed on in report that the resident called 911. LPN-FF stated that was not the first time R27 had called the police. LPN-FF stated R27 told LPN-FF that the CNAs were giving R27 threatening stares. LPN-FF stated LPN-FF talked R27 down and R27 thought that the staff did not want R27 at the facility.<br><br>GRIEVANCES<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Surveyor reviewed the facility grievance log. No entries were made in the log that correlated to the 911 calls placed by residents that were not getting care or services in a timely manner.<br><br>INTERVIEWS<br><br>On 3/8/2023 at 3:00 PM, Surveyor asked Nursing Home Administrator (NHA)-A and Chief Nursing Officer (CNO)-B for a log or list of when the police have been called by staff and residents to the facility using 911 since November 2022. NHA-A stated there is no log of when police come to the facility.<br><br>In an interview on 3/9/2023 at 2:15 PM, Surveyor asked NHA-A if NHA-A was aware of when the police are called to the facility by residents. NHA-A stated some residents inappropriately call the police. NHA-A stated any care concerns are written up as grievances and if there is an allegation of neglect, it is filed with the State Agency. Surveyor shared with NHA-A the police were called to the facility 26 times in December 2022 and January 2023, and more calls came in February 2023 and March 2023. (A total of 42 calls were provided to Surveyor from the police department.) NHA-A was not aware of the police being called that many times. Surveyor asked NHA-A if NHA-A was made aware when residents call 911 or when the police are in the building investigating a call. NHA-A stated NHA-A is told about any actual emergencies called to 911, but otherwise staff do not let NHA-A know about any other calls. Surveyor shared with NHA-A the concern residents are calling 911 because they are not receiving the cares that they need in a timely manner and the only recourse they have is to call 911 which could be considered an allegation of neglect. NHA-A stated they will discuss this in the next QAPI meeting and educate staff to let management know of abuse or neglect allegations. NHA-A stated if the resident calls 911 because they feel they are not getting the care they need, then, if it was NHA-A, NHA-A would ask to transfer to another facility.<br><br>In an interview on 3/13/2023 at 10:37 AM, Surveyor asked Assistant Chief Nursing Officer (ACNO)-D what the process or procedure was when police enter the building to answer a 911 call that was placed by a resident. ACNO-D stated NHA-A and CNO-B want to know about any time the police are in the building. ACNO-D was not sure if the police signed in when they entered the building. ACNO-D stated the police usually ask where the resident is and then they proceed to the resident's room. Surveyor shared with ACNO-C the conversations with RN-SS and LPN-FF; they would let the Unit Manager or supervisor know of the police presence. ACNO-D agreed and stated the Unit Manager would pass it up the chain of command. Surveyor shared with ACNO-D that NHA-A was unaware of when the police were in the building and Surveyor could not find any documentation that the 911 calls were being followed up to determine if they were allegations of abuse or neglect. ACNO-D did not know if any of the 911 calls were being investigated. Surveyor shared with ACNO-D that there was a gap in the facility process for when residents call 911 and staff pass that information of police being in the building up the chain of command, NHA-A, who is at the top of the chain, was unaware the police were in the building and no follow-up was done to determine why residents are calling 911 for care concerns.<br><br>In an interview on 3/13/2023 at 10:53 AM, RN-UU stated if a resident calls 911, RN-UU lets the CNO, the ACNO, or the Manager on Duty know about the situation.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 3/13/2023 at 11:17 AM, Hospitality Director-VV stated if a police officer comes through the front door, the receptionist will call Hospitality Director-VV and Hospitality Director-VV will notify administration. Hospitality Director-VV stated about seven to eight months ago, a resident with a common first name called 911 and Hospitality Director-VV and the police could not discover who called. Hospitality Director-VV stated they went to every room with a resident by that name and checked on every unit but were unable to find anyone that called or had a concern. Surveyor asked Hospitality Director-VV if a grievance is filled out for anyone who calls 911 with care concerns. Hospitality Director-VV stated it depends on if the concern was legitimate or not. Hospitality Director-VV stated some residents are frequent callers or have dementia, so the facility lets the family know and for frequent callers, it is in their care plan and the family is made aware. Surveyor asked Hospitality Director-VV how a 911 call is handled in the middle of the night when there is no one at the reception desk. Hospitality Director-VV stated there is a PM Manager through the evening shift and after hours there is a nurse in charge. Hospitality Director-VV stated there is a button at the front door that rings to all the units and a message can be left that the units can pick up and hear.<br><br>In an interview on 3/13/2023 at 2:27 PM, Director of Care Transitions-E stated employees on orientation learn how to fill out a grievance form and also know they can let their supervisor know of any grievances so the supervisor can follow up. Surveyor asked Director of Care Transitions-E how 911 calls are handled regarding grievances. Director of Care Transitions-E stated it depends on the scenario; if the staff did not come and the call light was on for a long time, then yes, a grievance form would be filled out. Director of Care Transitions-E stated if the resident used a life alert button instead of the call light, then no grievance form would be filled out, so it just depends. Surveyor asked if a log was completed when the police are called by a resident in order to determine if the resident had a legitimate grievance or allegation of abuse or neglect. Director of Care Transitions-E stated they do not keep a log for when the police are called. Surveyor asked Director of Care Transitions-E if any grievance was filed in the last three months due to a 911 call placed by a resident. Director of Care Transitions-E stated they would have to look. Surveyor supplied Director of Care Transitions-E with a list of residents that had called 911 with care concerns. On 3/14/2023 at 8:57 AM, Director of Care Transitions-E stated there were no grievances filed for any of the residents on the list Surveyor had provided.<br><br>On 3/13/2023 at 3:12 PM, Surveyor shared with Director of Clinical Operations-H, Director of Clinical Operations-I, and ACNO-D the concern no follow up was completed for residents that called 911 when cares and services were not being provided by staff and that those could be considered allegations of neglect. Surveyor shared NHA-A was not aware of when the police were in the building to investigate the 911 calls. No further information was provided at that time.<br><br>Resident to Resident abuse concerns:<br><br>6.) R66 was admitted to the facility on [DATE] and had diagnoses that include type 2 diabetes, interstitial lung disease, weakness, unsteadiness on feet, dementia, and anxiety. R66's quarterly Minimum Data Set (MDS) dated [DATE] indicated R66 had moderately impaired cognition with a Brief Interview Mental Status (BIMS) score of 9 and coded R66 needing supervision with bed mobility, transferring, walking, and toileting, and limited assist with dressing and extensive assist with hygiene. R66 used a wheeled walker and had episodes of hallucinating 1-3 days in a week, at risk for wandering and had a history of falls. R66 was occasionally incontinent of urine and frequently incontinent of bowel.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R67 was admitted to the facility on [DATE] and had diagnoses that include rhabdomyolysis (damage to muscle tissue), type 2 diabetes, weakness, age-related physical disability, and post-traumatic stress disorder. R67's significant change MDS dated [DATE] indicated R67 had intact cognition with a BIMS score of 15 and coded R67 needing limited assist with bed mobility and hygiene and extensive assist with transferring, dressing, and toileting. R67 required a Hoyer lift and assistance of 2 people with transfers and was not ambulatory. R67 was always incontinent of urine and bowel.<br><br>Surveyor reviewed the facility self-report submitted to the State Agency on 3/8/2023. Documented under Investigation Summary the Nursing Home Administrator (NHA)-A documented a summary statement of the self-report. NHA-A wrote, at approximately 3:30 AM on 3/8/2023, R66 got up to use the bathroom. NHA-A wrote when R66 came out of the bathroom, R67 noticed R66's bridge of nose was bleeding and R67 asked what happened to R66's nose. NHA-A wrote that R66 replied to R67 that R67 hit R66 and R66 asked R67 to get out of R66's room, R66 then pulled R67's covers off the bed. NHA-A wrote the facility conducted an investigation to ensure there was no truth to R66's statement. NHA-A wrote R66 has a BIMS score of 9/15 with increase confusion at nighttime. NHA-A wrote on 3/2/2023 R66 had a fall that resulted in bruises and abrasions that were fairly minor and R66 was able to be treated at the facility. NHA-A wrote the abrasion on the bridge of R66's nose was documented as a result of that fall. NHA-A wrote that interviews and reenactment of the situation between R66 and R67 leading to the allegation was conducted. NHA-A wrote that NHA-A does not see a plausible way for R67 to strike R66 and cause harm. NHA-A wrote R67 lacks strength to cause any harm to R66 and R67's bedridden status reduces the likelihood of the situation to have occurred. NHA-A wrote that R66 and R67 were moved into new rooms with R66 and R67's consent. NHA-A wrote that R66 in not able to recall the event that occurred. NHA-A wrote R67 was able to recall the event and R67 states R67 feels safe and does not have any adverse emotional trauma related to what had occurred.<br><br>On 3/8/2023 the NHA-A obtained a statement from R67. NHA-A wrote R67 stated that last night around 3:30 AM R66 got up to go to the bathroom. When R66 came out, R67 noticed R66 nose was bleeding. R67 asked R66 what happened and R66 stated R67 punched R66. R66 then took of R67's covers. NHA-A wrote that R67 states R67 blew off R66 and went back to bed.<br><br>There are two certified nursing assistant (CNA) statements in the self- report that were obtained via phone by the staffing coordinator. The two statements do not have dates on them. In the first statement the staffing coordinator wrote the CNA did not see anything, the CNA walked into R66 and R67's room and R66 was bleeding. The CNA did not witness a fight. On the second statement the staffing coordinator wrote the CNA did not witness an altercation. The CNA went into R66 and R67's room and there was an abrasion on top of R66 nose. The CNA asked R66 what happened and R66 did not respond. The CNA stated that R67 mentioned R66 was messing with R67's bed.<br><br>On 3/8/2023 at 8:21 AM in the progress notes for R66, nursing charted R66 had an unwitnessed physical altercation with R67. Nursing charted according to R66, R67 swung at R66. R66 has an abrasion to nose. Nursing charted R66 had no pain and R66's vital signs were stable, pain and skin assessment completed. Nursing charted that R66's POA, Physician, and administration was notified.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 3/8/2023 at 8:32 AM in the progress notes for R67, nursing charted R67 had an unwitnessed altercation with R66. Nursing charted according to R67, R66 removed R67's covers off of R67 after R66 returned from the bathroom. Nursing charted R67 stated R66 told R67 to get out of R66's house. Nursing charted R67 denied hitting R66. Nursing charted R67 has no signs of skin alterations, denies pain, vital signs were stable, and a skin/ pain assessment were completed. Nursing charted that R67's POA, Physician, and administration were notified.<br><br>On 3/13/2023 at 8:35 AM Surveyor observed R67 in the bedroom next to R66's room. R67 was lying in bed. Surveyor asked R67 about the altercation between R66 and R67 that occurred on 3/8/23. R67 replied R67 woke up and saw R66's nose bleeding. R67 asked R66 what happened and R66 took R67's sheets off and R66 said R67 hit R66. R67 stated R67 never hit R66 and R67 was glad R67 moved out of the room. Surveyor asked R67 when R67 moved rooms. R67 replied almost immediately the next morning R67 moved to the room next door. Surveyor asked R67 if R67 sees R66 anymore. R67 replied that R [TRUNCATED] |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20025<br><br>Based on interview and record review the facility did not ensure 2 (R42 and R12) of 13 residents with allegations of abuse or neglect had these allegations reported to the State agency.<br><br>R42's Managed Care staff reported to the facility on [DATE] regarding an allegation of neglect that occurred on 12/17/22.<br><br>The allegation indicates the facility staff did not give R42 oxygen when he needed it so R42 called 911 for assistance. This allegation was not shared with NHA A until 12/28/22. The allegation was investigated but not reported to the state agency.<br><br>R12 had an allegation of abuse that was not reported to the State agency.<br><br>Findings include:<br><br>The facility's abuse policy dated November 2018 indicate:<br><br>Reporting of potential abuse-<br><br>If an allegation of abuse is made, the facility employee who becomes made aware of the allegation is required to immediately report the allegation to the facility Administrator. If the Administrator is not present, the employee should immediately report the allegation to their immediate supervisor and/or the facility Director of Nursing. The facility Administrator or designee shall report the initial notification to the Department of Health and Senior Services immediately (within 2 hours if actual harm is suspected, and 24 hours for all other alleged allegations. The initial report should contain the following information, if known at the time of report:<br><br>-Name, age, diagnosis and mental status of the resident allegedly abuse or neglected<br><br>-Type of abuse reported (physical, sexual, misappropriation, neglect, verbal or mental abuse)<br><br>-Date, time, location and circumstances of the alleged incident<br><br>-any obvious injuries or complaints of injury<br><br>-Steps facility has taken to protect the resident<br><br>-Any additional information relevant to the allegation<br><br>The administrator or designee will also inform any responsible party of the allegation and that an investigation is being conducted. If reasonable suspicion of a crime has occurred, local law enforcement shall be notified immediately.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Five day Final abuse investigation report. Within five working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Health and Senior Services.<br><br>1.) R42 was admitted to the facility on [DATE] with diagnoses of ventricular fibrillation, metabolic encephalopathy, COPD (chronic obstructive pulmonary disease), type 2 diabetes and atrial fibrillation. R42 was discharged on [DATE] to the hospital and did not return to the facility.<br><br>Surveyor reviewed the grievance log and discovered a grievance for R42 dated 12/28/22.<br><br>The grievance indicate R42's Managed Care Staff corresponded with the facility on 12/21/22 via a provider portal. The correspondence indicates on 12/17/22 R42 was complaining of having shortness of breath and the facility nursing staff just came in by R42 checked his oxygen level and stated it was fine and left without resolving the issue of his shortness of breath. R42 had to call 911 himself to be transported to the hospital.<br><br>The facility did not conduct the investigation until 12/28/22.<br><br>On 3/13/23 at 1:30 p.m. Surveyor interviewed Director of Care Transition E. Surveyor asked why the investigation began on 12/28/22, when the facility received the correspondence on 12/21/22. Director of Care Transition E stated human resources is the only one that has access to that portal, and they were on vacation. So, when they came back from vacation, they reported this allegation to Nursing Home Administrator (NHA) A. Surveyor asked Director of Care Transition E if this investigation was reported to the state agency and she stated it was not.<br><br>On 3/13/23 at 3:20 p.m. Surveyor explained to Assistant Chief Nursing Officer D the concern an allegation of neglect was not investigated timely because only one staff person has access to a portal that communicates with the Managed Care and concern this investigation was not reported to the State agency. Assistant Chief Nursing Officer D had no further information to provide.<br><br>40533<br><br>2.) Surveyor reviewed facility's Grievances policy with a date of April 2022. Documented was:<br><br>Grievance Guideline<br><br>Purpose: To provide a process to voice grievances (such as those about treatment, care, management of funds, lost clothing, or violation of rights) and respond with prompt efforts to resolve while keeping the resident and / or resident representative appropriately apprised of progress toward resolution .<br><br>- Consistent with S483.12(c(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued .<br><br>Upon receipt of a grievance or concerns, the Grievance Official will review the grievance, determine immediately if the grievance meets a reportable complaint consistent with the facility Abuse Prevention Policy. The Grievance Official will immediately report all alleged violations involving neglect, abuse, including injuries of unknown sources and / or misappropriation of resident property by anyone to the Administrator as required by State Law .<br><br>R12 was admitted to the facility 6/24/22 with diagnoses that included Unspecified Dementia without Behavioral Disturbances, Encounter for Surgical Aftercare Following Surgery on the Digestive System and Adult Failure to Thrive. R12 had designated her daughter as Power of Attorney (POA)-KK.<br><br>Surveyor reviewed documented Grievance with a date of 2/8/23 by filed by POA-KK about R12 . Documented was:<br><br>I was at the facility from 4:00PM until 6:30PM. I fed her, toileted her, cleaned her dentures, combed her hair, washed her, and put a clean diaper on her. At 8:30PM I received a call from her crying and apologizing, stating she didn't know what to do. She had been waiting for a bed pan since 7:30PM and no one had come. She couldn't help it and had a bowel movement in her diaper and was sorry. I directed her to hit the call button while she was on the phone with me. Someone came in almost immediately, (R12) attempted to tell her she needed help and had been waiting an hour but, she shut off her call button and left the room stating she would be back. I told (R12) to hit the button again. She came back into the room, went directly to shut the call light off and I told (R12) to tell her I wanted to speak with her. Due to her dementia my mother sometimes states that I am her mother, she stated to the aid, my mother wants to talk to you I could hear her laughing at her and stated, YOUR MOTHER wants to talk to me?<br><br>Hahahahhaha. (R12) responded, yes, my mother. She got on the phone and I asked her whom I was speaking to, she said [Certified Nursing Assistant (CNA)-O]. I stated that (R12)had waited over an hour for a bed pan and seeing as no one responded to her call light she defecated in her diaper and was now sitting in crap and had been for quite some time. She responded to me, well, (R12) isn't the only person here. I stated, you did not just say that to me did you [CNA-O]? I continued, you are going to say that to me when (R12) has been sitting in shit for an hour and calling me crying? I told her I was aware that (R12) is not the only resident there, and I know this as I am there a minimum of five days a week. I asked her if she wanted me to come there and she asked me what would I come there for and I stated, to do your job. I stated that the time it was taking her to argue with me on the phone about doing her job, she could have already changed her. I asked her directly if she would please help (R12) and change her diaper, I stated that I would pay her. She said then said she would take care of it. I thanked her and asked her to tell (R12) I would call her back in 15 minutes. I called back about 10 minutes later and [CNA-O] was just leaving the room. (R12) thanked her and her response was, YEP.<br><br>RESIDENT GRIEVANCE FORM<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | DATE: 2/25<br><br>RESIDENT: [R12] .<br><br>NAME OF PERSON FILING GRIEVANCE: [POA-KK]<br><br>STATEMENT OF GRIEVANCE (Explanation of incident to include dates, times and witnesses as applicable):<br><br>Writer spoke at length [with] CNA via telephone who stated all allegations were untrue. See statement<br><br>INVESTIGATED BY: [Signed by Director of Nursing (DON)-B]<br><br>DATE OF RESOLUTION: 2/28/23<br><br>SUMMARY OF RESOLUTION: unable to substantiate<br><br>ADMINISTRATOR'S SIGNATURE: [Signed by DON-B]<br><br>DATE: 2/28/23<br><br>Employee Statements<br><br>Per CNA she did not laugh [at] daughter, she did not state your mother isn't the only one here. [R12] was never sitting in [feces], I [check and changed] her every two hours [and] went into her room multiple times to see if she needed anything. [POA-KK] was very rude [and] aggressive to staff per norm [and] was making false allegations that were not true.<br><br>Signature: via telephone with [CNA-O]<br><br>2/28/23 [Signed by DON-B].<br><br>Surveyor noted that CNA-O allegedly laughed at resident and made fun of her. Surveyor noted this as an allegation of abuse. Surveyor reviewed self-reports submitted to the state agency. There was no report of abuse from 2/8/23 for R12 reported to the state agency.<br><br>Surveyor reviewed documented Grievance with a date of 2/20/23 by filed by POA-KK about R12. Documented was:<br><br>On the above date, I received a call from (R12's) [Hospice CNA]. She informed me that this morning was the 3rd time in two weeks where she had found (R12) soaked in urine from head to toe. She informed me that she had completed a full bed change, bathed her, and put clean clothes and a fresh diaper on her. While I was on the phone with her, she was out by the nurse's station attempting to speak to someone regarding the issue. The two aids she spoke to said they didn't know who was in charge. She talked to [RN-SS] and she was told that she could speak to [Assistant Chief Nursing Officer (ACNO)-D]. I told her where her office was and she was going to attempt to speak with her. Due to my job responsibilities, I could not stay on the phone with her while she attempted to talk to someone.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | [Family member] was at the facility from 3:15PM to 4:30PM. He stated that (R12) was doing OK, but, was really confused. He informed me he cleaned up her room and provided her with some snacks and a soda.<br><br>At 7:15PM, (R12) called me and told me that she had to use the bedpan and needed help with being boosted as she had slid down in the bed. I directed her to hit the call button, which she did, and I waited on the phone with her. As soon as I heard someone come in the room I told her they would attend to her and I would call her back in 10 minutes to ensure she was taken care of. Within 5 minutes she called me back and was crying. She said that someone came in the room and grabbed her by her bad arm in an attempt to move her. She was crying.<br><br>She said that after this happened the woman left the room. I told her I was on my way and arrived at the facility just before 8:00PM. Upon entering the [unit], I saw a nurse who I am not familiar with, [RN-M], and I went to talk to her. I informed her of what transpired and what my mother reported to me, she just stared at me blankly. I informed her I wanted this reported and asked her who the aids were. She informed me that [CNA-V] and [CNA-TT] were working (I don't know [CNA-V], and I don't want to know her, but, [CNA-TT], I believe I have met before).<br><br>Upon entering the room (R12) was laying with her head in one corner of the bed and her body the opposite way (see picture) she, did not have any pajama pants on and she was sopping wet. I hit the call button and proceeded to get her sopping wet diaper off of her and get clean clothes together to change her. I put her on the bed pan and went to throw the sopping wet diaper away when [name of person] walked in the room. I have never met this woman, and I said Hi, and she immediately said to me, what's da problem. I said, well, it's after 8:00 at night and I am standing here in my pajamas and slippers, with no bra on because apparently (R12) was wet, needed to use the bed pan, and someone pulled on her arm causing her pain. I asked her how many times she was in the room with her in the last hour and she said twice. She then became indignant with me and stated that she changed her and proceeded to get [R63] to say this as well.<br><br>[R63] responded that she didn't know what she did and she was not going to get her involved. As I went to the garbage can in the bathroom to show her the sopping wet diaper, I asked her what color her pajama bottoms were when she changed her, (she didn't have any on) and she immediately said she was going to go get the nurse. I informed her that I already spoke to [RN-M], so, there was no point to it, and I shut the door when she left. Upon getting (R12) off the bed pan, I washed her up, changed the sheet and chuck, and put clean pajamas/diaper on her, I went out in the hall and asked [RN-M] if she would help me boost her. [CNA-TT] came in the room and assisted me and took care of the bed pan. I had asked [R63] while this was going on if she was wet and she said she was, I told her I would ask someone to come and help her and she adamantly said, no, she would rather be wet than have [CNA-V] assist her, as she was afraid of her. [CNA-TT] helped [R63] get ready for bed. I gave both the women ice cream and put some water on their tables and left at about 9:00PM.<br><br>RESIDENT GRIEVANCE FORM<br><br>DATE: 2/25/23<br><br>RESIDENT: [R12] .<br><br>NAME OF PERSON FILING GRIEVANCE: [POA-KK]<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | STATEMENT OF GRIEVANCE (Explanation of incident to include dates, times and witnesses as applicable):<br><br>See statements. CNA [changed] [patient] 2x prior to daughter being there.<br><br>INVESTIGATED BY: [Signed by DON-B]<br><br>DATE OF RESOLUTION: [blank]<br><br>SUMMARY OF RESOLUTION: [blank]<br><br>ADMINISTRATOR'S SIGNATURE: [Signed by NHA-A]<br><br>DATE: 3/6/23<br><br>Employee Statements<br><br>I went into [R12's] room when I first came on to shift because her light. I went in there to see what she wanted, she stated to me she didn't ring her bell that she didn't know why it was on. So, I turned off her light and proceeded to exit the room to start on my rounds about 7:10. I had started my rounds as I was moving from room to room I noticed [R12's] light on so I was went to answer it. She stated she wanted to be changed so proceeded to clear her up and her roommate up. After I was done I removed my garbage out of her room and proceeded to continue on with my rounding on others. So, as I am moving around in the hallway I noticed [R12's] room light was on so I went in to answer the light. Soon as I went into her room it was a lady yelling, screaming, pointing in my face asking me how many times been in there. I responded twice then she proceeds to say her mom was wet. I told her I was just in I was just in there changing (R12) so she couldn't be (sic) wet. So, she grabbed [sic] a diaper out of the garbage and was holding it up to my face. I told her she was being (sic) really rude and I'll step out and get the nurse. I spoke with [RN-M] and told her about what had happened and she said OK. I told her that I was just in there to change [R12] and they can roll the camera back when I was in there and see me leave out with my garbage right before as [POA-KK] came. Also, after I changed [R12] I hung her pants on the back of the chair in the room. So, she didn't even have pants on when her daughter came.<br><br>[signed by CNA-V]<br><br>Employee Statement<br><br>03/01/2023<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/20/23 a woman came rushing down the hallway and stated she was the [POA-KK] of the [R12]. She asked the names of the CNAs working tonight and gave said information. [POA-KK] states (R12) called her [complaining of (c/o)] needing the bathroom and that she should not have to come over here and change (R12). [POA-KK] had made several complaints in a very short amount of time and took a few moments to process everything that was said. I told woman I would get the CNAs right away as I was under impression they had already been in the room and had changed the pt. The woman states never mind and she'll do it since she's all the way there already. The woman asks who the manager will be in the morning. The pt had no c/o pain and reported no arm pulling to writer. Spoke [with] CNAs regarding checking [and] changing pt [every 2 hours and [as needed (PRN)].<br><br>[Completed by RN-M]<br><br>Employee Statement<br><br>To: [RN-II]<br><br>From: [CNA-TT]<br><br>RE: RESIDENCE GRIEVANCE FORM<br><br>Thanks for sending the residence grievance form to me. I did not work on that day and was unaware of what happened regarding the resident.<br><br>Thanks, and Blessings!<br><br>[Signed by CNA-TT] Date: March 6, 2023<br><br>Surveyor noted a staff member allegedly pulled on R12's bad arm and caused her pain. Surveyor noted this as an allegation of abuse. Surveyor reviewed self-reports submitted to the state agency. There was no report of abuse from 2/20/23 for R12 reported to the state agency.<br><br>On 3/13/23 at 11:12 AM Surveyor interviewed Director of Care Transitions (DCT)-E. Surveyor asked who was in charge of grievances. DCT-E stated she was. Surveyor asked about the grievance filed by POA-KK on 2/8/23. DCT-E stated it was unsubstantiated because DON-B interviewed the CNA and she said it was not true. Surveyor asked if the facility would consider this an allegation of abuse or neglect. DCT-E stated it would definitely be something to investigate but not sure about abuse, DON-B would investigate that. Surveyor asked if it was reported to the state agency as an allegation of abuse or neglect. DCT-E stated she did not think so. Surveyor asked about the grievance filed by POA-KK on 2/20/23. DCT-E stated it was unsubstantiated because DON-B interviewed the CNA and she said she did not grab her, she just moved her. Surveyor asked if the facility would consider this an allegation of abuse. DCT-E stated she but not sure about abuse, because she was unsure if R12 was hurt or not. Surveyor noted that is why there is the process of reporting allegations of abuse and then time to investigate the allegation to see if the abuse actually happened. Surveyor asked if it was reported to the state agency as an allegation of abuse. DCT-E stated no. Surveyor asked for any additional reported incidents or self-reports for R12. No additional information was provided and DON-B was unavailable for interview. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40533<br><br>UNCORRECTED ON REVISIT<br><br>Based on observation, interview, and record review, the facility did not thoroughly investigate or prevent further potential abuse while the investigation was in progress for 3 (R66, R67, R12) of 13 residents reviewed.<br><br>* R66 and R67 were involved in a resident to resident altercation on 3/8/2023 that was not thoroughly investigated including putting interventions in place on R66 and R67's care plan to prevent further resident to resident abuse. The facility investigation determined the injury sustained by R66 was not as a result of a resident to resident altercation but did not investigate further to determine the cause of the injury of unknown origin.<br><br>* R12 has 2 grievances filed by R12's Power of Attorney (POA) with allegations of abuse/neglect that were not investigated by the facility.<br><br>Findings include:<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility policy and procedure entitled Abuse Policy dated 11/2018 states: The facility Administrator will be designated as the facility Abuse Coordinator and is responsible for overseeing all components of the abuse policy. Prevention: This facility will prohibit abuse, neglect, and mistreatment of residents. Resident care plans will be reassessed on a regular basis and any necessary changes will be implemented as needed. Resident behaviors will be monitored regularly for any changes and any aggressive behaviors that might lead to abuse will be assessed and any necessary interventions will be implemented. This facility will notify all residents of the Abuse Policy and will inform them that any concerns and/or allegations of abuse should be reported to facility administration without any fear of retaliation. Residents will also be notified regarding the facility grievance policy and 24-hour hotline. This facility will make every effort to identify residents who are at high risk for potential abuse of other residents. Facility staff will report immediately to facility administration any identified behaviors, injuries, bruises, and/or any concerns of potential abuse of residents. Investigation: Any allegation of abuse must be reported immediately to the facility Director of Nursing and Administrator. The facility Administrator will initiate and complete a thorough investigation of the allegations and will gather and document all relevant information. Facility Administrator or designee will visit the resident and notify them that they are safe and that an investigation has been initiated. Immediate action will be taken to protect facility residents from further abuse. Two facility staff members will conduct an interview with the resident. The responsible party will be contacted and notified of the allegation. Interviews will be conducted and documented with any witnesses, staff, other residents, or visitors who potentially have any knowledge or information regarding the allegation. Interviews will be conducted with a sample of other residents residing on the same unit as the resident. Every staff member working on the specific unit that the resident resides who was working or present during the period of time of the allegation will be interviewed. A licensed nurse will assess the resident for signs of injury and notify the physician and responsible party of any findings. All interviews, statements, and/or information will be documented and collected by facility Administrator or designee. Protection: . If another resident is identified in the allegation, a licensed staff member will complete an evaluation of the resident's status and condition and notify the physician to determine if any treatment is necessary. Facility Administrator or designee will assess all of the relevant information and determine whether or not a discharge from the facility is needed. The resident will be prohibited from having any contact with the resident alleging abuse while the investigation is completed. The facility Administrator or designee will determine if further action and/or intervention is needed upon completion of the investigation. Definitions: Abuse: the infliction of physical, sexual, or emotional injury or harm including financial exploitation by any person, firm, or corporation. Neglect: the failure to provide services to an eligible adult by any person, firm, or corporation with a legal or contractual duty to do so, when such failure presents either an imminent danger to the health, safety, or welfare of the client or a substantial probability that death or serious physical harm would result .<br><br>1.) R66 was admitted to the facility on [DATE] and had diagnoses to include type 2 diabetes, interstitial lung disease, weakness, unsteadiness on feet, dementia, and anxiety. R66's quarterly Minimum Data Set (MDS) dated [DATE] indicated R66 had moderately impaired cognition with a Brief Interview Mental Status (BIMS) score of 9 and coded R66 needing supervision with bed mobility, transferring, walking, and toileting, and limited assist with dressing and extensive assist with hygiene. R66 used a wheeled walker and had episodes of hallucinating 1-3 days in a week, was at risk for wandering, and had a history of falls. R66 was occasionally incontinent of urine and frequently incontinent of bowel.<br><br>(continued on next page) |

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| | 525730 | A. Building<br>B. Wing | 03/23/2023 |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R67 was admitted to the facility on [DATE] and had diagnoses to include rhabdomyolysis (damage to muscle tissue,) type 2 diabetes, weakness, age-related physical disability, and post-traumatic stress disorder. R67's significant change MDS dated [DATE] indicated R67 had intact cognition with a BIMS score of 15 and coded R67 needing limited assist with bed mobility and hygiene and extensive assist with transferring, dressing, and toileting. R67 required a Hoyer lift and assistance of 2 people with transfers and was not ambulatory. R67 was always incontinent of urine and bowel.<br><br>On 3/8/2023 at 8:21 AM in the progress notes for R66, nursing charted R66 had an unwitnessed physical altercation with R67. Nursing charted according to R66, R67 swung at R66. R66 has an abrasion to nose. Nursing charted R66 had no pain and R66's vital signs were stable, pain and skin assessment completed. Nursing charted that R66's POA, Physician, and administration were notified.<br><br>On 3/8/2023 at 8:32 AM in the progress notes for R67, nursing charted R67 had an unwitnessed altercation with R66. Nursing charted according to R67, R66 removed R67's covers off of R67 after R66 returned from the bathroom. Nursing charted R67 stated R66 told R67 to get out of R66's house. Nursing charted R67 denied hitting R66. Nursing charted R67 has no signs of skin alterations, denies pain, vital signs were stable, and a skin/pain assessment was completed. Nursing charted that R67's POA, Physician, and administration were notified.<br><br>Surveyor reviewed the facility self-report which was submitted to the State Agency on 3/8/2023. Documented under Investigation Summary the Nursing Home Administrator (NHA)-A documented a summary statement of the self-report. NHA-A wrote, at approximately 3:30 AM on 3/8/2023, R66 got up to use the bathroom. NHA-A wrote when R66 came out of the bathroom, R67 noticed R66's bridge of nose was bleeding and R67 asked what happened to R66's nose. NHA-A wrote that R66 replied to R67 that R67 hit R66 and R66 asked R67 to get out of R66's room, R66 then pulled R67's covers off the bed. NHA-A wrote the facility conducted an investigation to ensure there was no truth to R66's statement. NHA-A wrote R66 has a BIMS score of 9/15 with increased confusion at nighttime. NHA-A wrote on 3/2/2023 R66 had a fall that resulted in bruises and abrasions that were fairly minor and R66 was able to be treated at the facility. NHA-A wrote the abrasion on the bridge of R66's nose was documented as a result of that fall. (Surveyor reviewed R66's medical record; R66 did not have a fall on 3/2/2023 and no documentation was found regarding the abrasion to the bridge of the nose.) NHA-A wrote that interviews and reenactment of the situation between R66 and R67 leading to the allegation were conducted. NHA-A wrote that NHA-A does not see a plausible way for R67 to strike R66 and cause harm. NHA-A wrote R67 lacks strength to cause any harm to R66 and R67's bedridden status reduces the likelihood of the situation to have occurred. NHA-A wrote that R66 and R67 were moved into new rooms with R66 and R67's consent. NHA-A wrote that R66 is not able to recall the event that occurred. NHA-A wrote R67 was able to recall the event and R67 states R67 feels safe and does not have any adverse emotional trauma related to what had occurred.<br><br>On 3/8/2023 the NHA-A obtained a statement from R67. NHA-A wrote R67 stated that last night around 3:30 AM R66 got up to go to the bathroom. When R66 came out, R67 noticed R66's nose was bleeding. R67 asked R66 what happened and R66 stated R67 punched R66. R66 then took of R67's covers. NHA-A wrote that R67 states R67 blew off R66 and went back to bed.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | There are two certified nursing assistant (CNA) statements in the self-report that were obtained via phone by the staffing coordinator. The two statements do not have dates on them. In the first statement the staffing coordinator wrote the CNA did not see anything, the CNA walked into R66 and R67's room and R66 was bleeding. The CNA did not witness a fight. The second statement the staffing coordinator wrote the CNA did not witness an altercation. The CNA went into R66 and R67's room and there was an abrasion on top of R66 nose. The CNA asked R66 what happened and R66 did not respond. The CNA stated that R67 mentioned R66 was messing with R67's bed.<br><br>Surveyor noted no licensed nursing staff was interviewed regarding the altercation between R66 and R67 and no investigation was completed to discover the origin of the abrasion to the bridge of the nose.<br><br>On 3/13/2023 at 8:35 AM, Surveyor observed R66 lying in bed. Surveyor observed a scab to the bridge of R66's nose. Surveyor asked R66 how R66 got the scab to the nose. R66 replied that R66 does not recall how it got there and probably scratched it. Surveyor asked R66 if R66 had issues with other residents. R66 replied that R66 was the only person in the facility and did not have issues with anyone.<br><br>On 3/13/2023 at 8:39 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-FF. Surveyor asked LPN-FF if LPN-FF had any information regarding the room change for R66 and R67? LPN-FF replied that LPN-FF only knew R66 and R67 used to be roommates, but the social worker would have more information.<br><br>On 3/13/2023 at 3:53 PM, Surveyor informed Assistant Chief Nursing Officer-D of Surveyor's concern that R66 and R67's altercation on 3/8/2023 was not thoroughly investigated to determine the origin of the nose abrasion for R66. No further information was provided at that time.<br><br>2.) R12 was admitted to the facility 6/24/22 with diagnoses to include Unspecified Dementia without Behavioral Disturbances, Encounter for Surgical Aftercare Following Surgery on the Digestive System, and Adult Failure to Thrive. R12 had designated her daughter as Power of Attorney (POA)-KK.<br><br>Surveyor reviewed documented Grievance with a date of 2/8/23 by filed by POA-KK about R12. Documented was:<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | I was at the facility from 4:00PM until 6:30PM. I fed her, toileted her, cleaned her dentures, combed her hair, washed her, and put a clean diaper on her. At 8:30PM I received a call from her crying and apologizing, stating she didn't know what to do. She had been waiting for a bed pan since 7:30PM and no one had come. She couldn't help it and had a bowel movement in her diaper and was sorry. I directed her to hit the call button while she was on the phone with me. Someone came in almost immediately, my mom attempted to tell her she needed help and had been waiting an hour but, she shut off her call button and left the room stating she would be back. I told (R12) to hit the button again. She came back into the room, went directly to shut the call light off and I told (R12) to tell her I wanted to speak with her. Due to her dementia (R12) sometimes states that I am her mother, she stated to the aid, my mother wants to talk to you I could hear her laughing at her and stated, YOUR MOTHER wants to talk to me? Hahahahhaha. (R12) responded, yes, my mother. She got on the phone and I asked her whom I was speaking to, she said [Certified Nursing Assistant (CNA)-O]. I stated that (R12) had waited over an hour for a bed pan and seeing as no one responded to her call light she defecated in her diaper and was now sitting in crap and had been for quite some time. She responded to me, well, (R12) isn't the only person here. I stated, you did not just say that to me did you [CNA-O]? I continued, you are going to say that to me when (R12) has been sitting in shit for an hour and calling me crying? I told her I was aware that (R12) is not the only resident there, and I know this as I am there a minimum of five days a week. I asked her if she wanted me to come there and she asked me what would I come there for and I stated, to do your job. I stated that the time it was taking her to argue with me on the phone about doing her job, she could have already changed her. I asked her directly if she would please help (R12) and change her diaper, I stated that I would pay her. She said then said she would take care of it. I thanked her and asked her to tell (R12) I would call her back in 15 minutes. I called back about 10 minutes later and [CNA-O] was just leaving the room. (R12) thanked her and her response was, YEP.<br><br>RESIDENT GRIEVANCE FORM<br><br>DATE: 2/25<br><br>RESIDENT: [R12] .<br><br>NAME OF PERSON FILING GRIEVANCE: [POA-KK]<br><br>STATEMENT OF GRIEVANCE (Explanation of incident to include dates, times and witnesses as applicable):<br><br>Writer spoke at length [with] CNA via telephone who stated all allegations were untrue. See statement<br><br>INVESTIGATED BY: [Signed by Director of Nursing (DON)-B]<br><br>DATE OF RESOLUTION: 2/28/23<br><br>SUMMARY OF RESOLUTION: unable to substantiate<br><br>ADMINISTRATOR'S SIGNATURE: [Signed by DON-B]<br><br>DATE: 2/28/23<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Employee Statements<br><br>Per CNA she did not laugh [at] [POA-KK], she did not state your mother isn't the only one here. [R12] was never sitting in [feces], I [check and changed] her every two hours [and] went into her room multiple times to see if she needed anything. [POA-KK] was very rude [and] aggressive to staff per norm [and] was making false allegations that were not true.<br><br>Signature: via telephone with [CNA-O]<br><br>2/28/23 [Signed by DON-B].<br><br>Surveyor noted that CNA-O allegedly laughed at resident and made fun of her. Surveyor noted this as an allegation of abuse. Surveyor noted there was no investigation into the allegation of abuse to R12. No other staff statements, interviews of other residents, or follow-up of psychosocial harm caused to R12 from this incident could be located.<br><br>Surveyor reviewed documented Grievance with a date of 2/20/23 by filed by POA-KK about R12 . Documented was:<br><br>On the above date, I received a call from (R12's) [Hospice CNA]. She informed me that this morning was the 3rd time in two weeks where she had found (R12) soaked in urine from head to toe. She informed me that she had completed a full bed change, bathed her, and put clean clothes and a fresh diaper on her. While I was on the phone with her, she was out by the nurse's station attempting to speak to someone regarding the issue. The two aids she spoke to said they didn't know who was in charge. She talked to [RN-SS] and she was told that she could speak to [Assistant Chief Nursing Officer (ACNO)-D]. I told her where her office was and she was going to attempt to speak with her. Due to my job responsibilities, I could not stay on the phone with her while she attempted to talk to someone.<br><br>[Family member] was at the facility from 3:15PM to 4:30PM. He stated that (R12) was doing OK, but, was really confused. He informed me he cleaned up her room and provided her with some snacks and a soda.<br><br>At 7:15PM, (R12) called me and told me that she had to use the bedpan and needed help with being boosted as she had slid down in the bed. I directed her to hit the call button, which she did, and I waited on the phone with her. As soon as I heard someone come in the room I told her they would attend to her and I would call her back in 10 minutes to ensure she was taken care of. Within 5 minutes she called me back and was crying. She said that someone came in the room and grabbed her by her bad arm in an attempt to move her. She was crying.<br><br>She said that after this happened the woman left the room. I told her I was on my way and arrived at the facility just before 8:00PM. Upon entering the [unit], I saw a nurse who I am not familiar with, [RN-M], and I went to talk to her. I informed her of what transpired and what (R12) reported to me, she just stared at me blankly. I informed her I wanted this reported and asked her who the aids were. She informed me that [CNA-V] and [CNA-TT] were working (I don't know [CNA-V], and I don't want to know her, but, [CNA-TT], I believe I have met before).<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Upon entering the room (R12) was laying with her head in one corner of the bed and her body the opposite way (see picture) she, did not have any pajama pants on and she was sopping wet. I hit the call button and proceeded to get her sopping wet diaper off of her and get clean clothes together to change her. I put her on the bed pan and went to throw the sopping wet diaper away when [name of person] walked in the room. I have never met this woman, and I said Hi, and she immediately said to me, what's da problem. I said, well, it's after 8:00 at night and I am standing here in my pajamas and slippers, with no bra on because apparently (R12) was wet, needed to use the bed pan, and someone pulled on her arm causing her pain. I asked her how many times she was in the room with her in the last hour and she said twice. She then became indignant with me and stated that she changed her and proceeded to get [R63] to say this as well.<br><br>[R63] responded that she didn't know what she did and she was not going to get her involved. As I went to the garbage can in the bathroom to show her the sopping wet diaper, I asked her what color her pajama bottoms were when she changed her, (she didn't have any on) and she immediately said she was going to go get the nurse. I informed her that I already spoke to [RN-M], so, there was no point to it, and I shut the door when she left. Upon getting (R12) off the bed pan, I washed her up, changed the sheet and chuck, and put clean pajamas/diaper on her, I went out in the hall and asked [RN-M] if she would help me boost her. [CNA-TT] came in the room and assisted me and took care of the bed pan. I had asked [R63] while this was going on if she was wet and she said she was, I told her I would ask someone to come and help her and she adamantly said, no, she would rather be wet than have [CNA-V] assist her, as she was afraid of her. [CNA-TT] helped [R63] get ready for bed. I gave both the women ice cream and put some water on their tables and left at about 9:00PM.<br><br>RESIDENT GRIEVANCE FORM<br><br>DATE: 2/25/23<br><br>RESIDENT: [R12] .<br><br>NAME OF PERSON FILING GRIEVANCE: [POA-KK]<br><br>STATEMENT OF GRIEVANCE (Explanation of incident to include dates, times and witnesses as applicable):<br><br>See statements. CNA [changed] [patient] 2x prior to daughter being there.<br><br>INVESTIGATED BY: [Signed by DON-B]<br><br>DATE OF RESOLUTION: [blank]<br><br>SUMMARY OF RESOLUTION: [blank]<br><br>ADMINISTRATOR'S SIGNATURE: [Signed by NHA-A]<br><br>DATE: 3/6/23<br><br>Employee Statements<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | I went into [R12's] room when I first came on to shift because her light. I went in there to see what she wanted, she stated to me she didn't ring her bell that she didn't know why it was on. So, I turned off her light and proceeded to exit the room to start on my rounds about 7:10. I had started my rounds as I was moving from room to room I noticed [R12's] light on so I was went to answer it. She stated she wanted to be changed so proceeded to clear her up and her roommate up. After I was done I removed my garbage out of her room and proceeded to continue on with my rounding on others. So, as I am moving around in the hallway I noticed [R12's] room light was on so I went in to answer the light. Soon as I went into her room it was a lady yelling, screaming, pointing in my face asking me how many times been in there. I responded twice then she proceeds to say (R12) was wet. I told her I was just in I was just in there changing (R12) so she couldn't be (sic) wet. So, she grabbed [sic] a diaper out of the garbage and was holding it up to my face. I told her she was being (sic) really rude and I'll step out and get the nurse. I spoke with [RN-M] and told her about what had happened and she said OK. I told her that I was just in there to change [R12] and they can roll the camera back when I was in there and see me leave out with my garbage right before as [POA-KK] came. Also, after I changed [R12] I hung her pants on the back of the chair in the room. So, she didn't even have pants on when [POA-KK] came.<br><br>[signed by CNA-V]<br><br>Employee Statement<br><br>03/01/2023<br><br>On 2/20/23 a woman came rushing down the hallway and stated she was [POA-KK] of the [R12]. She asked the names of the CNAs working tonight and gave said information. Pt. [POA-KK] states (R12) called her [complaining of (c/o)] needing the bathroom and that she should not have to come over here and change (R12). [POA-KK] had made several complaints in a very short amount of time and took a few moments to process everything that was said. I told woman I would get the CNAs right away as I was under impression they had already been in the room and had changed the pt. The woman states never mind and she'll do it since she's all the way there already. The woman asks who the manager will be in the morning. The pt had no c/o pain and reported no arm pulling to writer. Spoke [with] CNAs regarding checking [and] changing pt [every 2 hours and [as needed (PRN)].<br><br>[Completed by RN-M]<br><br>Employee Statement<br><br>To: [RN-II]<br><br>From: [CNA-TT]<br><br>RE: RESIDENCE GRIEVANCE FORM<br><br>Thanks for sending the residence grievance form to me. I did not work on that day and was unaware of what happened regarding the resident.<br><br>Thanks, and Blessings!<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | [Signed by CNA-TT] Date: March 6, 2023<br><br>Surveyor noted a staff member allegedly pulled on R12's bad arm and caused her pain. Surveyor noted this as an allegation of abuse. Surveyor noted there was no investigation into the allegation of abuse to R12. No other staff statements, interviews of other residents, follow-up of physical or psychosocial harm, no skin assessments or pain assessments were completed investigating any outcome to R12 from this incident.<br><br>On 3/13/23 at 11:12 AM, Surveyor interviewed Director of Care Transitions (DCT)-E. Surveyor asked who was in charge of grievances? DCT-E stated she was. Surveyor asked about the grievance filed by POA-KK on 2/8/23. DCT-E stated it was unsubstantiated because DON-B interviewed the CNA and she said it was not true. Surveyor asked if the facility would consider this an allegation of abuse? DCT-E stated it would definitely be something to investigate but not sure about abuse, DON-B would investigate that. Surveyor asked if it was investigated as an allegation of abuse? DCT-E stated she did not think so. Surveyor asked about the grievance filed by POA-KK on 2/20/23. DCT-E stated it was unsubstantiated because DON-B interviewed the CNA and she said she did not grab her, she just moved her. Surveyor asked if the facility would consider this an allegation of abuse? DCT-E stated she was not sure about abuse, because she was unsure if R12 was hurt or not. Surveyor noted that is why there is the process of investigating the allegation to see if the abuse actually happened. Surveyor asked if it was investigated as an allegation of abuse? DCT-E stated no. Surveyor asked for any additional incident investigations for R12. No additional information was provided and DON-B was unavailable for interview. |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829<br><br>Based on interview and record review, the facility did not notify the Resident or Resident's representative in writing of a transfer and the reasons for the transfer including the effective date of transfer, the location to which the Resident is transferred, a statement of the Resident's appeal rights with the name, address, and telephone number of the entity which receives the request, and information on how to obtain an appeal form as well as the name, address, and telephone number of the Office of the State Long-Term Care Ombudsman for 14 (R83, R87, R84, R85, R88, R86, R68, R89, R90, R91, R92, R93, R94, and R82) of 14 Residents reviewed for transfers to the hospital.<br><br>*R83 was transferred and admitted into the hospital on 3/13/2023. No documentation was found indicating a transfer notice was provided to R83 or R83's representative.<br><br>*R87 was transferred and admitted into the hospital on 3/18/2023. No documentation was found indicating a transfer notice was provided to R87 or R87's representative.<br><br>*R84 was transferred and admitted into the hospital on 3/6/2023. No documentation was found indicating a transfer notice was provided to R84 or R84's representative.<br><br>*R85 was transferred and admitted into the hospital on 3/4/2023. No documentation was found indicating a transfer notice was provided to R85 or R85's representative.<br><br>*R88 was transferred and admitted into the hospital on 3/10/2023. No documentation was found indicating a transfer notice was provided to R88 or R88's representative.<br><br>*R86 was transferred and admitted into the hospital on 3/3/2023. No documentation was found indicating a transfer notice was provided to R86 or R86's representative.<br><br>*R68 was transferred and admitted into the hospital on 3/8/2023. No documentation was found indicating a transfer notice was provided to R68 or R68's representative.<br><br>*R89 was transferred and admitted into the hospital on 3/9/2023. No documentation was found indicating a transfer notice was provided to R89 or R89's representative.<br><br>*R90 was transferred and admitted into the hospital on 3/10/2023. No documentation was found indicating a transfer notice was provided to R90 or R90's representative.<br><br>*R91 was transferred and admitted into the hospital on 3/12/2023. No documentation was found indicating a transfer notice was provided to R91 or R91's representative.<br><br>*R92 was transferred and admitted into the hospital on 3/14/2023. No documentation was found indicating a transfer notice was provided to R92 or R92's representative.<br><br>*R93 was transferred and admitted into the hospital on 3/15/2023. No documentation was found indicating a transfer notice was provided to R93 or R93's representative.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 525730 | A. Building<br>B. Wing | 03/23/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Ignite Medical Resort Oak Creek | 2700 Honadel Boulevard<br>Oak Creek, WI 53154 |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | *R94 was transferred and admitted into the hospital on 3/19/2023. No documentation was found indicating a transfer notice was provided to R94 or R94's representative.<br><br>*R82 was transferred and admitted into the hospital on 3/21/2023. No documentation was found indicating a transfer notice was provided to R82 or R82's representative.<br><br>Findings Include:<br><br>Surveyor reviewed the facility's Transfer Agreement policy and procedure dated 4/22 and noted the following:<br><br>Purpose:<br><br>.To provide a formalized arrangements with one or more hospitals approached for participation under the Medicare and Medicaid programs within proximity to our facility.<br><br>Guideline:<br><br>Where possible, our facility will have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonable assures that:<br><br>-Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with and consistent with state law.<br><br>Surveyor also reviewed the facility's Discharges policy and procedure dated 11/2018 and the following is applicable to hospital transfers:<br><br>4. Inform the Resident and the Resident's responsible party of the transfer.<br><br>5. Prepare a transfer form, send the original with the Resident and put a copy in the chart.<br><br>1.) R83 was admitted to the facility on [DATE] with diagnoses of Metabolic Encephalopathy, Dependence on Renal Dialysis, Sepsis, Peripheral Vascular Disease, Essential Hypertension, and Adult Failure to Thrive. R83 has an activated Health Care Power of Attorney (HCPOA). R83 discharged to the hospital on 3/13/23 and the facility did not notify R83 or R83's representative in writing of the transfer and the reasons for the transfer including the effective date of transfer, the location to which R83 is transferred, a statement of the R83's appeal rights with the name, address, and telephone number of the entity which receives the request, and information on how to obtain an appeal form as well as the name, address, and telephone number of the Office of the State Long-Term Care Ombudsman. R83's primary payer source is managed care. R83 has not returned to the facility.<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2.) R87 was admitted to the facility on [DATE] with diagnoses of Metabolic Encephalopathy, Malignant Neoplasm of Breast and Bone, Adult Failure to Thrive, Anxiety Disorder, and Major Depressive Disorder. R87 has an activated Health Care Power of Attorney (HCPOA). R87 discharged to the hospital on 3/18/23 and the facility did not notify R87 or R87's representative in writing of the transfer and the reasons for the transfer including the effective date of transfer, the location to which R87 is transferred, a statement of the R87's appeal rights with the name, address, and telephone number of the entity which receives the request and information on how to obtain an appeal form as well as the name, address, and telephone number of the Office of the State Long-Term Care Ombudsman. R87's primary payer source is managed care. R87 has not returned to the facility.<br><br>3.) R84 was admitted to the facility on [DATE] with diagnoses of Cerebral Infarction, Chronic Lymphocytic Leukemia, Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Essential Hypertension, Suicidal Ideations, and Adjustment Disorder with Mixed Anxiety and Depressed Mood. R84 is their own person. R84 discharged to the hospital on 3/6/23 and the facility did not notify R84 in writing of the transfer and the reasons for the transfer including the effective date of transfer, the location to which R84 is transferred, a statement of the R84's appeal rights with the name, address, and telephone number of the entity which receives the request and information on how to obtain an appeal form as well as the name, address, and telephone number of the Office of the State Long-Term Care Ombudsman. R84's primary payer source is managed care. R84 returned to the facility on [DATE] and discharged back to the hospital on 3/17/23 and has not returned.<br><br>4.) R85 was admitted to the facility on [DATE] with diagnoses of Type 2 Diabetes Mellitus, Morbid Obesity, Fracture of Unspecified Part of Neck of Left Femur, Parkinson's Disease, Bipolar Disorder, Anxiety Disorder, and Major Depressive Disorder. R85 is their own person. R85 discharged to the hospital on 3/4/23 and the facility did not notify R85 in writing of the transfer and the reasons for the transfer including the effective date of transfer, the location to which R85 is transferred, a statement of R85's appeal rights with the name, address, and telephone number of the entity which receives the request and information on how to obtain an appeal form as well as the name, address, and telephone number of the Office of the State Long-Term Care Ombudsman. R85's primary payer source is managed Medicaid and R85 has not returned to the facility.<br><br>5.) R88 was admitted to the facility on [DATE] with diagnoses of Malignant Neoplasm of Vagina, Chronic Kidney Disease, Stage 4, Unspecified Atrial Fibrillation, Essential Hypertension, Cerebrovascular Disease, Dysphagia, and Hematemesis. R88 has an activated Health Care Power of Attorney (HCPOA). R88 discharged to the hospital on 3/1/23 and the facility did not notify R88 or R88's representative in writing of the transfer and the reasons for the transfer including the effective date of transfer, the location to which R88 is transferred, a statement of R88's appeal rights with the name, address, and telephone number of the entity which receives the request and information on how to obtain an appeal form as well as the name, address, and telephone number of the Office of the State Long-Term Care Ombudsman. R88's primary payer source is hospice Medicare. R88 returned to the facility on [DATE].<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 6.) R86 was admitted to the facility 2/20/23 with diagnoses of Unspecified Atrial Fibrillation, Heart Failure, Anorexia, Depression, and Major Depressive Disorder. R86 is their own person. R86's primary payer source was managed care insurance. R86 was discharged to the hospital on 3/3/23, and the facility did not notify R86 in writing of the transfer and the reasons for the transfer including the effective date of transfer, the location to which R86 is transferred, a statement of R86's appeal rights with the name, address, and telephone number of the entity which receives the request and information on how to obtain an appeal form as well as the name, address, and telephone number of the Office of the State Long-Term Care Ombudsman. R86 returned to the facility on [DATE] and discharged to another facility on 3/20/23.<br><br>7.) R68 was admitted to the facility on [DATE] with diagnoses of Metabolic Encephalopathy, Severe Sepsis with Septic Shock, Type 2 Diabetes Mellitus, Dysphagia, and Essential Hypertension. R68 has an unactivated Health Care Power of Attorney (HCPOA). R68's primary payer source was managed care insurance. R68 was discharged to the hospital on 3/8/23, and the facility did not notify R68 in writing of the transfer and the reasons for the transfer including the effective date of transfer, the location to which R68 is transferred, a statement of R68's appeal rights with the name, address, and telephone number of the entity which receives the request and information on how to obtain an appeal form as well as the name, address, and telephone number of the Office of the State Long-Term Care Ombudsman. The hospital was informed R68 could not return to the facility on [DATE].<br><br>8.) R89 was admitted to the facility on [DATE] with diagnoses of Chronic Respiratory Failure with Hypoxia, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, Morbid Obesity, and Major Depressive Disorder. R89 is their own person. R89's primary payer source is managed Medicaid. R89 discharged to the hospital on 3/9/23, and the facility did not notify R89 in writing of the transfer and the reasons for the transfer including the effective date of transfer, the location to which R89 is transferred, a statement of R89's appeal rights with the name, address, and telephone number of the entity which receives the request and information on how to obtain an appeal form as well as the name, address, and telephone number of the Office of the State Long-Term Care Ombudsman. R89 returned to the facility on [DATE].<br><br>9.) R90 was admitted to the facility on [DATE] with diagnoses of Metabolic Encephalopathy, Osteomyelitis, Type 2 Diabetes Mellitus, Kidney Transplant Failure, Peripheral Vascular Disease, and End Stage Renal Disease. R90 has an activated Health Care Power of Attorney (HCPOA). R90's primary payer source was Medicare. R90 was discharged to the hospital on 3/10/23, and the facility did not notify R90 or R90's representative in writing of the transfer and the reasons for the transfer including the effective date of transfer, the location to which R90 is transferred, a statement of the R90's appeal rights with the name, address, and telephone number of the entity which receives the request and information on how to obtain an appeal form as well as the name, address, and telephone number of the Office of the State Long-Term Care Ombudsman. The hospital was informed on 3/15/23, R90 could not return to the facility.<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 10.) R91 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure with Hypoxia, Dysphagia, Cerebral Infarction, Major Depressive Disorder, and Anxiety Disorder. R91 was their own person. R91's primary payer source was managed care. R91 was discharged to the hospital on 3/12/23, and the facility did not notify R91 in writing of the transfer and the reasons for the transfer including the effective date of transfer, the location to which R91 is transferred, a statement of the R91's appeal rights with the name, address, and telephone number of the entity which receives the request and information on how to obtain an appeal form as well as the name, address, and telephone number of the Office of the State Long-Term Care Ombudsman. The hospital was informed R91 could not return to the facility.<br><br>11.) R92 was admitted to the facility on [DATE] with diagnoses of Type 2 Diabetes Mellitus with Hyperglycemia, Chronic Kidney Disease, Dementia, Early Onset Alzheimer's Disease, Generalized Anxiety Disorder, and Major Depressive Disorder. R92 is their own person. R92's primary payer source is managed Medicaid. R92 discharged to the hospital on 3/14/23 and 3/20/23 and the facility did not notify R92 in writing of the transfer and the reasons for the transfer including the effective date of transfer, the location to which R92 is transferred, a statement of the R92's appeal rights with the name, address, and telephone number of the entity which receives the request and information on how to obtain an appeal form as well as the name, address, and telephone number of the Office of the State Long-Term Care Ombudsman. R92 returned to the facility on [DATE].<br><br>12.) R93 was admitted to the facility on [DATE] with diagnoses of Type 1 Diabetes Mellitus, Morbid Obesity, Obesity, Chronic Diastolic Heart Failure, and End Stage Renal Disease. R93 is their own person. R93's primary payer source is Medicaid. R93 was discharged to the hospital on 3/15/23 and the facility did not notify R93 in writing of the transfer and the reasons for the transfer including the effective date of transfer, the location to which R93 is transferred, a statement of the R93's appeal rights with the name, address, and telephone number of the entity which receives the request and information on how to obtain an appeal form as well as the name, address, and telephone number of the Office of the State Long-Term Care Ombudsman. R93 returned to the facility on [DATE].<br><br>13.) R94 was admitted to the facility on [DATE] with diagnoses of Parkinson's Disease, Obstructive and Reflux Uropathy, Unspecified Dementia, Paranoid Schizophrenia, and Anxiety Disorder. R94 has an activated Health Care Power of Attorney (HCPOA). R94 discharged to the hospital on 3/19/23 and the facility did not notify the R94 or R94's representative in writing of the transfer and the reasons for the transfer including the effective date of transfer, the location to which R94 is transferred, a statement of R94's appeal rights with the name, address, and telephone number of the entity which receives the request and information on how to obtain an appeal form as well as the name, address, and telephone number of the Office of the State Long-Term Care Ombudsman. R94's primary payer source is managed Medicaid. As of 3/22/23, R94 has not returned to the facility.<br><br>14.) R82 was admitted to the facility on [DATE] with diagnoses of Encephalopathy, Chronic Obstructive Pulmonary Disease, Epilepsy, Essential Hypertension, and Unspecified Dementia. R82 has an activated Health Care Power of Attorney (HCPOA). R82 discharged to the hospital on 3/21/23 and the facility did not notify the R82 or R82's representative in writing of the transfer and the reasons for the transfer including the effective date of transfer, the location to which R82 is transferred, a statement of R82's appeal rights with the name, address, and telephone number of the entity which receives the request and information on how to obtain an appeal form as well as the name, address, and telephone number of the Office of the State Long-Term Care Ombudsman. R82's primary payer source was managed Medicare. As of 3/22/23, R82 has not returned to the facility.<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 3/23/23 at 11:41 AM, Surveyor informed Administrator (NHA-A) and Director of Nursing (DON-B) that Surveyor has repeatedly asked for transfer forms for all 14 (R83, R87, R85, R88, R86, R68, R89, R90, R91, R92, R93, R94, and R82) Residents transferred to the hospital per regulation. NHA-A informed Surveyor that the facility can not produce any documented/written transfer form per regulation. No further information was provided at this time. |

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| F 0626<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829<br><br>Based on interview and record review the facility did not ensure that 4 (R68, R90, R91 and R83) of 14 Residents reviewed was permitted to return to the facility following a hospitalization .<br><br>*On 3/8/23 R68 was transferred to the hospital. R68 and R68's representative did not receive notification of the transfer including appeal rights, bed-hold notice which would have included information permitting a resident to return, or a 30 day discharge notice.<br><br>On 3/16/23, the hospital was notified that the facility would not permit R68 to return to the facility.<br><br>*On 3/10/23 R90 was transferred to the hospital. R90 and R90's representative did not receive notification of the transfer including appeal rights, bed-hold notice which would have included information permitting a resident to return, or a 30 day discharge notice.<br><br>On 3/15/23, the hospital was notified that the facility would not permit R90 to return to the facility.<br><br>*On 3/12/23 R91 was transferred to the hospital. R91 and R1's representative did not receive notification of the transfer including appeal rights, bed-hold notice which would have included information permitting a resident to return, or a 30 day discharge notice.<br><br>On 3/15/23, the hospital was notified that the facility would not permit R91 to return to the facility.<br><br>On 3/13/23, R83 was discharged to the hospital from the facility and admitted to another skilled nursing facility on 3/23/23.<br><br>Findings include:<br><br>Surveyor reviewed the following undated facility Bed Hold Notice policy and procedure and notes the following applicable:<br><br>.It is the policy of the facility to remind you of the bed-hold policy for such absences and to provide you/your representative with information about holding your bed. The facility complies with the Nursing Home Care Act to ensure you resident rights are met regarding bed-holds.<br><br>If your stay in the facility is paid by Medicare, Managed Care(Insurance), or Private Pat, there is no bed-hold benefit. As a result, please let the facility know if you are choosing to request your bed be held. There are some circumstances in which the facility may ask you to pay a fee to hold your bed. Please speak with a facility representative upon discharge, or within 24 hours, to discuss you plans or your bed may be relinquished.<br><br>(continued on next page) |

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| F 0626<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 3/22/23, Surveyor reviewed all discharges from the facility from 3/1/23-3/22/23. Surveyor notes there was 14 Resident discharges to the hospital during this time period.<br><br>On 3/22/23 at 11:21 AM, Social Worker(SW-E) informed Surveyor that no 30 day discharge letters had been given to any Resident.<br><br>On 3/23/23 at 11:42 AM, Admissions(AD-XX) explained to Surveyor that the facility is not taking any admissions due to the facility being in denial of payment. AD-XX explained that the facility is only taking long term Medicaid Residents back from the hospital. AD-XX stated that the facility is not taking any short term Residents with Medicare of Managed Care insurance back from the hospital because the facility is in denial of payment. AD-XX stated AD-XX was instructed to only take back the Residents with Medicaid from the hospital. AD-XX stated the directive was given by 'Administration'.<br><br>On 3/22/23 at 4:21 PM, Surveyor interviewed both Chief Clinical Officer (CCO-H) and VP of Operations (VPO-I) in regards to discharges from the facility. Both informed Surveyor that there were conversations about discharged Residents that were in the hospital. Surveyor was informed that the corporate social worker was also a part of that conversation. Both CCO-H and VPO-I informed Surveyor that the therapy department was starting furlough due to the facility being in denial of payment as a result of a staffing tag the facility received.<br><br>On 3/23/23 at 9:25 AM, Surveyor reached out to four hospitals whom the facility identified Residents had been admitted to. Surveyor was able to speak with Supervisor of Social Services (SS-DDD) in regard to three Residents whom were still a patient in the hospital. SS-DDD stated SS-DDD would get back to Surveyor with more information.<br><br>On 3/23/23 at 10:03 AM, SS-DDD informed Surveyor that R68 was not medically ready to be discharged from the hospital. SS-DDD informed Surveyor that the hospital was notified on 3/16/23 that the facility would not allow R68 to return to the facility. The facility notified on 3/15/23 that R90 would not be able to return to the facility. The hospital has not been able to find placement for R90. The facility notified the hospital on 3/15/23 that R91 would not be able to return to the facility and the hospital has found alternative placement for R91. SS-DDD stated that AD-XX informed the hospital that R68, R90, R91, would not be able to return to the facility.<br><br>1)R68 was admitted to the facility on [DATE] with diagnoses of Metabolic Encephalopathy, Severe Sepsis with Septic Shock, Type 2 Diabetes Mellitus, Dysphagia, and Essential Hypertension. R68's primary payer source was managed care insurance. R68 was discharged to the hospital on 3/8/23 and the hospital was informed R68 could not return to the facility.<br><br>2)R90 was admitted to the facility on [DATE] with diagnoses of Metabolic Encephalopathy, Osteomyelitis, Type 2 Diabetes Mellitus, Kidney Transplant Failure, Peripheral Vascular Disease, and End Stage Renal Disease. R90's primary payer source was Medicare. R90 was discharged to the hospital on 3/10/23 and the hospital was informed R90 could not return to the facility.<br><br>3)R91 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure with Hypoxia, Dysphagia, Cerebral Infarction, Major Depressive Disorder, and Anxiety Disorder. R91's primary payer source was managed care. R91 was discharged to the hospital on 3/12/23 and the hospital was informed R91 could not return to the facility.<br><br>(continued on next page) |

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| F 0626<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 4)R83 was discharged from the facility on 3/13/23 with diagnoses of Metabolic Encephalopathy, Sepsis, Unspecified Organism, End Stage Renal Disease, Anemia In Chronic Kidney Disease, Essential (PRIMARY) Hypertension, Type 2 Diabets Mellitus With Diabetic Chronic Kidney Disease, Hyperkalemia, Other Cerebral Infarction Due To Occlusion Or Stenosis Of Small Artery, Acquired Absence Of Other Specified Parts Of Digestive Tract, and Gastro-Esophageal Reflux Disease Without Esophagitis. R83's primary payer source was managed care insurance. R83 did not return to the facility and was admitted to another Skilled Nursing Facility(SNF) on 3/23/23.<br><br>On 3/23/23 at 10:17 AM, Surveyor again interviewed AD-XX in regards to the hospital discharges. AD-XX stated that AD-XX was given the directive to call the hospitals and inform them the facility would not be able to take the Residents back to the facility by VPO-I and [NAME] President of Admissions and Marketing (VPA-EEE). AD-XX stated that AD-XX was given the directive on 3/15/23 to call and inform the hospitals that the facility could not take the Medicare and managed care payer source facility Residents back to the facility. Surveyor confirmed with AD-XX that AD-XX was instructed to only take the long term Medicaid Residents back to the facility due to the facility being in denial of payment. AD-XX stated: It was very hard for me to do that. I didn't believe it was right. I care about the Residents.<br><br>On 3/23/23 at 11:41 AM, Surveyor interviewed CCO-H, VPO-I, Assistant Chief Nursing Officer (CNO-D), Director of Nursing (DON-B) and Administrator (NHA-A) in regards to the three Residents not being permitted to return to the facility. NHA-A and DON-B confirmed they were not in the building during this time period and were unaware that a directive had been given to not allow the Residents to return to the facility. VPO-I confirmed that the facility being in denial of payment was part of the reason for relocating Residents from the facility. VPO-I denies giving the directive to not permit Residents to return from the hospital. Surveyor shared the concern that the hospital confirmed the hospital was informed that the three Residents could not return to the facility. No further information was provided by the facility. |

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| Ignite Medical Resort Oak Creek | 2700 Honadel Boulevard<br>Oak Creek, WI 53154 |

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| F 0660<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Plan the resident's discharge to meet the resident's goals and needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829<br><br>Based on interview and record review, the facility did not develop and implement an effective discharge planning process for 10 (R73, R74, R75, R76, R77, R78, R79, R80, R81, and R95) of 10 Residents reviewed who were transferred to another skilled nursing facility(SNF).<br><br>*R73's discharge plan was originally to be discharged home upon completion of rehabilitation. R73 was abruptly discharged to another facility and no discharge planning occurred for R73 to be transferred to another facility. R73 discharged from the facility on 3/17/23.<br><br>* R74's discharge plan was originally to be discharged home upon completion of rehabilitation. R74 was abruptly discharged to another facility and no discharge planning occurred for R74 to be transferred to another facility. R74 discharged from the facility on 3/17/23.<br><br>*R75's discharge plan was originally to be discharged home upon completion of rehabilitation. R75 was abruptly discharged to another facility and no discharge planning occurred for R75 to be transferred to another facility. R75 discharged from the facility on 3/17/23.<br><br>*R76's discharge plan was originally to be discharged home upon completion of rehabilitation. R76 was abruptly discharged to another facility and no discharge planning occurred for R76 to be transferred to another facility. R76 discharged from the facility on 3/17/23.<br><br>*R77's discharge plan was originally to be discharged home upon completion of rehabilitation. R77 was abruptly discharged to another facility and no discharge planning occurred for R77 to be transferred to another facility. R77 discharged from the facility on 3/18/23.<br><br>*R78's discharge plan was originally to be discharged home upon completion of rehabilitation. R78 was abruptly discharged to another facility and no discharge planning occurred for R78 to be transferred to another facility. R78 discharged from the facility on 3/18/23.<br><br>*R79's discharge plan was originally to be discharged home upon completion of rehabilitation. R79 was abruptly discharged to another facility and no discharge planning occurred for R79 to be transferred to another facility. R79 discharged from the facility on 3/18/23.<br><br>*R80's discharge plan was originally to be discharged home upon completion of rehabilitation. R80 was abruptly discharged to another facility and no discharge planning occurred for R80 to be transferred to another facility. R80 discharged from the facility on 3/21/23.<br><br>*R81's discharge plan was originally to be discharged home upon completion of rehabilitation. R81 was abruptly discharged to another facility and no discharge planning occurred for R81 to be transferred to another facility. R81 discharged from the facility on 3/21/23.<br><br>*R95's discharge plan was originally to be discharged home upon completion of rehabilitation. R95 was abruptly discharged to another facility and no discharge planning occurred for R95 to be transferred to another facility. R95 discharged from the facility on 3/16/23.<br><br>(continued on next page) |

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| F 0660<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Findings Include:<br><br>Surveyor reviewed the facility's Discharges policy and procedure dated 11/2018 and noted the following applicable to Residents being discharged to SNFs.<br><br>.Discharge to Another Facility<br><br>1. Obtain an order for discharge<br><br>2. Explain to Resident reason for discharge<br><br>3. Prepare transfer form; original goes with patient, copy in chart.<br><br>4. If Resident is going to another nursing home, and payer type is public aid, send medications with the Resident.<br><br>5. Attempt to send belongings with the Resident<br><br>6. Call the receiving facility and give report.<br><br>7. Document in nursing notes time of transfer, where Resident is going, condition of Resident, method of transportation, disposition of all belongings and medications and that all parties are aware of the discharge.<br><br>1)R73 was admitted to the facility on [DATE] with diagnoses of Radiculopathy, Cervical Region, Polymyalgia Rheumatica, Chronic Kidney Disease, Stage 4, Morbid Obesity, Type 2 Diabetes Mellitus, Anorexia, and Cognitive Communication Deficit. R73 is R73's own person. R73's primary payer source was Medicare A. R73 was discharged on [DATE] to another SNF.<br><br>A physician order for R73's discharge to another SNF was obtained on 3/15/23.<br><br>R73 had the following care plan effective 2/10/23 in regards to discharge planning:<br><br>-R73 wishes to return/be discharged to previous home situation.<br><br>Initiated 2/10/23<br><br>Surveyor notes this discharge care plan was not revised to indicate R73 wanted to be discharged to another SNF.<br><br>Surveyor reviewed all electronic medical records(EMR) for R73 from 2/10/23 until 3/22/23. Surveyor notes there is no documentation that R73 requested to be discharged to another SNF, had been presented options for SNFs, or that a discharge planning meeting had been conducted.<br><br>On 3/17/23, the first discharge planning documentation is that R73 was being discharged to another facility on 3/17/23 by car/taxi, discharge instructions reviewed with R73 and R73 ambulates independently with devices.<br><br>(continued on next page) |

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| F 0660<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2)R74 was admitted to the facility on [DATE] with diagnose of Disease of Spinal Cord, Malignant Neoplasm of Bladder, and Nerve Root and Plexus Compressions in Diseases. R74 is R74's own person. R74's primary payer source was Medicare A. Surveyor requested a physician's order for discharge to another SNF, but was not provided with the documentation. R74 was discharged to another SNF on 3/17/23.<br><br>There is no documentation that a physician's order was obtained for R74's discharge to another SNF.<br><br>R74 had the following care plan effective 3/14/23 in regards to discharge planning:<br><br>-R74 wishes to return/be discharged to previous home situation.<br><br>Initiated 3/14/23<br><br>Surveyor notes this discharge care plan was not revised to indicate R74 wanted to be discharged to another SNF.<br><br>Surveyor reviewed all electronic medical records(EMR) for R74 from 3/13/23 until 3/22/23. Surveyor notes there is no documentation that R74 requested to be discharged to another SNF, had been presented options for SNFs, or that a discharge planning meeting had been conducted.<br><br>On 3/15/23, the first discharge planning documentation is that R74 was agreeable to transfer to alternative SNF for continued rehabilitation. Referrals were sent to two SNFs. On 3/16/23, 3 more referrals were sent to SNFs. On 3/17/23, it is documented that R74 is being discharged to a SNF out of state, and not one of the SNF that referrals were originally sent to.<br><br>3)R75 was admitted to the facility on [DATE] with diagnoses of Morbid Obesity, Type 2 Diabetes Mellitus, Chronic Kidney Disease, Stage 3, and Peripheral Vascular Disease. R75 is R75's own person. R75's primary payer source was Medicare A. R75 was discharged to another facility on 3/17/23.<br><br>A physician order for R75's discharge to another SNF was obtained on 3/16/23.<br><br>R75 had the following care plan effective 3/7/23 in regards to discharge planning:<br><br>-R75 wishes to return/be discharged to previous home situation.<br><br>Initiated 3/7/23<br><br>Surveyor notes this discharge care plan was not revised to indicate R75 wanted to be discharged to another SNF.<br><br>Surveyor reviewed all electronic medical records(EMR) for R75 from 3/7/23 until 3/17/23. Surveyor notes there is no documentation that R75 requested to be discharged to another SNF, had been presented options for SNFs, or that a discharge planning meeting had been conducted.<br><br>On 3/10/23, the first discharge planning documentation is that R75 had the goal to return home upon completion of therapy.<br><br>On 3/16/23, R75 consented to a SNF referral.<br><br>(continued on next page) |

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| F 0660<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 3/17/23, R75 was discharged to another SNF.<br><br>4)R76 was admitted to the facility on [DATE] with diagnoses of Dependence on Renal Dialysis, Cardiac Arrest, Chronic Obstructive Pulmonary Disease, Dysphagia, Heart Failure, and End Stage Renal Disease. R76 is R76's own person. R76's primary payer source was Medicare A. R76 was discharged from the facility on 3/17/23 to another SNF.<br><br>A physician order for R76's discharge to another SNF was obtained on 3/15/23.<br><br>R76 had the following care plan effective 2/28/23 in regards to discharge planning:<br><br>-R76 wishes to return/be discharged to previous home situation.<br><br>Initiated 2/28/23<br><br>Surveyor notes this discharge care plan was not revised to indicate R76 wanted to be discharged to another SNF.<br><br>Surveyor reviewed all electronic medical records(EMR) for R76 from 2/28/23 until 3/17/23. Surveyor notes there is no documentation that R76 requested to be discharged to another SNF, had been presented options for SNFs, or that a discharge planning meeting had been conducted.<br><br>On 3/7/23, the first discharge planning documentation is that R76 was agreeable to move to a first floor apartment and referrals sent to assisted living facility's.<br><br>On 3/15/23, it documented that R76 and family is agreeable to referral to be sent to another SNF.<br><br>On 3/17/23, R76 and family notified of transfer to another SNF other than the original referral sent to.<br><br>5)R77 was admitted to the facility on [DATE] with diagnoses of Type 2 Diabetes Mellitus, Chronic Kidney Disease, Stage 3 and Essential Hypertension. R77 is R77's own person. R77's primary payer source was Medicare A. R77 discharged from the facility on 3/18/23 to another SNF.<br><br>A physician order for R77's discharge to another SNF was obtained on 3/15/23.<br><br>R77 had the following care plan effective 3/14/23 in regards to discharge planning:<br><br>-R77 wishes to return/be discharged to previous home situation.<br><br>Initiated 3/14/23<br><br>Surveyor notes this discharge care plan was not revised to indicate R77 wanted to be discharged to another SNF.<br><br>Surveyor reviewed all electronic medical records(EMR) for R77 from 3/14/23 until 3/18/23. Surveyor notes there is no documentation that R77 requested to be discharged to another SNF, had been presented options for SNFs, or that a discharge planning meeting had been conducted.<br><br>(continued on next page) |

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| F 0660<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 3/16/23, the first discharge planning documentation is that family consented to referrals to another SNF.<br><br>On 3/18/23, R77 was discharged to another SNF.<br><br>6)R78 was admitted to the facility on [DATE] with diagnoses of Multiple Sclerosis, Disorder Involving the Immune Mechanism, Essential Hypertension, and Chronic Fatigue. R78 is R78's own person. R78's primary payer source was Medicare A. R78 discharged from the facility on 3/18/23.<br><br>A physician order for R78's discharge to another SNF was obtained on 3/15/23.<br><br>R78 had the following care plan effective 3/13/23 in regards to discharge planning:<br><br>-R78 wishes to return/be discharged to previous home situation.<br><br>Initiated 3/13/23<br><br>Surveyor notes this discharge care plan was not revised to indicate R78 wanted to be discharged to another SNF.<br><br>Surveyor reviewed all electronic medical records(EMR) for R78 from 3/10/23 until 3/18/23. Surveyor notes there is no documentation that R78 requested to be discharged to another SNF, had been presented options for SNFs, or that a discharge planning meeting had been conducted.<br><br>On 3/13/23, a care conference was held, and documentation indicates the goal was for R78 to return home with spouse.<br><br>On 3/18/23, documentation indicates R78 was discharged to another SNF and transported by car/taxi.<br><br>7)R79 was admitted to the facility on [DATE] with diagnoses of Coronary Artery Disease, Hypertension, Peripheral Vascular Disease, and Respiratory Failure. R79 was R79's own person. R79's primary payer source was Medicare A. R79 discharged from the facility on 3/18/23 to another SNF.<br><br>A physician order for R79's discharge to another SNF was obtained on 3/17/23.<br><br>R79 had the following care plan effective 3/13/23 in regards to discharge planning:<br><br>-R79 wishes to return/be discharged to previous home situation.<br><br>Initiated 3/13/23<br><br>Surveyor notes this discharge care plan was not revised to indicate R79 wanted to be discharged to another SNF.<br><br>Surveyor reviewed all electronic medical records(EMR) for R79 from 3/13/23 until 3/18/23. Surveyor notes there is no documentation that R79 requested to be discharged to another SNF, had been presented options for SNFs, or that a discharge planning meeting had been conducted.<br><br>(continued on next page) |

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| F 0660<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 3/17/23, documentation indicates R79 would prefer discharge to home with family support. Additional documentation indicates R79 was discharged to another SNF on 3/17/23.<br><br>8)R80 was admitted to the facility on [DATE] with diagnoses of Multiple Fractures of Ribs, Type 2 Diabetes Mellitus, Hypokalemia, Essential Hypertension, and Chronic Kidney Disease, Stage 3. R80 is R80's own person. R80's primary payer was managed Medicare. R80 discharged from the facility to another SNF on 3/21/23.<br><br>A physician order for R80's discharge to another SNF was obtained on 3/15/23.<br><br>R80 had the following care plan effective 3/15/23 in regards to discharge planning:<br><br>-R80 wishes to return/be discharged to previous home situation.<br><br>Initiated 3/15/23<br><br>Surveyor notes this discharge care plan was not revised to indicate R80 wanted to be discharged to another SNF.<br><br>Surveyor reviewed all electronic medical records(EMR) for R80 from 3/3/23 until 3/21/23. Surveyor notes there is no documentation that R80 requested to be discharged to another SNF, had been presented options for SNFs, or that a discharge planning meeting had been conducted.<br><br>On 3/17/23, documentation indicates R80 is being discharged to another facility and transported by car/taxi.<br><br>On 3/21/23, R80 was discharged to another SNF.<br><br>9)R81 was admitted to the facility on [DATE] with diagnoses of Chronic Respiratory Failure with Hypoxia, Hypokalemia, Barrett's Esophagus, Chronic Kidney Disease, Unspecified Dementia, and Adjustment Disorder with Depressed Mood. R81 has an activated Health Care Power of Attorney(HCPOA). R81's primary payer source was Medicare A. R81 discharged from the facility to another SNF on 3/21/23.<br><br>A physician order for R81's discharge to another SNF was obtained on 3/15/23.<br><br>R81 had the following care plan effective 3/10/23 in regards to discharge planning:<br><br>-R81 wishes to return/be discharged to previous home situation.<br><br>Initiated 3/10/23<br><br>Surveyor notes this discharge care plan was not revised to indicate R81 wanted to be discharged to another SNF.<br><br>Surveyor reviewed all electronic medical records(EMR) for R81 from 3/10/23 until 3/21/23. Surveyor notes there is no documentation that R81 requested to be discharged to another SNF, had been presented options for SNFs, or that a discharge planning meeting had been conducted.<br><br>(continued on next page) |

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| F 0660<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 3/20/23, documentation indicates R81 was discharged to another SNF.<br><br>10)R95 was admitted to the facility on [DATE] with diagnoses of Chronic Respiratory Failure with Hypoxia, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus, Cognitive Communication Deficit, and Anxiety Disorder. R95 has an activated Health Care Power of Attorney(HCPOA). R95's primary payer source was Medicare A. R95 discharged from the facility on 3/16/23 to another SNF.<br><br>A physician order for R95's discharge to another SNF was obtained on 3/15/23.<br><br>R95 had the following care plan effective 3/9/23 in regards to discharge planning:<br><br>-R95 wishes to return/be discharged to previous home situation.<br><br>Initiated 3/9/23<br><br>Surveyor notes this discharge care plan was not revised to indicate R95 wanted to be discharged to another SNF.<br><br>Surveyor reviewed all electronic medical records(EMR) for R95 from 3/8/23 until 3/16/23. Surveyor notes there is no documentation that R95 requested to be discharged to another SNF, had been presented options for SNFs, or that a discharge planning meeting had been conducted.<br><br>On 3/16/23, documentation indicates that family consented for R95 to be transferred to an alternative SNF, referral sent, and R95 was discharged to an alternative SNF on 3/16/23.<br><br>Surveyor notes that R73, R74, R75, R76, R77, R78, R79, R80, R81, and R95's primary payer source while a Resident at the facility was either Medicare A or a managed care insurance.<br><br>On 3/22/23 at 11:21 AM, Surveyor confirmed with Social Worker(SW-E) that the facility had not initiated any 30 day discharge notices.<br><br>On 3/22/23 at 4:00 PM, Surveyor addressed the concern with SW-E that proper discharge planning had not been implemented for/with R73, R74, R75, R76, R77, R78, R79, R80, R81, and R95 who were transferred to another SNF. SW-E stated the facility was pairing down facility staff including therapy staff, it was discussed as team and the decision was made to approach the Residents to have the Residents transferred to another SNF. SW-E indicates SW-E asked the Residents if they wanted to go to another SNF and SW-E obtained consent. SW-E stated R73, R74, R75, R76, R77, R78, R79, R80, R81, and R95 were informed they were being transferred to another SNF due to quality of care issues. SW-E stated the facility was not able to take admissions due to denial of payment and the facility needed to cut down on therapy staff due to census. Surveyor asked SW-E who gave the directive to transfer Residents to other SNFs. SW-E stated, it was a team decision.<br><br>On 3/22/23 at 4:08 PM, Surveyor interviewed Administrator(NHA-A) who stated NHA-A was not in the building during this time period. NHA-A stated the decision or meeting to transfer Residents to other SNFs took place without NHA-A's knowledge. Surveyor asked NHA-A who was in charge while NHA-A was out of the building. NHA-A informed Surveyor that Chief Clinical Officer(CCO-H) and VP of Operations(VPO-I) were in charge.<br><br>(continued on next page) |

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| F 0660<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 3/22/23 at 4:21 PM, Surveyor interviewed both CCO-H and VPO-I together. CCO-H and VPO-I stated that the therapy department was starting 'furlough' due to the facility being in denial of payment. CCO-H and VPO-H stated that the corporate social worker suggested talking to Residents and suggesting Residents go to other SNFs. CCO-H and VPO-I understood that Residents were given choices and if the Residents demanded to stay, the facility would have let them stay.<br><br>On 3/23/23 at 11:41 AM, Surveyor interviewed NHA-A, Director of Nursing(DON-B), CCO-H and VPO-I in regards to Surveyor's concern that R73, R74, R75, R76, R77, R78, R79, R80, R81, and R95 did not receive proper discharge planning consisting of being provided options along with a formal discharge planning team meeting. Surveyor was informed that R73, R74, R75, R76, R77, R78, R79, R80, R81, and R95 were not given the opportunity to tour alternative SNFs. VPO-I confirmed that the facility being in denial of payment was part of the reason to relocate Residents to alternative SNFs. VPO-I stated that therapy and other staff were being furloughed because the state had given a staffing cite. The facility assessed the ability to care for Residents. Surveyor shared the concern with NHA-A, DON-B, CCO-H, and VPO-I that R73, R74, R75, R76, R77, R78, R79, R80, R81, and R95 did not receive proper discharge planning in the transition to alternative SNFs. Surveyor shared the concern that the facility when agreeing to admit R73, R74, R75, R76, R77, R78, R79, R80, R81, and R95, the facility was in agreement that R73, R74, R75, R76, R77, R78, R79, R80, R81, and R95's needs could be met. No further information was provided by the facility at this time. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16584<br><br>UNCORRECTED ON REVISIT<br><br>Based on record review and staff interviews, the facility did not ensure 3 out of 12 residents ( R61, R47, R60) who were dependent on staff assistance for activities of daily living were provided with the necessary services to maintain grooming and personal hygiene by receiving a bath and/ or shower per the plan of care.<br><br>R47 and R61 are dependent on staff assistance for showers/ bathing. Both R47 and R61 were not provided with scheduled showers/ baths per the plan of care.<br><br>R60 is dependent on staff for bathing/ showers as well as incontinence cares. R60 was not provided with showers or incontinence care per the plan of care.<br><br>1.) R61 was originally admitted to the facility on [DATE] and discharged on [DATE].<br><br>Admission MDS (Minimum Data Set), dated 8/29/22, stated that it is very important to him to choose between a tub bath, shower, bed bath or sponge bath. R61 needs extensive assistance/ 1-person physical assist for personal hygiene. R61 is totally dependent on staff for bathing. Shower/ bathing: the ability to bathe self, including washing, rinsing, and drying self- R61 needs substantial/ maximal assistance from staff. R61 had a BIMS (brief interview for mental status) score of 15 - cognitively intact.<br><br>A review of the individual plan of care for R61 stated that R61 has an Assistance for Daily Living (ADL) self-care performance deficit and limited physical mobility r/t (related to) Primary Dx (diagnosis): Right hip Arthrotomy/wash, Osteomyelitis, Degenerative Lumbar Spondylosis, Septic Arthritis, Valvular Heart Disease Ankylosis of the bilateral sacroiliac joints, severe bilateral degenerative hip, Pelvic abscess. This plan of care was initiated on 08/23/202. Interventions included: -Bathing: Physical Assist, Personal Hygiene: Physical Assist Date Initiated: 08/23/2022.<br><br>According to the Certified Nursing Assistant (CNA) care tracker, R61 is to receive a shower on Monday and Friday evenings.<br><br>Surveyor conducted a review of the CNA documentation on the care tracker for the months of August, September, October and November 2022. The following was noted:<br><br>August 2022; R61 received a shower on Sunday 8/28/22 and Tuesday 8/30/22.<br><br>September 2022; R61 received a shower on Saturday 9/10/22, Refused on Tuesday 9/13/22, Saturday 9/24/22 and Tuesday 9/27/22. The facility documented that 3 total showers for the month of September 2022 were provided to R61.<br><br>October 2022; R61 received a shower on Saturday 10/1/22 (refused), Saturday 10/8/22, Tuesday 10/11/22, Saturday 10/15/22 and Saturday 10/22/22. The facility documented that R61 was only provided with 4 total showers for the month of October 2022.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | November 2022; R61 was not provided any showers in the Month of November 2022. R61 was discharged on [DATE] and did not return.<br><br>On 3/13/23 at 3:00 p.m., Surveyor shared the above information about R61 only receiving 9 showers from 8/23/22 until 11/16/22 with the administrative staff. No additional was provided as to why the facility did not assist R61 with twice weekly showers per the plan of care.<br><br>21855<br><br>2.) R60's medical record was reviewed by Surveyor. R60 is their own person.<br><br>R60 had a Quarterly MDS (minimum data set) assessment completed on 12/22/22. This assessment indicates no cognitive impairment; requires 2 staff for transfers and 1 assist for hygiene/toileting, mechanical lift for non-ambulatory. The Bathing section for a 7 day look back indicates no bathing was provided.<br><br>The Annual MDS assessment completed on 9/21/22 indicates no cognitive impairments, requires 2 assist with transfers and 1 assist with hygiene/toileting, Hoyer lift for non-ambulatory. The Bathing section 7 day look back indicates 1 bath was provided and 1 was refused.<br><br>R60's plan of care was reviewed with the following:<br><br>-A self-care performance deficit and limited physical mobility initiated 9/11/2020 with interventions of:<br>-Bathing with physical assist of one; Toileting requires assist of 1 staff; Transfers with Hoyer; Hygiene and dressing assist of 1 staff.<br><br>- Has Bladder incontinence initiated 9/11/2020 with interventions of:- check and change; uses disposable briefs; check every 2- 3 hours for incontinence.<br><br>-Has potential for impaired skin integrity related to incontinence initiated 10/16/2020 with interventions of:- Apply barrier cream to protect skin from excessive moisture; change bedding/clothing if moist; encourage bed bath when showers declined.<br><br>The facility's Grievance's were reviewed. On 10/5/2022 R60 indicated the Staff did not change them. The Investigation indicates R60 was up in the wheelchair too long and did not want a shower. R60 refused a bed bath at first and then changed their mind once they were in bed. The resolution was R60 received a bed bath. On 1/15/23 R60 expressed they were not getting their showers on their scheduled days. The Investigation indicates R60 has received their scheduled showers with 1 refusal. R60 was on a Covid Isolation as well during this time. There is an attached shower documentation with a 30-day look back. The Shower are Tuesday/Friday PM and as needed. R60 is supposed to have showers twice a week and as needed. The 30 day look back indicates R60 had either a bed-bath or shower 3 times in 30 days. There is no additional information about the showers/bed baths.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/8/2023 at 10:17 PM, Surveyor observed R60 in their room. R60 was sitting in a wheelchair next to the bed. R60 stated R60 had pushed the call light over an hour ago and the CNA came in and told R60 that the CNA was the only one working until 10:00 PM so R60 would have to wait until after 10:00 PM to get any assistance. R60 stated R60 had a bowel movement over an hour ago and has been sitting in it since that time. R60 stated CNA-V said CNA-V would come back as soon as the other CNA got to work. Surveyor asked R60 how R60 is transferred from the wheelchair to the bed. R60 stated they use a lift because R60 had left-sided weakness from a stroke. At 10:25 PM, CNA-V and CNA-W came into R60's room with a mechanical lift to put R60 to bed and provide cares. At 10:44 PM, Surveyor asked CNA-V if R60 had a bowel movement and needed cleaning up after being transferred to bed. CNA-V stated yes, R60 had a bowel movement.<br><br>On 3/9/23 at 8:37 AM Surveyor spoke with R60. They indicated they are supposed to have showers on Tuesday and Friday Evenings. R60 indicated they do not get showers due to there is no staff available. R60 indicated they used to use the bathroom when they first got to the facility. They don't get up now to use the bathroom. They rely on staff.<br><br>On 3/9/23 at 11:48 AM Surveyor spoke with RN-M (Registered Nurse who has been involved with R60's care at the facility. RN-M indicates R60 will shower depending on their mood and if they are up in their wheelchair. When R60 stays up later they will take showers, if staff put R60 in bed early R60 doesn't want to get up again to shower.<br><br>On 3/9/23 at 1:08 PM Surveyor spoke with ACNO-D (Assistant Chief Nursing Officer) who oversees R60's living unit. ACNO-D indicated R60 will refuse showers and it also depends on their mood. ACNO-D did not indicate any revised interventions to ensure showering was completed.<br><br>On 3/13/23 at 8:48 AM Surveyor spoke with DCT-E (Director of Care Transitions). DCT-E is currently taking over and did not conduct the Grievance's for R60. The previous Social Worker is no longer at the facility. DCT-E indicates they conduct Care Conferences and just knows R60 refuses showers. DCT-E did not know the circumstances why R60 refuses showers besides R60's mood varies.<br><br>On 3/13/23 at 3:12 PM at the Facility Exit Meeting Surveyor shared the concerns with R60's showers and incontinence care. No further information was provided.<br><br>38253<br><br>3.) R47 was admitted to the facility on [DATE] with diagnoses of spinal stenosis, diabetes, pressure ulcer of the right hip, and pressure ulcer to the right buttock with Methicillin Susceptible Staphylococcus Aureus infection. R47's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated R47 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 and coded as needing total assistance with bathing.<br><br>On 2/22/2023 at 12:48 AM, R47 told a police officer that R47 had been in the wheelchair from 1:00 PM that afternoon until the time the police officer arrived at approximately 12:50 AM. R47 told the police officer R47 had been trying to contact facility staff to transfer R47 from the wheelchair to the bed and was sitting in a urine-soaked adult diaper. The police officer noted a strong smell of urine and feces while inside the room. R47 told the police officer R47 was supposed to have showers twice a week on Saturdays and Wednesdays but that does not routinely happen.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Surveyor reviewed R47's bathing/shower documentation by Certified Nursing Assistants (CNAs) for December 2022, January 2023, and February 2023.<br><br>December 2022 - R47 received a bath/shower on 12/1/2022, 12/8/2022, and 12/10/2022. The documentation does not indicate if it was a shower or bath that was provided. On 12/15/2022, the CNA documented NA indicating Not Applicable with no other explanation. R47 did not have a bath or shower documented after 12/10/2022 until 1/1/2023, 21 days.<br><br>January 2023 - R47 received a bath/shower on 1/1/2023 and then on 1/12/2023, eleven days later. R47 received a bath or shower twice weekly from 1/12/2023 until the time of discharge 3/2/2023.<br><br>On 3/13/2023 at 3:00 PM, Surveyor shared with Director of Clinical Operations-H, Director of Clinical Operations-I, and Assistant Chief Nursing Officer-D the concern of R47 not having incontinence care done on 2/22/2023 and baths or showers not completed twice weekly as per resident preference and Care Plan. |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40533<br><br>Based on observation, interview, and record review, the facility failed to ensure that residents with Pressure Injuries receive appropriate care, treatment, and preventative interventions to promote healing for 2 of 6 residents (R58 and R22) reviewed for pressure injuries.<br><br>~ R58 was admitted to the facility [DATE] with no pressure injuries and at high risk for skin breakdown due to pressure, arterial, and diabetic comorbidities. R58 had a plan of care in place but no resident specific interventions to prevent skin breakdown.<br><br>R58 was hospitalized [DATE] through [DATE]. Upon readmission, R58 was assessed by a Licensed Practical Nurse (LPN) and not a Registered Nurse (RN). Bruising, dry, flaky feet and a scab to left pinky toe was noted but was not assessed comprehensively or reported to the Nurse Practitioner (NP) or an MD<br><br>R58 developed a skin tear to his buttocks on [DATE] that was not assessed comprehensively by an RN or reported to the NP or a physician. R58's family noted a wound that was causing pain to R58's right ankle on [DATE] and alerted the LPN on duty. The LPN charted the wound as a necrotic pressure injury and reported it to the Unit Manager RN. LPN stated the wound was 3 to 4 inches in length and 2 to 3 inches long when she saw it on [DATE]. There was no RN assessment of the wound and it was not reported to the NP or physician.<br><br>Diabetic foot checks were recorded as completed but no nurse could recall or remember checking R58's feet the week leading up to the family reporting the wound and no Certified Nursing Assistant (CNA), that were interviewed, could recall or remember looking at R58's feet. R58 was transferred to the hospital on [DATE] at approximately 11:15 AM and the wound was noted in the emergency room documents by a Wound MD at 4:35 PM, as an Unstageable Pressure Injury along with numerous other diabetic wounds and a Stage 2 Pressure Ulcer to his sacrum. R58's wounds continued to worsen, needing debridement and eventually causing osteomyelitis. R58 passed away [DATE].<br><br>The facility's failure to have R58's wounds and skin comprehensively assessed by an RN, the failure to complete skin and foot checks, the failure to report the wounds to the MD/NP and prevent new wounds from forming created a finding of Immediate Jeopardy (IJ) that began on [DATE]. Surveyor notified Chief Clinical Operator (CCO)-H, VP of Operations (VPO)-I, VP of Clinical Operations-J, and Assistant Chief Nursing Officer (ACNO)-D of the IJ on [DATE] at 2:02 PM. The IJ was removed on [DATE], however the deficient practice continues at a scope/severity level of D (Potential for Harm/Isolated) as evidenced by:<br><br>~ R22 did not have a comprehensive skin assessment, along with treatment orders, upon readmission to the facility from a hospital stay.<br><br>Findings include:<br><br>The Mayo Clinic's website describes the complications of pressure injuries, including:<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | o Sepsis. Sepsis occurs when bacteria enter the bloodstream through broken skin and spread throughout the body. It's a rapidly progressing, life-threatening condition that can cause organ failure.<br><br>o Cellulitis. Cellulitis is an infection of the skin and connected soft tissues. It can cause severe pain, redness and swelling. People with nerve damage often do not feel pain with this condition. Cellulitis can lead to life-threatening complications.<br><br>o Bone and joint infections. An infection from a pressure sore can burrow into joints and bones. Joint infections (septic arthritis) can damage cartilage and tissue. Bone infections (osteomyelitis) may reduce the function of joints and limbs. Such infections can lead to life-threatening complications.<br><br>http://www.mayoclinic.org/diseases-conditions/bedsores/basics/risk-factors/con-20030848<br><br>The AMDA (American Medical Directors Association) clinical practice guideline entitled 'Pressure Ulcers and Other Wounds,' dated 2017, states in part:<br><br>.A pressure ulcer [Injury] is localized damage to the skin or underlying soft tissue, usually over a bony prominence or related to a medical or other device. The ulcer may present as intact skin or as an open ulcer and may be painful. The ulcer occurs as a result of intense or prolonged pressure or pressure in combination with shear.<br><br>Recognition: Early recognition of pressure ulcers and of any risk associated with the development of pressure ulcers and other wounds is critical to their successful prevention and management.<br><br>Assessment: The purpose of the assessment is to collect enough information to evaluate the patient's general condition, characterize a pressure ulcer; and identify related causes and complications.<br><br>Step 2. Examine the patient's skin thoroughly to identify existing pressure ulcers. Examine the patient's skin upon admission or readmission.<br><br>Step 3. Assess the patient's overall physical and psychosocial health and characterize the pressure ulcers. A pressure ulcer should be assessed along with the patient's overall clinical, functional, and cognitive status weekly reassessment and documentation of ulcer characteristics is recommended. More frequent assessment may be necessary for ulcers that are not responding to treatment or are worsening despite treatment.<br><br>Step 4. Identify factors that can influence ulcer treatment and healing.functional status. Functional factors, including impaired mobility, a self-care deficit, and incontinence (especially fecal incontinence), may influence the severity, duration, and healing of a pressure ulcer.<br><br>Step 5.Documentation should cover all pertinent characteristics of existing pressure ulcers, including location; size; depth; maceration; color of the ulcer and surrounding tissues; a description of any drainage, eschar, necrosis, odor, tunneling, or undermining; tissue types covering the wound bed; .and a description of the peri-wound skin .including type and amount of drainage.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Step 6. Identifying priorities in managing the ulcer and the patient .Pain control related to the ulcer and any comorbid conditions.The same factors that increase a patient's susceptibility to developing pressure ulcers . may also impair the healing of an existing pressure ulcer .<br><br>Surveyor reviewed facility's Wound Policy & Procedure with a date of [DATE]. Documented was:<br><br>Policy:<br><br>The facility is committed to providing a comprehensive wound management program to promote the resident's highest level of functioning and well-being and to minimize the development of in-house acquired pressure ulcers, unless the individual's clinical condition demonstrates they are unavoidable.<br><br>Any resident with a wound receives treatment and services consistent with the resident's goals of treatment. Typically the goal is one of promoting healing and preventing infection unless a resident's preferences and medical condition necessitate palliative care as the primary focus.<br><br>A commitment to the Wound Management Program is demonstrated by implementation of processes founded on accepted standards of practice, research-driven clinical guidelines, and interdisciplinary involvement .<br><br>Procedure:<br><br>Accountability<br><br>The Wound Management Program identifies staff participation and accountability to include:<br><br>-Person responsible for program oversight and coordination<br><br>-Staff involved in prevention and treatment (and their roles)<br><br>-Expectation of all caregivers to observe resident skin integrity during the daily provision of the resident's personal care<br><br>Admission Wound Assessment and Management<br><br>-At the time of admission, the discharge records from the prior facility are reviewed for information relating to wounds or alteration in skin integrity. Staging from another facility is not adopted for use in the facility<br><br>-Any Wounds assessed will be captured in the PC nursing evaluation, in progress notes, or by completing in Wound Rounds via Quick Shot (within ,d+[DATE] hours of admission)<br><br>-The admission wound assessment should include at a minimum:<br><br>-Interview of resident or family about history of skin alterations<br><br>-4 Physical evaluation to include identification of:<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | -Skin alterations present on admission, skin discolorations and any evidence of scarring on pressure points<br><br>-Signs/symptoms/diagnosis of peripheral vascular disease<br><br>-Bed mobility Continence<br><br>-Recent surgical procedure Head-to-toe skin assessment<br><br>-Nutritional status and issues<br><br>-Completion of Braden or [NAME] Skin Risk Assessment Tool<br><br>-Comprehensive assessment of any wound to include:<br><br>-Location of wound<br><br>-Length, width, and depth measurements recorded in centimeters<br><br>-Direction and length of tunneling and undermining<br><br>-Appearance of the wound base<br><br>-Type and percentage of tissue in wound<br><br>-Drainage amount and characteristics including color, consistency, and odor<br><br>-Appearance of wound edges<br><br>-Description of the peri-wound condition or evaluation of the skin adjacent to the wound<br><br>-Presence or absence of new epithelium at wound rim<br><br>-Risk reduction measures such as use of heel protectors (designed for friction/shear reduction versus pressure reduction), elevation of lower extremities, participation in bowel and bladder program, etc. are initiated if determined appropriate<br><br>-Discussion with the attending physician and resident/ representative includes notification of any skin impairment identified on admission<br><br>-Orders are verified or obtained as needed<br><br>-An admission/interim/ baseline care plan is developed<br><br>-Assessments and interventions implemented are documented in the resident clinical record .<br><br>Documentation and Care Planning<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | -The wound management program documentation requirements include:<br><br>o Identification of the location and frequency of wound documentation<br><br>o Required comprehensive description of pressure ulcer weekly, at a minimum<br><br>o Delineation of in-house documentation required (for example, weekly reports to the Director of Nurses) and by whom<br><br>o Goals of the wound care plan collaboratively determined with the resident, family, and interdisciplinary team<br><br>o Assigned responsibility/accountability for the initial care plan and for subsequent updating<br><br>o Determined facility time frames for care plan updating<br><br>-Resident risk factors and interventions are documented including:<br><br>o Impaired mobility<br><br>o Need for pressure relief such as support surfaces, repositioning, pressure relieving devices<br><br>o Assigned responsibility/ accountability for the initial care plan and for subsequent updating<br><br>o Nutritional status<br><br>o Incontinence<br><br>o Skin condition<br><br>o Complications such as infection and pain<br><br>o General treatment regimen (delineating specific treatment is not necessary) .<br><br>Notification<br><br>-A written protocol is established for:<br><br>o Physician notification of pressure ulcer presence and responses to treatment<br><br>o Family notification of pressure ulcer presence, treatment plan, response to treatment, and changes in treatment due to wound deterioration<br><br>o In-house notification of interdisciplinary team members of the presence of a pressure ulcer and/or deterioration in wound status<br><br>o MDS Coordinator notification of the number of pressure ulcers and stages .<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Surveyor reviewed facility's Skin Integrity policy with a date of [DATE]. Documented was:<br><br>Policy: Based on the comprehensive assessment of the resident, facility clinical staff will ensure that the resident who enters the facility without a pressure sore(s) will not develop a pressure sore(s) unless the resident's clinical condition demonstrates that the condition was unavoidable.<br><br>Procedure:<br><br>The licensed nurse and interdisciplinary team will assess and periodically reassess each resident's risk for developing a pressure ulcer and take action to address any identified risks.<br><br>-The interdisciplinary team will create a written plan for the identification of risk for and prevention of pressure ulcers.<br><br>o Identification and evaluation of risk factors of:<br><br>o Increased/decreased mobility and decreased functional ability<br><br>o Cognitive impairment<br><br>o Under-nutrition, malnutrition including significant weight loss with mobility/positioning concerns<br><br>o Use of medications which may affect wound healing<br><br>o Any decline in clinical status or co-morbid diagnoses affecting mobility/positioning or ability of skin to endure effects of pressure<br><br>o History of healed ulcer(s)<br><br>o Exposure of skin to urinary and fecal incontinence<br><br>-The nurse will perform a full-body initial skin assessment to identify if the resident is at risk for a pressure ulcer within ,d+[DATE] hours of admission to the facility and weekly.<br><br>o Identification, on admission of the presence of a pressure ulcer, or the presence of possible deep tissue injury or skin areas at risk for breakdown<br><br>o Wound site and characteristics at the time of admission<br><br>o Possibility of underlying tissue damage related to immobility or illness prior to admission<br><br>o Skin condition on or within 24 hours of admission<br><br>o History of impaired nutrition<br><br>o History of previous pressure ulcers .<br><br>(continued on next page) |

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| Ignite Medical Resort Oak Creek | 2700 Honadel Boulevard<br>Oak Creek, WI 53154 |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | -Care planning for pressure ulcers will:<br><br>o Be based on assessment and will be consistent with resident's specific conditions, risks, needs, behaviors, preferences, and current standards of practice<br><br>o Will include specific interventions/ services to prevent development of pressure ulcers and/or to treat existing pressure ulcers and potential associated complications and will include measurable goals and time tables and will include:<br><br>o Pressure redistribution/relief based on identified resident needs including repositioning, heel protection, use of wheelchair, reclining chair, and bed/mattress pressure redistribution surfaces<br><br>o Prevention of shearing and friction<br><br>o Weekly skin assessments by licensed nurses and twice weekly skin observations by direct care providers<br><br>o Identification of comorbid conditions affecting risk for and healing of pressure ulcers and efforts to stabilize conditions<br><br>o Daily evaluation of status of dressing and surrounding skin<br><br>o Pressure ulcer care and treatment as ordered by physician including type of dressing, frequency of dressing change, wound cleansing techniques, debridement of wound and prevention/ management of infections<br><br>o Approaches to manage and monitor pain including preemptive measures if pain occurs during dressing changes<br><br>o Resident and/or Responsible Party choices and preferences including alternative efforts if resident refuses or resists staff interventions to reduce risk or treat existing pressure ulcers<br><br>o Care plan revisions will include:<br><br>-Care plan will be revised to modify prevention strategies and address the presence and treatment of any newly developed pressure ulcer.<br><br>1.) R58 was admitted to the facility on [DATE] with diagnoses that included Cardiogenic Shock, End Stage Renal Disease (ESRD) with Dependence on Renal Dialysis, Type 2 Diabetes Mellitus (DM), Chronic Obstructive Respiratory Disease (COPD), Morbid (Severe) Obesity Due to Excess Calories, Absence of Other Left Toe(s), Ventricular Tachycardia, Personal History of Malignant Neoplasm of Bladder, Peripheral Vascular Disease, Gastrointestinal Hemorrhage, Coronary Artery Disease (CAD), and Peripheral Autonomic Neuropathy.<br><br>Surveyor reviewed R58's Braden Scale for Predicting Pressure Sore Risks with assessment dates of [DATE], [DATE], and [DATE]. Documented for all was a score of 12 which indicated high risk.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Surveyor reviewed R58's Admission Minimum Data Set (MDS) with an assessment reference date of [DATE]. Documented under Section C, Cognition was a Brief Interview for Mental Status (BIMS) score of 15 which indicated cognitively intact. Documented under Section G, Functional Status for Bed Mobility was , d+[DATE] which indicated Limited assistance - resident highly involved in activity, staff provide guided maneuvering of limbs and other non-weight bearing assistance; One person physical assist. Documented under Transfers was ,d+[DATE] which indicated Total dependence - full staff performance every time during entire 7-day period; Two plus persons physical assist. Documented under Section M, Determination of Pressure Ulcer/Injury Risk was Is this resident at risk of developing pressure ulcers/injuries? Yes. Does this resident have one or more unhealed pressure ulcers/injuries? No.<br><br>Surveyor reviewed R58's Care Area Assessment (CAA) related to Pressure Ulcer/Injury with an assessment date of [DATE]. Documented under Nature of the Problem/Condition was The [pressure injury] CAA triggered because this guest needs limited to extensive assistance with [activities of daily living (ADLs)], mobility, and [bowel and bladder (B&B)] management. This guest is at risk for pressure injury and skin breakdown. The plan is for nursing to monitor his skin integrity. The goal is for this guest to remain free of skin breakdown while participating in therapy to regain his strength and return to the community [at previous level of functioning - minimal assist (PLOF-MI)].<br><br>Surveyor reviewed R58's Comprehensive Care Plan with initiation date of [DATE]. Documented was:<br><br>Focus:<br><br>The resident has potential for impairment to skin integrity [related to (r/t)] limited mobility, heart failure, impaired mobility, ESRD, DM, CAD<br><br>Goal:<br><br>The resident will remain free of new skin impairment through the review date<br><br>Interventions:<br><br>~ Apply barrier cream per facility protocol to help protect skin from excess moisture.<br><br>~ Avoid scratching and keep hands and body parts from excessive moisture. Keep<br><br>fingernails short.<br><br>~ Change bedding/clothing if moist<br><br>~ Encourage activity as tolerated<br><br>~ Encourage good nutrition and hydration in order to promote healthier skin.<br><br>~ Encourage proper fitting footwear<br><br>~ Encourage that heels are elevated while resident is lying in bed<br><br>~ Encourage/assist resident reposition when in wheelchair every 2 hours<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | ~ Encourage/assist with turning and repositioning every ,d+[DATE] hours<br><br>~ Monitor skin when providing cares, notify nurse of any changes in skin appearance<br><br>~ Use draw sheet when turning/repositioning.<br><br>Surveyor noted there were no updates, revisions, or additional skin or wound care plans added to R58's chart throughout his stay at the facility. There were no resident specific interventions put in place for R58 to prevent skin breakdown.<br><br>Surveyor reviewed R58's MD Orders. Documented with a start date of [DATE] was Diabetic foot checks [every bedtime (q HS)] at bedtime. Documented with a start date of [DATE] was Skin Checks Weekly Thursday AMS complete under evaluations in [electronic chart] every day shift every Thu for SKIN CHECK - Must open and document Skin Evaluation for each assessment (including no new areas found).<br><br>R58 was hospitalized from [DATE] through [DATE]. Upon readmission, LPN-S assessed R58. Surveyor reviewed R58's readmission Nursing Evaluation with a date of [DATE]. Documented under the Skin Integrity was:<br><br>a. Does the resident have skin integrity concerns? Yes.<br><br>1a. Skin Impairments: Document impairment site. Under Description document initial wound measurements and general evaluation:<br><br>Site: 49) Right heel. Description: dry and hard; flaky skin.<br><br>Site: 50) Left heel. Description: dry and hard; flaky skin.<br><br>Site: 52) Left toe(s). Description: pinky toe healed scab.<br><br>Site: Other (specify). Description: left and right arm bruising .<br><br>There were no comprehensive assessment or measurement of the pinky toe wound or bruising to left and right arm by an RN. There were no other assessments of the wounds or measurements. There were no treatment orders or new preventative measures added to R58's care plan to prevent further breakdown.<br><br>Surveyor reviewed R58's MD Orders. Documented with a start date of [DATE] was Diabetic foot checks q HS at bedtime. Documented with a start date of [DATE] was Skin Checks Weekly Monday AM every day shift every Mon - Must open and document Skin Evaluation for each assessment (including no new areas found).<br><br>Surveyor reviewed R58's Skin Observation assessment with a date of [DATE]. Documented by Assistant Chief Nursing Officer RN (ACNO)-C was: A. Skin Observation. 1. Does the Resident have ANY Skin Issues Observed (including new and old)? B. No .<br><br>Surveyor reviewed R58's Skin Observation assessment with a date of [DATE]. Documented by LPN-S was<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A. Skin Observation. 1. Does the Resident have ANY Skin Issues Observed (including new and old)? A. Yes.<br><br>Document and Describe ALL Skin Issues.<br><br>2. Skin Issues:<br><br>Site: 32) Left buttocks. Description: open area.<br><br>3. Other Observations: blank.<br><br>4. Wound Team Notified of new area? a. Yes.<br><br>Surveyor reviewed R58's eINTERACT SBAR Summary for Providers with an assessment date of [DATE]. Documented was:<br><br>Situation: The [Change In Condition/s (CIC)] reported on this CIC Evaluation are/were: Change in skin color or condition .<br><br>- Skin Status Evaluation: Skin tear .<br><br>Primary Care Clinician Notified: NO .<br><br>Surveyor noted there was no comprehensive assessment of the wound bed by an RN. There were no other assessments of the wound or measurements.<br><br>Surveyor reviewed R58's MD Orders. Documented by LPN-S with a start date of [DATE] was daily foam border to buttock every day and night shift for skin integrity. The order was discontinued on [DATE]. Documented by ACNO-C with a start date of [DATE] was daily foam border to buttock every day shift for skin integrity.<br><br>Surveyor reviewed R58's Treatment Administration Record (TAR) for [DATE] through [DATE]. Diabetic foot checks were documented as completed on all dates from [DATE] through [DATE].<br><br>Surveyor reviewed R58's Pain Evaluation assessment with a date of [DATE]. Documented was<br><br>.Numerical Pain Scale:<br><br>1b. Pain score out of 10 where 1 is mild pain and 10 is the worst pain: h. 7.<br><br>2. Pain Location: Site: 49) Right heel. Description: open necrotic area .<br><br>Surveyor noted there was no further assessment of R58's pain or the wound causing the pain.<br><br>Surveyor reviewed R58's Progress Notes. Documented on [DATE] at 11:15 AM was Resident's life vest starting alarming. Life vest delivered 2 shocks. 911 called. Instructions for life vest explained to paramedics. Extra life vest batteries sent with paramedics. Resident transferred to [hospital]. NP aware.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Surveyor reviewed R58's Hospital Record from admission to theER on [DATE]. Documented at 3:05 PM was History of the Present Illness: [R58] presenting with a LifeVest shock. He was at his facility getting ready to go to dialysis when his life vest deep to (sic). He received 2 shocks 1 minute apart. He has been coughing for the last week or 10 days. He has also noticed a wound on his right ankle in the last day although it has been painful for a couple of weeks since he left the hospital and went to his current facility . Extremities: Wound with eschar right posterior ankle .<br><br>ER MD requested a Wound Consult and Wound MD assessed R48 at 4:35 PM on [DATE]. Documented was:<br><br>SUBJECTIVE:<br><br>Chief Complaint: Lower leg ulcers<br><br>Wound/Ulcer Present:<br><br>Diabetic lower extremity ulcer: [NAME] grade 1 (superficial diabetic ulcer).<br><br>Diabetic foot exam performed? No.<br><br>Current Vascular Assessment: Venous duplex study.<br><br>Current Antibiotic Regimen: None.<br><br>Current Offloading Modality: unsure.<br><br>Additional Wound Category: None<br><br>Maximum Baseline Ambulatory Status: Unable to assess<br><br>History of Present Illness: [R58] with past medical history of hypertension, severe aortic stenosis, hypercholesterolemia, coronary artery disease, chronic kidney disease, renal calculi, diabetes type 2, and sleep apnea. Presenting to the ED with a LifeVest shock. He received 2 shocks 1 minute apart. Hx of Covid last week - currently in Covid isolation<br><br>Wound care consulted to evaluate lower leg wounds and sacral wounds.<br><br>Interval history ([DATE]):<br><br>L/S [DATE] for lower leg wounds. States he noticed a wound on his right ankle for the past few days. X-ray ordered R ankle .<br><br>Also complaining of sore on sacral that is uncomfortable .<br><br>DIAGNOSES:<br><br>Diabetic lower extremity ulcer, [NAME] grade 1 (superficial diabetic ulcer) L toe<br><br>Pressure ulcer of the lower extremity, stage Unstageable R heel<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Pressure ulcer, other site, stage II sacral, lower leg ulcers .<br><br>Wound NP update on [DATE] documented:<br><br>admitted for [bilateral lower extremities] wounds and sacral pressure ulcer - present on admission.<br><br>Right heel and Achilles eschar is starting to slough from margins with tunneling proximally near Achilles and early cellulitis to peri wound.<br><br>-Discussed with [Surgeon], patient, family: they are interested in pursuing further interventions to help with wound healing including surgical intervention. Aware that his PAD increases risk for wound non-healing and limb loss. Aware that patient may ultimately need an amputation in the future regardless of current wound care actions.<br><br>-Surgical consultation for debridement vs amputation .<br><br>-Can start with an X-ray of affected area, may need MRI depending on surgeries impression for debridement candidacy.<br><br>Sacral ulcers tender. Needs to mobilize in bed, continue offloading surfaces.<br><br>Left toe eschar is stable.<br><br>Local wound care:<br><br>Vashe moist packing strip to right Achilles tunnel and Vashe moist gauze to slough at wound margins. Cover with dry dressing. Change daily and PRN.<br><br>Betadine paint to L toe eschar's and right knee scabs.<br><br>Layer Lidocaine and Calazime cream to sacral pressure ulcer BID and PRN.<br><br>Interdry to skin folds. Change daily and PRN.<br><br>Vaseline daily to left heel callus.<br><br>Prevalon boots at all times while in bed .<br><br>Infectious diseases:<br><br>Signs of cellulitis and turbid drainage from tunnel.<br><br>Primary team starting empiric abx.<br><br>Cultured today.<br><br>Endocrine:<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Encourage glycemic control to promote wound healing.<br><br>Nutrition:<br><br>Encourage protein rich diet to promote wound healing.<br><br>Offloading:<br><br>At risk for pressure ulcers<br><br>aggressive off-loading with a stage IV mattress with skin guard mattress. gel chair cushion and Prevalon boots at all times while in bed, Must turn at least q2 and reposition frequently.<br><br>Hospital Discharge Summary with a date of [DATE] documented:<br><br>Cause of Death:<br><br>1. Renal Failure<br><br>Interval Between Onset & Death:<br><br>Years<br><br>Other Significant Conditions<br><br>1. Left foot osteomyelitis<br><br>2. Severe aortic stenosis<br><br>3. Pulmonary embolism<br><br>4. Ischemic cardiomyopathy<br><br>5. Chronic hypotension<br><br>Hospital Course:<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | .presented to ED after receiving 2 shocks from LifeVest. Patient was asymptomatic. Evaluated by electrophysiology, upon review of tracing LifeVest shock was due to an artifact. Hospital stay complicated by multiple events, initially epistaxis that required packing, severe hypotension despite midodrine that persisted despite increasing the dose to 15 mg [three times daily]. During hospital stay evaluated by Cardiology given known severe aortic stenosis but was deemed not a candidate for TAVR (transcatheter aortic valve replacement). Patient with very poor oral intake, after discussion with patient and his family decision was made to place a G-tube and was started on tube feeds up to goal. On admission patient with a wound on the right heel that during hospital stay worsen and required extensive surgical debridement, infection involved all the way down to the calcaneus bone. Patient treated with broad-spectrum antibiotics, amputation was considered but patient consider very high risk. Patient also developed a GI bleed with drop in hemoglobin requiring [blood] transfusion and stopping anticoagulation, since then hemoglobin remained stable but blood pressure consistently low to the point he could not tolerate dialysis x2. During hospital stay multiple family meetings were held with the family and palliative care, eventually as patient continued to decline on , d+[DATE] decision was to transition to comfort care in the hospital. Patient eventually expired on ,d+[DATE] 1048.<br><br>On [DATE] at 10:30 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-L. Surveyor asked if she remembers providing cares to R58? CNA-L stated maybe a couple of times. Surveyor asked if she would provide foot care to R58? CNA-L stated she does not remember. Surveyor asked if she remembers looking at his feet the week leading up to his discharge? CNA-L stated no, she does not remember.<br><br>On [DATE] at 9:09 AM, Surveyor interviewed RN-N. Surveyor asked if she remembers looking at R58's feet the week leading up to his discharge? RN-N stated no, she does not remember.<br><br>On [DATE] at 9:20 AM, Surveyor interviewed LPN-K. Surveyor asked if she remembers looking at R58's feet the week leading up to his discharge? LPN-K stated no, she does not remember. Surveyor asked if she remembers completing a diabetic foot check on [DATE] that she signed out as completed? LPN-K stated she thinks she put lotion on his feet once but not sure when that was. Surveyor asked if she remembers any open areas or wounds? LPN-K stated she does not remember.<br><br>On [DATE] at 9:49 AM, Surveyor interviewed LPN-R. Surveyor asked if she remembers looking at R58's feet the week leading up to his discharge? LPN-R stated no, she does not remember. Surveyor asked if she remembers completing a diabetic foot check on [DATE] that she signed out as completed? LPN-R stated she does not remember. Surveyor asked if she remembers any open areas or wounds? LPN-R stated she does not remember.<br><br>On [DATE] at 10:13 AM, Surveyor interviewed LPN-T. Surveyor asked if she remembers looking at R58's feet the week leading up to his discharge? LPN-T stated no, she does not remember. Surveyor asked if she remembers completing a diabetic foot check on [DATE] that she signed out as completed? LPN-T stated she does not remember. Surveyor asked if she remembers any open areas or wounds? LPN-T stated no, if he did have wounds there were no treatments on her shift (7:00 PM to 7:00 AM.) Surveyor asked if LPN-T found a wound who would she report it to? LPN-T stated she would chart it and then tell the unit manager assigned to that unit.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On [DATE] at 10:23 AM, Surveyor interviewed NP-F who oversaw R58's care. Surveyor asked when was the last time she saw R58 before he discharged ? NP-F stated [DATE] she had a visit with him; that she did speak with him about Paxlovid a few days after that but did not assess him. Surveyor asked NP-F if R58 was ever out of bed? NP-F stated she always saw him in bed but he did have dialysis three times a week so he did get out of bed sometimes. Surveyor asked if she was updated on any wounds? NP-F stated she was unaware he had any wounds. Surveyor asked if she would expect to be updated with new wounds? NP-F stated yes. Surveyor noted the [DATE] and [DATE] wounds that were documented. NP-F stated that was a weekend so they may have called the on-call service. Surveyor noted they did not call the on-call service. Surveyor asked if she ever assessed R58's feet? NP-F stated not that she could recall.<br><br>On [DATE] at 1:45 PM and [DATE] at 9:40 AM, Surveyor interviewed LPN-S. Surveyor asked if she finds an open area who does she report it to? LPN-S stated usually the unit manager (ACNO-C,) wound team, or the Director of Nursing (DON)-B. Surveyor asked who calls the MD and gets orders? LPN-S stated the nurse doing the assessment, either the unit manager or RN. Surveyor asked about the wound found to R58's buttocks on [DATE]. LPN-S stated it looked like a skin tear and she applied some cream to it. Surveyor asked if she reported this to anyone? LPN-S stated yes, to ACNO-C when she found it. Surveyor asked about the necrotic area to R58's ankle. LPN-S stated R58's spouse told her he was having pain from a wound on his ankle. LPN-S stated she was unaware of any wound and looked at R58's right ankle and found a 3 to 4 inches by 2 to 3 inches black necrotic area from his heel to his Achilles that looked like a pressure injury. LPN-S stated she either texted or called ACNO-C because it was a Sunday and she was going to follow up [DATE] which was a Monday. LPN-S stated on [DATE] ACNO-C followed up with her and told her it was not a pressure injury but rather a vascular wound. LPN-S stated she never heard about it agai<br>[TRUNCATED] |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253<br><br>UNCORRECTED ON REVISIT<br><br>Based on interview, and record review, the facility did not ensure that 1 (R48) of 6 residents reviewed for accidents received adequate interventions to prevent the resident from sustaining continued falls.<br><br>R48 had falls while in the facility that were not investigated to find the root cause of the fall, care plans were not always revised with recommended interventions that were patient centered or patient specific. Additionally, the facility did not complete evaluations of current interventions after falls occurred to determine if those interventions were adequate in preventing future falls. Staff statements regarding R48's falls presented conflicting timelines and details regarding R48's falls that were not addressed by the facility to ensure a thorough root cause analysis was completed regarding R48's falls.<br><br>Findings include:<br><br>The facility policy, titled INCIDENTS-ACCIDENTS, dated 11/2018 states: It is the policy of Avanti (sic) to ensure proper usage of facility equipment and policy and procedures.<br><br>POLICY: .<br><br>4. If an incident or accidents occurs, a full investigation will be initiated, including staff interviews, equipment checks, and follow through on policy and procedures.<br><br>7. Facility will monitor the effectiveness of the interventions including adequate supervision consistent with the resident's needs, goals, plan of care, and current standards of practice in order to reduce the risk of an accident.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility policy, titled Post-Fall Policy, dated 11/2020 states: To ensure all appropriate measures are implemented to ensure resident safety post-fall in accordance with all state and federal regulations. Each resident residing in this facility will be provided services and care that ensures that the resident's environment remains free from accident hazards as is possible and each resident receives adequate supervision and assistive devices to prevent accidents. Every resident will be assessed for casual risk factors for falling at the time of admission, upon return from a health care facility and after every fall in the facility. Each resident of this facility who experiences a fall will be treated and assessed to adequately treat any current injuries, either physical or psychosocial, and comprehensively assessed to determine casual effects of the fall to develop interventions to prevent further falls. Procedure: *When a resident has fallen the caregiver present during fall will stay with the residents and get someone to find the nurse after providing a safe place for the resident to lie while moving the resident as little as possible. *If the incident is un-witnessed the person that finds the resident will remain with the resident until the nurse comes to assess the resident. *A fall is defined as an incident in which the resident unintentionally was unable to maintain his/her balance and descended to a lower level, including incidents that occur when the resident would have fallen if care partners had not intervened. The definition applies regardless of whether or not an injury occurred. *The licensed practical nurse (LPN)/ RN will assess the resident for injury and give care/treatment needed at that time. Evaluating the resident's needs for: -First aid, - Assessments (vital signs, skin assessment, and neurological assessment), -range of motion, . -pain . - The LPN/RN notifies the physician of the fall and findings from his/her assessment. The physician makes the clinical decision to transfer resident to hospital or monitor and treat in facility.<br><br>R48 was admitted to the facility on [DATE], R48 transitioned to Hospice care on 2/6/2023 and passed away on 2/21/2023 in the facility.<br><br>R48's diagnoses included end stage renal disease, Large B- Cell Lymphoma, Type 2 Diabetes, morbid obesity, lack of coordination, difficulty in walking, history of insomnia, and need for assistance with personal care.<br><br>R48's admission minimum data set (MDS) assessment dated [DATE] indicated R48 had moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 12 and assessed R48 as needing extensive assistance with transferring, dressing, bathing, and toileting and R48 needed limited assisted with bed mobility and hygiene. R48 was occasionally incontinent of urine, always incontinent of bowel, wore an adult brief and used a bed pan. R48 was coded high risk for falls with a fall risk score of 6.<br><br>R48's Risk for Falls Care Plan was initiated on 1/17/2023 with the following interventions:<br><br>- Anticipate and meet the resident's needs.<br><br>- Ensure bed brakes are locked.<br><br>- Ensure footwear fits properly.<br><br>- Ensure the residents call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/17/23 a care plan was initiated for R23 with a focus area indicating the resident is on sedative/hypnotic therapy r/t (related to) insomnia. Goals include: the resident will be free of any discomfort or adverse side effects of hypnotic use through the review date - target date 5/3/23. Interventions include:<br><br>- Administer SEDATIVE/HYPNOTIC medication as ordered by physician. Monitor/document side effects and effectiveness. Q-shift (each shift).<br><br>- Monitor/Document/Report PRN (as needed) for following adverse effects of SEDATIVE/HYPNOTIC therapy: daytime drowsiness, confusion, loss of appetite in the morning, increased risk of falls, dizziness.<br><br>On 1/18/2023 at 5:32 AM in the progress notes, nursing charted R48 was found on R48's bedroom floor at 5:20 AM. R48 stated R48 rolled out bed.<br><br>On 1/18/2023 nursing started a fall investigation report for R48's fall. Nursing documented related to the fall that the bed height was not appropriate for R48 and there was equipment malfunction and listed on the investigation report R48's bed remote plug broken. Nursing documented the initial interventions taken after R48's fall was low bed, remote fixed, and floor mats. On the fall risk evaluation nursing documented that R48 was encouraged to use the call light for help and for R48's bed to stay in a low position.<br><br>On 1/18/2023 the interdisciplinary team (IDT) did not document anything in the root cause of the fall and concluded intervention to have body pillows for R48.<br><br>R48's Risk for Falls Care Plan was revised on 1/18/2023 to include the following interventions:<br><br>-body pillows while in bed<br><br>Surveyor noted that there was not an RN assessment done for R48 after R48's fall before R48 was moved back to bed. Surveyor noted the floor mat and low bed interventions were not added to the care plan as interventions after R48's fall. Surveyor noted there is no detail by the IDT to explain why their recommendation differed from the recommended intervention at the time of the fall and how the recommended intervention related to the completion of a root cause analysis.<br><br>On 1/19/2023 at 2:00 AM in the progress notes nursing charted R48 was found on R48's bedroom floor. R48 stated R48 was trying to get to the bathroom.<br><br>On 1/19/2023 at 2:00 AM nursing started a fall investigation report for R48's fall. Nursing documented that R48 was ambulating without assistance, call light was in reach and R48 did not use the call light. Nursing charted that R48 was put back into bed.<br><br>On 1/19/2023 at 3:07 AM nursing documented that 3rd Eye (after hours on call for physicians) was contacted.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The certified nursing assistant (CNA) documented on the fall investigation report that R48 was watching television until 11:00 PM. The CNA indicated they toileted R48 and R48 went to bed. The CNA documented that at 12:00 AM R48 got out of bed and that is when R48 fell and was found on the floor by the CNA.<br><br>Surveyor noted there is a discrepancy in the time of R48's fall. Nursing documented that R48 fell at 2:00AM and the CNA documented R48 was found at 12:00 AM.<br><br>In the investigation documentation for R48's fall on 1/19/2023 the root cause is crossed out and not assessed. Nursing documented that education was provided to R48 to use call light for assistance. On the fall risk evaluation, nursing documented R48 will not use call light for assistance even though R48 was educated to do so.<br><br>Surveyor noted that this intervention was not assessed if appropriate for resident. The call light is documented as being in reach at time of fall, but R48 did not use it. There was no assessment done to see if R48 knew how to use the call light or if R48 could see the call light. Surveyor also noted with the timeline discrepancies between staff involved in the fall it would be difficult to determine a clear root cause for this fall as there is not clear detail on when staff last saw R48 or provided cares to R48. There also would be question as to whether R48's insomnia may be a factor in the fall etc. to help establish effective interventions to prevent future falls.<br><br>R48's Risk for Falls Care Plan was revised on 1/19/2023 with the following interventions:<br><br>-Signs in room to remind guest to call for assistance. Surveyor noted R48 wears glasses, and it is not clear if R48 can see such a sign if he wakes up without glasses to remind him to call for assistance. R48's intervention to encourage R48 to use call light for assistance continues to not be assessed to determine if it was an appropriate intervention for R48 to prevent falls.<br><br>On 1/25/2023 at 12:45 AM in the progress notes nursing charted R48 was found on floor in a sitting position. R48 stated R48 was trying to get out of bed. Nursing charted R48 was assisted back into bed.<br><br>On 1/25/2023 at 3:11 AM nursing documented 3rd eye was contacted.<br><br>On 1/25/2022 nursing documented conflicting information regarding R48's mental status at the time of the fall. R48's mental status was documented as being alert and oriented X2, on the fall investigation sheet. It is also documented that R48 had a mental status of alert and oriented X4. On the fall scene investigation report nursing documented R48's mental status prior to fall, as being alert and oriented X3. On the CNA fall investigation report, the CNA documents R48 was displaying confusion before the fall.<br><br>Surveyor noted the discrepancy in the assessment of R48's mental status at time of fall and noted R48 was not assessed by an RN for R48's confusion prior to R48's fall. In information provided by the CNA related to R48's fall, the CNA notes R48 was displaying confusion prior to the fall.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/25/2023 on R48's fall scene investigation report nursing documented that the root cause of fall was: R48 did not use the call light and ambulated without assistance. The CNA documented that R48 was last changed at 12:00 AM. The CNA documented that at 12:45 AM R48 put on the call light, when the CNA walked into R48's room R48 was observed sitting on R48's floor on the side of R48's bed.<br><br>Surveyor noted a discrepancy between the nursing and CNA documentation on the fall scene investigation report noting nursing and the CNA both documented different information regarding if R48 pushed the call light or not prior to R48's fall. Surveyor noted there is no detail or information to determine if indeed R48 activated their call light, how long was the call light on before staff responded. Surveyor also noted there is no detail to explain why nursing indicated on the fall reports that the call light was not activated.<br><br>On 1/25/2023 on R48's fall risk evaluation report nursing documented R48 was restless on night shift and awake.<br><br>Surveyor noted there were no assessments or root cause analysis to determine why R48 was restless and awake on night shift or to assess if interventions were appropriate for R48 at nighttime despite R48 having a care plan related to insomnia.<br><br>R48's Risk for Falls Care Plan was revised on 1/25/2023 with the following interventions:<br><br>-Scoop mattress placed to ensure safety.<br><br>Surveyor noted that there is no documentation to clearly indicate if/when the scoop mattress was put on R48's bed.<br><br>On 2/3/2023 at 3:55 AM in the progress notes nursing charted R48 had a fall at 2:00 AM. Nursing charted R48 stated R48 was sleeping and rolled out of bed.<br><br>On 2/3/2023 in the fall investigation report nursing documented that R48 was assisted back to bed and nursing notified 3rd Eye at 2:51 AM.<br><br>On 2/3/2023 in the fall scene investigation report nursing documented that R48 was incontinent of bowel. The CNA documented that the CNA checked on and changed R48 at 8:00 PM, the CNA checked on R48 again at 10:00 PM and R48 was asleep, and R48 rolled out of bed and the CNA notified nursing.<br><br>Surveyor noted a discrepancy in the time of CNA's documentation of when R48's fall happened and what time nursing documented when R48's fall happened. Surveyor noted that staff did not specify what time R48 was incontinent of bowel. No information was included in the post fall documents to indicate if R48 had voided the last time R48 was toileted which was at 8:00 PM.<br><br>On 2/3/2023 in the fall scene investigation report for R48 nursing documented the root cause of the fall was R48 did not have side barriers on bed.<br><br>On 2/3/2023 in the assigned CNA fall investigation report for R48 the CNA documented that body pillows were not in place at the time of R48's fall, the CNA also noted R48's fall was at 11:00 PM.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Surveyor noted the time of R48's fall is different from when nursing wrote R48's time of fall was. Surveyor noted that the IDT did not investigate the actual time of fall or assess to see if R48's bed was appropriate for R48 or if the interventions in place were appropriate due to R48 rolling out of bed several times. Surveyor noted previous recommendations were for R48 to have a scoop mattress, it is unclear if this intervention was in place at the time of this fall as the recommendation is for interventions that were previously recommended and should have been in place.<br><br>On 2/3/2023 in the post fall neurological evaluation done for R48's fall nursing checked that R48 was oriented only to situation. Surveyor noted the nursing documentation related to R48's fall was being completed by a Licensed Practical Nurse. Surveyor noted R48 being oriented to situation only would be a change for R48. In other documentation regarding the fall, it is documented R48's mental status was alert and oriented times 4.<br><br>R48's Risk for Falls Care Plan was revised on 2/3/2023 with the following interventions:<br><br>-move R48 to room closer to nursing station for safety.<br><br>Surveyor noted that this intervention was not done immediately after R48's fall and no other interventions were put in place to prevent further accidents from happening to R48 until the room change could take place for R48. Surveyor noted there is no review of R48's continence status or if R48's care plan for continence should be revised. Surveyor noted there was no clear review to determine what fall intervention should have been in place at the time of the fall and what intervention were in place at the time of the fall. Surveyor noted R48 was displaying confusion and a pattern of falls at around the same time of night with a history of insomnia. There is no indication this was taken into consideration to determine interventions for R48 or to help determine if a room change would be in the best interest of R48 overall.<br><br>On 3/8/2023 at 12:22 PM Surveyor spoke with family member-GGG. Family member-GGG reported that family member-GGG would often stay overnight when able because there was not enough staffing to care for R48 through the night. Family member-GGG reported R48 would call family member-GGG often looking for help and when family member-GGG called the facility no one would pick up the phone at the facility. Family member-GGG reported they lived 2 hours away from R48, so family member-GGG was not able to go to facility to be with R48 all the time. Family member-GGG reported that family member-GGG feels the falls did (R48) in and R48 went downhill after that.<br><br>On 3/8/2023 at 3:30 PM Surveyor spoke with family member-FFF. Family member-FFF reported R48 would call family member-FFF on the phone asking for help. When family member-FFF would arrive at the facility R48 and family-member-FFF would wait 45 minutes to an hour until staff answered R48's call light. Family member-FFF would sometimes look for staff and always found staff in a meeting room on the other side of the building. Family member-FFF reported staff were never with residents when needed. Family member-FFF reported one of the CNA's told family member-FFF that the CNA would show family member-FFF how to do the cares for R48 so family member-FFF could do them for R48. R48 reported that R48 did not urinate often because of being on dialysis, so when R48's adults brief has urine in it or was very wet family member-FFF knew R48 was not toileted for a long period of time. Family member-FFF reported R48 was not getting better and not getting the treatment R48 deserved and family member-FFF felt that did R48 in and R48 gave up.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/9/2023 at 10:32 AM Surveyor called and left messages for nursing staff that initiated R48's fall reports. Surveyor did not get a call back from nursing staff .<br><br>On 3/14/2023 at 12:50 PM surveyor shared concerns with the assistant chief nursing officer-D regarding R48 falls. No further information provided. |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20025<br><br>UNCORRECTED ON REVISIT<br><br>Based interview and record review the facility did not ensure 1 (R68) of 3 residents received the necessary hydration needs to prevent dehydration.<br><br>On 3/8/23 R68 was transferred to the hospital due to a change in condition. The hospital record dated 3/8/23 indicated R68 was severely dehydrated and needed 14 liters of lactated ringers to rehydrate.<br><br>R68 was receiving pureed foods and nectar thick liquids and the facility was not monitoring R68's fluid intake.<br><br>Assistant Chief Nursing Officer CC stated R68 would refuse to drink at times. There is no evidence of R68 refusing to drink. There is no evidence R68 was educated on the importance of nectar thick liquids, options to the diet or discussion of possible waiver to the diet.<br><br>Findings include:<br><br>The facility policy for residents with thickened liquids dated November 2018 indicate .<br><br>5. Instructions on monitoring of residents on thickened liquids will be directed by Speech Therapy an/or provider as needed.<br><br>7. If a resident refuses to follow treatment plan, the physician will be notified, education done and the care plan updated to reflect the resident's non compliance .<br><br>R68 was admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy, acute respiratory failure, type 2 diabetes, dysphagia and cardiomyopathy.<br><br>R68 was transferred to the hospital on 3/8/23 as a result of a change in condition. R68 did not return to the facility.<br><br>The admission MDS (minimum data set) dated 2/19/23 indicates R68 was cognitively impaired, needed extensive assistance with bed mobility, transfers and dressing. R68 needed limited assistance with meals.<br><br>The hospital speech therapist recommendations dated 2/9/23 indicate R68 is to have a pureed diet with nectar thick liquids and needs supervision with meals.<br><br>Speech therapy DD's note dated 3/1/23 indicates she discussed with R68 that he would need to continue with the pureed foods and nectar thick liquids. The note indicates R68 expressed understanding and agreement.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The comprehensive nutrition assessment dated [DATE] indicates R68 appeared thin, not well nourished and moderate fat and muscle loss. The assessment indicates R68 has evident protein calorie malnutrition related to acute on chronic condition AEB (as evidence by) hx (history) inadequate oral intake, muscle/fat wasting, decline in function. The nutrition intervention was mighty shakes TID (three times a day) with meals for nutritional supplementation. Probiotic BID (twice a day). Mechanically altered diet per SLP (speech language pathologist) recommendations. Staff continues to monitor and encourage intake, offer alternate as appropriate. Nutritional needs were assessed at 1910 calories, 83 grams protein and 2090 ml (milliliter) of fluids.<br><br>Surveyor reviewed R68's meal intake, and noted it varied from 25% to 75% for intake. Surveyor noted the meal intake does not indicate how much fluids R68 was taking in.<br><br>Surveyor reviewed the MAR (medication administration record) for R68. The MAR revealed Mighty shakes supplements were being given with meals but the amount that R68 drank is not calculated.<br><br>The nutritional care plan indicates one of the interventions as Provide general, pureed/nectar thick liquids diet as ordered. Monitor intake and record every meal.<br><br>The nurses note dated 3/8/23 indicates R68 became unresponsive, BP 60/30, sent out via 911, NP and family update.<br><br>Surveyor obtained R68's hospital record for 3/8/23.<br><br>The hospital record dated 3/8/23 indicates R68 came in with severe dehydration and hyperkalemia (high potassium). The hospital record indicates on 3/8/23 R68 received two liters of normal saline IV solution in the emergency department.<br><br>On 3/9/23 R68 received a total of seven liters of lactated ringers solution and one 500 ml lactated ringers solution.<br><br>On 3/10/23 R68 received total of two liters of lactated ringers and one 500ml lactated ringers solution.<br><br>On 3/11/23 R68 received a total of two liters of lactated ringers solution.<br><br>On 3/12/23 R68 received one liter of lactated ringers and one 500 ml of lactated ringers solution.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 3/13/23 at 11:30 a.m. Surveyor interviewed Assistant Chief Nursing Officer CC. Assistant Chief Nursing Officer CC stated on 3/8/23 R68 was found slumped over in his wheelchair and unresponsive with a low blood pressure. Assistant Chief Nursing Officer CC stated R68 was sent out 911 to the hospital. Surveyor explained to Assistant Chief Nursing Officer CC that R68 was admitted to the hospital with severe dehydration. Surveyor asked Assistant Chief Nursing Officer CC if R68's fluids were being monitored along with his meal intakes. Assistant Chief Nursing Officer CC stated they don't monitor fluids unless there is a doctor's order for it. Surveyor asked if R68 needed assistance with drinking. Assistant Chief Nursing Officer CC stated that R68 did need assistance and would at times refuse to drink the thickened fluid. Assistant Chief Nursing Officer CC stated she would offer R68 fluids while he was sitting near the nurses' station and R68 would refuse. Assistant Chief Nursing Officer CC stated R68's health was declining, and she was thinking a conversation about hospice would need to be discussed but this did not occur. Assistant Chief Nursing Officer CC stated fluids are monitored for residents on renal diets or fluid restrictions.<br><br>On 3/13/23 at 2:00 p.m. Surveyor interviewed Speech Therapist GG. Speech Therapist GG stated R68 needed supervision with eating and drinking because of his dysphagia. Speech Therapist GG stated R68 did not refuse to eat or drink while she was working with him. Speech Therapist GG stated if a cup was given to R68 he would drink it. Speech Therapist GG stated if R68 was refusing then she would go down the education route, but it didn't get to that point with R68.<br><br>On 3/13/23 at 2:10 p.m. Surveyor interviewed Certified Nursing Assistant (CNA) EE. Surveyor asked CNA EE if they took care of R68 and she stated she often did take care of him. Surveyor asked if R68 would refuse to eat or drink. CNA EE stated R68 did not refuse but did he did say he did not like the texture of the pureed food, but he ate it anyway. CNA EE stated when a cup was handed to R68 he would drink it.<br><br>On 3/13/23 at 3:20 p.m. Surveyor discussed with Assistant Chief Nursing Officer D the concern R68 was admitted to the facility with diagnosis of dysphagia, had a nutritional assessment of R68 having inadequate oral intake and needed pureed food and nectar thick liquids and there was no monitoring of the liquid intakes. Surveyor explained Assistant Chief Nursing Officer CC stated R68 would refuse to drink the thickened fluids, but other staff interviews mention he did not refuse to drink. There is no evidence R68 refused to eat or drink. There is no evidence of monitoring of his fluids. There is no evidence if R68 was refusing that education was provided and the physician was made aware. Surveyor explained to Assistant Chief Nursing Officer D, R68 was admitted to the hospital on 3/8/23 with severe dehydration and there is no evidence the facility was monitoring R68 to prevent dehydration. Assistant Chief Nursing Officer D had no further information to provide. |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>38253<br><br>Based on observation, record review, and interview, the facility did not ensure sufficient nursing staff was available to provide nursing and related services to assure residents attained or maintained the highest practicable physical, mental, and psychosocial well-being of each resident as determined by the resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment potentially affecting 112 of 112 residents in the facility.<br><br>Residents voiced concerns there were not enough staff to care for their needs from 7:00 PM to 7:00 AM. Observations were made of residents not being put to bed when requested by the resident due to needing two staff to use a mechanical lift to transfer the resident and incontinence cares not completed when requested by the resident. Observations were made of medications being administered at 11:00 PM when the medication was scheduled for 8:00 PM. Oxygen was not provided to R64 for five hours after admission due to staff not bringing an oxygen concentrator to the room. Staff voiced concerns of not being able to attend to residents' needs when there were not enough staff on the unit to assist with answering call lights, providing incontinence cares, and transferring residents from wheelchairs to beds.<br><br>Findings include:<br><br>The Facility Assessment stated the following for RN (Registered Nurse), LPN (Licensed Practical Nurse), and CNA (Certified Nursing Assistant) staffing coverage: TBD (to be determined) based on acuity, census, and facility geography. No numbers of staff or range of staff was listed to show adequate coverage to provide care for the residents in the facility.<br><br>The facility uses a 12-hour staffing schedule. Day shift is from 7:00 AM to 7:00 PM. Night shift is from 7:00 PM to 7:00 AM. There are three units in the facility, each with a census averaging 35 residents.<br><br>In an interview on 3/13/2023 at 1:45 PM, Staffing Coordinator-BB stated each unit can hold 40 residents and Staffing Coordinator-BB tries to have two nurses or one nurse and one Med Tech on each unit along with two to three CNAs for the day shift, a total of 6 nurses and 9 CNAs. Staffing Coordinator-BB stated on night shift there should be two nurses and two CNAs on each unit, a total of 6 nurses and 6 CNAs, plus there is a PM Supervisor from 4:00 PM to 7:00 PM. Staffing Coordinator-BB stated there is also an admission nurse that is in the building from 4:00 PM to 2:00 AM that helps along with the PM Supervisor and there is also an on-call nurse. Staffing Coordinator-BB stated any of those individuals can be called in to help and can work as either a nurse or a CNA. Surveyor asked Staffing Coordinator-BB how they determined how many staff were needed per shift. Staffing Coordinator-BB stated there is a staffing ladder that is used to figure out how many staff are needed based on the census. Surveyor noted the acuity of the residents was not figured in when calculating the staffing needs.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 12/25/2022, the census was 103 residents. Day shift had four nurses that worked a 12-hour shift, one nurse that worked an 8-hour shift, and one Med Tech that worked a 12-hour shift for passing medications. Day shift had seven CNAs that worked the 12-hour shift and one CNA that worked a 9-hour shift. Night shift had three nurses that worked a 12-hour shift, one nurse worked a 4-hour shift as a CNA, and one Med Tech that worked a 6-hour shift. Night shift had two CNAs that worked a 12-hour shift and one CNA that worked a 9-hour shift. Surveyor noted the night shift had one nurse and one CNA on two of the three units and one unit did not have any CNAs from 1:00 AM to 3:00 AM.<br><br>On 12/26/2022, the census was 103 residents. Day shift had 4 nurses that worked a 12-hour shift, a Med Tech that worked an 8-hour shift, 4 CNAs that worked a 12- hour shift, and 1 CNA worked a 10.5-hour shift. Night shift had 3 nurses and 5 CNAs that worked a 12-hour shift. Surveyor noted one unit had one nurse and one CNA on both day and night shift.<br><br>On 1/1/2023, the census was 104 residents. Day shift had five nurses that worked a 12-hour shift, 5 CNAs that worked a 12-hour shift, and one CNA that worked a 6-hour shift. Night shift had four nurses and five CNAs that worked a 12-hour shift. Surveyor noted one unit on day shift had one CNA for six hours and one unit on night shift had one CNA for the whole shift.<br><br>On 2/5/2023, the census was 107 residents. Day shift had five nurses, one Med Tech, and nine CNAs that worked a 12-hour shift. Night shift had three nurses and three CNAs that worked a 12-hour shift and one CNA that worked a 4-hour shift. Surveyor noted night shift had one nurse and one CNA on each unit.<br><br>On 2/7/2023, the census was 106 residents. Day shift had six nurses and eight CNAs that worked a 12-hour shift. Night shift had three nurses and two CNAs that worked a 12-hour shift, one CNA that worked a 9-hour shift, one CNA that worked an 8.5-hour shift, and one CNA that worked a 4-hour shift. Surveyor noted one unit on night shift had one CNA for the whole shift, one unit had one CNA for two and a half hours and then two CNAs for the rest of the shift, and one unit had no CNAs from 7:00 PM to 8:00 PM, one CNA from 8:00 PM to 10:00 PM, two CNAs from 10:00 PM to midnight, and one CNA from midnight to 7:00 AM.<br><br>On 2/13/2023, the census was 104 residents. Day shift had five nurses and six CNAs that worked a 12-hour shift and two CNAs that worked a seven-hour shift. Night shift had two nurses and four CNAs that worked a 12-hour shift and one nurse that worked an 11-hour shift. Surveyor noted two of the three units on night shift had one nurse and one CNA.<br><br>On 2/15/2023, the census was 99 residents. Day shift had five nurses and six CNAs that worked a 12-hour shift, one CNA that worked and 8-hour shift, and one CNA and one Med Tech that worked a 6-hour shift. Night shift had three nurses and five CNAs that worked a 12-hour shift. Surveyor noted one unit on night shift had one nurse and one CNA.<br><br>On 2/16/2023, the census was 103 residents. Day shift had three nurses, one Med Tech, and five CNAs that worked a 12-hour shift, and two CNAs that worked an 8-hour shift. Night shift had three nurses and five CNAs that worked a 12-hour shift. Surveyor noted one unit on night shift had one nurse and one CNA.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 2/19/2023, the census was 107 residents. Day shift had five nurses, one Med Tech, and eight CNAs that worked a 12-hour shift. Night shift had three nurses and two CNAs that worked a 12-hour shift, one CNA that worked an 11-hour shift, one CNA that worked a 7-hour shift, and one CNA that worked a 5.5-hour shift. Surveyor noted one unit had two CNAs from 7:00 PM to 12:30 AM and then one CNA from 12:30 AM to 7:00 AM, one unit had one CNA from 7:00 PM to midnight and then two CNAs from midnight to 7:00 AM, and one unit had no CNAs from 7:00 PM to 8:00 PM and then one CNA from 8:00 PM to 7:00 AM.<br><br>On 2/21/2023, the census was 109 residents. Day shift had three nurses, one Med Tech, and eight CNAs that worked a 12-hour shift, one nurse worked a 7-hour shift, and one nurse worked a 6-hour shift. Night shift had three nurses and three CNAs that worked a 12-hour shift, and one nurse worked a 5-hour shift. Surveyor noted two units on night shift had one nurse and one CNA and one unit had two nurses and one CNA from 7:00 PM to midnight and then one nurse and one CNA from midnight to 7:00 AM.<br><br>On 2/22/2023, the census was 111 residents. Day shift had three nurses and six CNAs that worked a 12-hour shift, one nurse and one CNA that worked an 8-hour shift, and one nurse that worked a 6-hour shift. Night shift had three nurses and five CNAs that worked a 12-hour shift. Surveyor noted one unit on night shift had one nurse and one CNA.<br><br>On 2/23/2023, the census was 111 residents. Day shift had three nurses and eight CNAs that worked a 12-hour shift. Night shift had two nurses and four CNAs that worked a 12-hour shift, one nurse that worked an 8-hour shift, one nurse worked a 5-hour shift, and one nurse worked a 2-hour shift. Surveyor noted on day shift, the Director of Nursing and the LPN Supervisor covered one unit due to call-ins from nursing staff and on night shift, two of the three units had one nurse and one CNA.<br><br>On 2/27/2023, the census was 112 residents. Day shift had three nurses and six CNAs that worked a 12-hour shift, one CNA that worked a 9-hour shift, one nurse that worked a 7-hour shift, one nurse that worked a 6-hour shift, one nurse that worked a 5-hour shift, and one nurse that worked a 4-hour shift. Night shift had three nurses and five CNAs that worked a 12-hour shift. Surveyor noted one unit on night shift had one nurse and one CNA.<br><br>On 2/28/2023, the census was 112 residents. Day shift had four nurses and six CNAs that worked a 12-hour shift, one nurse and one CNA that worked an 8-hour shift, and one nurse that worked a 5-hour shift. Night shift had three nurses and four CNAs that worked a 12-hour shift and one CNA that worked a 10-hour shift. Surveyor noted one unit on night shift had one CNA from 7:00 PM to 9:00 PM and one unit had one nurse and one CNA.<br><br>On 3/1/2023, the census was 112 residents. Day shift had five nurses and five CNAs that worked a 12-hour shift, one CNA that worked a 9-hour shift, one CNA that worked an 8-hour shift, one CNA that worked a 6-hour shift, and one CNA that worked a 5-hour shift. Night shift had three nurses and five CNAs that worked a 12-hour shift. Surveyor noted one unit on night shift had one nurse and one CNA.<br><br>On 3/3/2023, the census was 112 residents. Day shift had three nurses, one Med Tech, and five CNAs that worked a 12-hour shift, one CNA that worked a 9-hour shift, one nurse that worked an 8-hour shift, and one nurse and one Med Tech that worked a 6-hour shift. Night shift had four nurses and four CNAs that worked a 12-hour shift. Surveyor noted two units on night shift had one nurse and one CNA.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 3/8/2023, the census was 112 residents. Day shift had four nurses, one Med Tech, and six CNAs that worked a 12-hour shift, one CNA worked a 9.5-hour shift, one CNA worked an 8-hour shift, and one nurse worked a 6-hour shift. Night shift had three nurses and five CNAs that worked a 12-hour shift. Surveyor noted one unit on night shift had one nurse and one CNA.<br><br>On 3/8/2023 at 9:34 PM, Surveyor entered the facility and clarified with LPN-T what staff was in the building working from 7:00 PM to 7:00 AM. LPN-T stated each unit had an LPN and two CNAs except for one unit that was expecting to have a second CNA come in at 10:00 PM.<br><br>In an interview on 3/8/2023 at 9:45 PM, CNA-V stated CNA-V was the only CNA on the unit at that time and it was hard keeping up with all the residents by herself.<br><br>On 3/8/2023 at 9:48 PM, Surveyor noted a call light was on for R12. Surveyor knocked on R12's door. R63 was in the first bed and invited Surveyor into the room. Surveyor told R63 the call light was on and R63 stated staff had been in the room about a half hour ago. The call light was answered at 9:59 PM, eleven minutes later, by CNA-V.<br><br>On 3/8/2023 at 9:52 PM, Surveyor noted LPN-U was passing medications. A resident was sitting in the unit dining room/common area with a personal stereo playing music loudly. CNA-V stopped to talk to the resident to offer a cookie before going to the next resident room.<br><br>On 3/8/2023 at 10:00 PM, CNA-V asked LPN-U to help with R12, but LPN-U was busy with another resident. A call light went off in the room next to where LPN-U was working at 10:03 PM. At 10:05 PM, the resident, where the light had gone off, came out into the hallway, walking with a walker and speaking Spanish. CNA-W had just gotten to the nurses' station on the unit to start working but did not have a mask on and did not know where to find a mask. CNA-W stated, I can't find a nurse, not an aide . At 10:08 PM, CNA-V intercepted the resident walking with a walker and sent the resident back into the room stating they would be in to help the resident in just a little while. CNA-V went into the resident's room and turned the call light off.<br><br>In an interview on 3/8/2023 at 10:11 PM, Surveyor asked LPN-U if all the action that was observed on the unit was typical. LPN-U stated it's very hectic with only one nurse and one CNA. Surveyor noted LPN-U was still passing medications that were scheduled to be passed at 8:00 PM. Surveyor asked LPN-U if it was typical for LPN-U to still be passing meds this late into the shift. LPN-U stated LPN-U has to help the CNA with cares and things because there is no one else to assist and blood sugars and blood pressures have to be gotten for some residents with their medications so LPN-U stated LPN-U's goal is to get medications passed by midnight. Surveyor asked LPN-U what time LPN-U started to pass medications. LPN-U stated the shift starts at 7:00 PM and right after report, LPN-U starts passing medications. Surveyor asked LPN-U how many residents were on the unit. LPN-U stated 36 residents.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 3/8/2023 at 10:17 PM, Surveyor observed R60 in their room. R60 was sitting in a wheelchair next to the bed. R60 stated R60 had pushed the call light over an hour ago and the CNA came in and told R60 that the CNA was the only one working until 10:00 PM so R60 would have to wait until after 10:00 PM to get any assistance. R60 stated R60 had a bowel movement over an hour ago and has been sitting in it since that time. R60 stated CNA-V said CNA-V would come back as soon as the other CNA got to work. Surveyor asked R60 how R60 transfers from the wheelchair to the bed. R60 stated they use a lift because R60 had left-sided weakness from a stroke. At 10:25 PM, CNA-V and CNA-W came into R60's room with a mechanical lift to put R60 to bed and provide cares. At 10:44 PM, Surveyor asked CNA-V if R60 had a bowel movement and needed cleaning up after being transferred to bed. CNA-V stated yes, R60 had a bowel movement.<br><br>On 3/8/2023 at 10:27 PM, Surveyor observed LPN-Z passing medications that were scheduled for 8:00 PM. Surveyor asked LPN-Z how long it takes to pass medications. LPN-Z stated usually it takes about two hours, but there were two admissions that evening that wanted things done for them, so was still passing medications at that time. Surveyor asked LPN-Z how many CNAs were working on that unit tonight and how many residents were on that unit. LPN-Z stated two CNAs were working but did not know what the census of the unit was.<br><br>On 3/8/2023 at 10:32 PM, Surveyor noted there were approximately four call lights activated at that time on the unit. A staff member went into a room where the light had been active for approximately four minutes. The resident told the staff member they wanted their medications and had not received them yet.<br><br>On 3/8/2023 at 10:37 PM a family member of a resident came up to Surveyor and asked if the oxygen was ready yet. (Surveyor noticed the family walking up and down the hallway at 10:30pm). Surveyor informed the family that the Surveyor was not an employee of the facility. The family member stated they had been waiting awhile and walked back to the resident's room. Surveyor followed the family member to R64's room. Surveyor observed R64 lying in bed with a portable oxygen tank on side table set at 3L/minute. Surveyor asked R64's family member how long they have been waiting for oxygen. The family member stated they could not remember but it had been a while. The family member stated they brought the portable oxygen from home and wanted to get back home so R64 could go to bed.<br><br>On 3/8/2023 at 10:40 PM R64 put the call light on. CNA-WW walked in and assisted R64 to the bathroom. Surveyor asked CNA-WW if R64 would be getting the oxygen soon. CNA-WW stated that nursing knew about R64 needing an oxygen concentrator and it would be coming. Surveyor asked CNA-WW how many residents CNA-WW is providing care for. CNA-WW stated typically 18-20 residents and CNA-WW feels overwhelmed a lot of the time. Surveyor asked CNA-WW if CNA-WW received help with caring for the residents. CNA-WW replied if CNA-WW asks for help, CNA-WW can get it.<br><br>On 3/8/2023 at 10:44 PM, Surveyor observed a staff member, Assistant Chief Nursing Officer (ACNO)-C, that had not been in the building when Surveyor entered the building at 9:30 PM, at the medication cart getting medication and water in a cup and bring the medication and water down the hall to a resident. Surveyor asked LPN-U who was helping pass medications. LPN-U stated another nurse just showed up at the facility and got medications for someone. LPN-U stated they did not know anyone was coming in to help.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 3/8/2023 at 10:48 PM, Surveyor observed another staff member, RN Supervisor-AA, that had not been in the building when Surveyor entered the building at 9:30 PM, on a unit assisting residents. Surveyor asked RN Supervisor-AA why she was in the building at 10:48 PM. RN Supervisor-AA stated RN Supervisor-AA does the admissions and was in the facility earlier, went home, and came back because two admissions came in that evening.<br><br>In an interview on 3/8/2023 at 10:54 PM, ACNO-C stated ACNO-C was on call this evening. ACNO-C stated the PM Supervisor LPN-T was working the unit passing meds, so ACNO-C came in to help after getting a call from LPN-T.<br><br>On 3/8/2023 at 11:00 PM surveyor observed Assistant Chief Nursing Officer (ACNO)-C bringing an oxygen concentrator to R64's bedroom. ACNO-C asked R64 how much oxygen she was supposed to be getting. ACNO-C plugged in the oxygen concentrator, but the oxygen concentrator did not work. ACNO-C went to grab a new concentrator. At 11:05 PM ACNO-C brought in a new oxygen concentrator that worked and got R64 set up with oxygen.<br><br>On 3/8/2023 at 11:10 PM, Surveyor observed LPN-Z was still passing medications that were due at 8:00 PM.<br><br>In an interview on 3/8/2023 at 11:14 PM, CNA-X and CNA-Y stated they did not have any concerns with staffing. CNA-X stated if there was only one CNA on a unit, another unit would send one of their CNAs to help after their residents were settled. Surveyor asked if they had any showers scheduled tonight. CNA-X stated they had only one bed bath scheduled, and CNA-Y stated they had two showers scheduled but both residents refused.<br><br>Surveyor noted during the observations of the facility on 8/3/2023 from 9:30 PM to 11:30 PM, all three units were very active and somewhat chaotic. Call lights were going off, music was playing loudly by a resident in the unit community area, a television in a gathering area on a unit was on at a loud volume with no one watching, and the majority of residents were awake with lights on in the rooms. Nurses on two of the units were passing medications scheduled for 8:00 PM after 11:00 PM.<br><br>The facility policy and procedure entitled Medication Administration Times/Person Centered Care dated 11/2020 states:<br><br>1. Unless otherwise directed by the provider medication pass times will follow person-centered care, the following medication pass windows are as follows:<br><br>I. AM Pass (7am-10am)<br><br>II Afternoon Pass (1pm-4pm)<br><br>III. HS Pass (7pm-10pm)<br><br>2. Medications ordered as once daily may be administered in accordance with the person-centered care model and resident preference unless otherwise directed by the provider.<br><br>3. Medications requiring vital sign parameters will be added to the medication order as directed by the provider under supplementary documentation.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 4. Medications may be administered 1 hour before or 1 hour after the liberalized medication pass times in accordance with resident preferences and the electronic medical record.<br><br>5. Unless otherwise directed by the provider, medications will be administered in accordance with the liberalized medication pass times and resident preferences.<br><br>Surveyor noted all medications in the electronic medical record had a specific time listed as when they were to be administered. The electronic medical record did not use the AM Pass, Afternoon Pass, or HS Pass windows as described in the policy and procedure.<br><br>On 3/13/2023 at 10:00 AM, Surveyor asked CNA-JJ how staffing was in the facility. CNA-JJ stated honestly it is not great and the residents cannot get the quality of care they deserve. Surveyor asked CNA-JJ if any thing gets missed such as showers or cares. CNA-JJ stated CNA-JJ would get their duties done and does not miss anything but stated residents had been complaining that they do not get showered on second shift. (Cross reference F677)<br><br>On 3/14/2023 at 8:08 AM, Surveyor asked ACNO-CC what the facility policy was for residents that use a sit-to-stand lift. ACNO-CC stated one CNA can transfer a resident with a sit-to-stand lift. Surveyor asked ACNO-CC how many residents were on that unit and how many residents require a mechanical lift using two staff to transfer. ACNO-CC stated there were 28 residents on that unit and 9 of the residents used a mechanical lift. Surveyor reviewed the unit census and there were 35 residents on that unit at that time with 9 residents using a mechanical lift for transfers.<br><br>Surveyor reviewed all resident Care Plans in the facility on 3/14/2023 to see what their transfer status was to help determine acuity of the residents.<br><br>-100 Unit: 35 residents with 9 mechanical lifts.<br><br>-200 Unit: 39 residents with 10 mechanical lifts.<br><br>-300 Unit: 34 residents with 13 mechanical lifts.<br><br>Total residents: 108. Residents needing assist of two for transfers: 32.<br><br>Surveyor noted the large number of residents needing an assist of 2 for transfers would delay cares if only one CNA was assigned to each unit.<br><br>On 3/13/2023 at 3:12 PM, Surveyor shared with Director of Clinical Operations-H, Director of Clinical Operations-I, and ACNO-D the observations and interviews made on 3/8/2023 from 9:30 PM to 11:30 PM with the concerns R60 was incontinent of stool and had to wait over an hour and a half to be put to bed and have incontinence cares completed due to only one CNA on the unit when R60 needs two staff members to transfer R60 with a mechanical lift, medications being passed to residents after 11:00 PM, oxygen not supplied to R64 timely, and residents and staff voicing concerns that cares are not being provided due to lack of staff. (Cross reference F600.) The Facility Assessment does not indicate the number of staff needed to provide care to the residents and the interview with Staffing Coordinator-BB did not take the acuity of the residents into account when scheduling nurses and CNAs. No further information was provided at that time. |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident must receive and the facility must provide necessary behavioral health care and services.<br><br>21855<br><br>UNCORRECTED ON REVISIT<br><br>Based on record review and interview, the facility did not ensure a resident received continuous psychological visits. This was discovered with 1 (R60) of 1 residents with psychological reviews.<br><br>R60 had been receiving active psychological services for medication and behavior monitoring. When the facility changed medical practitioners/services R60 was not transitioned to the new medical group to receive continued psychological services.<br><br>Findings include:<br><br>R60's medical record was reviewed by Surveyor. R60 is their own person and has resided in the facility since 9/10/2020. R60 has diagnoses that include obsessive-compulsive disorder, anxiety disorder, major depressive disorder and extrapyramidal and movement disorder.<br><br>R60's Physician Plan of Care, active as of 3/8/23, indicates Psychologist or Psychiatrist to evaluate and treat as needed. R60's current psychotropic medications include:<br><br>- Alprazolam 0.25 mg three times a day for anxiety.<br><br>- Belsomra 10 mg at bedtime for insomnia.<br><br>- Duloxentine 60 mg once a day for Depression.<br><br>- Fluvoxamine Maleate 100 mg three times a day for obsessive-compulsive disorder.<br><br>R60 was being seen by Psych services. Review of R60's medical record indicates 10/17/22 was the last Psych Follow-up with R60. This Psych Follow-up indicates to follow up in 1 month or sooner if acute issues arise.<br><br>There is no documentation in R60's medical record of a psych follow-up visit.<br><br>On 3/9/23 at 8:37 AM Surveyor spoke with R60. R60 indicated they did not feel their psych medications were prescribed correctly. They feel their anxiety medications were decreased and wants their medications the way there were before. R60 indicated they have not had any psych visits for awhile.<br><br>On 3/9/23 at 9:04 AM Surveyor spoke with DCT-E (Director of Care Transitions). DCT-E indicate a new Medical Group took over last Fall. DCT-E stated the resident would have to request to consent. DCT-E indicated they spoke with R60 and they did not want psych services. DCT-E indicated residents were not automatically transferred to the new Medical Group. DCT-E indicated they did not follow-up on the 10/17/22 Psych Follow-up order to see R60 in 1 month and that DCT-E will look for additional information.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/9/23 at 1:08 PM Surveyor spoke with ACNO-D (Assistant Chief Nursing Officer) who oversees R60's living unit. ACNO-D was not aware of any current psych concerns and did not have information related to Psych Consults.<br><br>On 3/13/23 at 8:48 AM DCT-E spoke with Surveyor. The new Medical Group took over on 11/30/2022. DCT-E indicated there was a previous Social Worker during that time as well. DCT-E provided a Progress Note that they approached R60 on 1/11/23 for Psych Services and R60 declined. DCT-E did not have any information regarding the psych follow-up from 10/17/22.<br><br>On 3/13/23 at 10:46 AM Surveyor spoke with NP-F (Nurse Practitioner) who follows R60's care at the facility. NP-F took over R60's medical needs last fall. NP-F would expect R60 to be seen by a Psych Service to follow their medications with diagnoses. NP-F was not aware of R60 not receiving psych services.<br><br>On 3/13/23 at 3:12 PM at the Facility Exit Meeting Surveyor shared the concerns with R60's lack of psych follow-up. There was no additional information. |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Administer the facility in a manner that enables it to use its resources effectively and efficiently.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16041<br><br>UNCORRECTED ON REVISIT<br><br>Based on observations, interviews, and record reviews, the facility was not administered in a manner that allowed residents to attain and maintain their highest level of well-being. This has the potential to affect all 112 residents residing in the facility.<br><br>There was a total of 28 calls to 911 made by residents and family members to report allegations of neglect, abuse, and lack of staff to meet their needs. These visits to the facility by law enforcement were not followed up on by the facility to address the residents and or families' concerns.<br><br>Residents and/or families filed a number of grievances with the facility. Review of those grievances found that the facility did not seek resolution to the concerns. 9 complaints received by the state agency had been filed as a grievance with the facility. The facility had knowledge there was a concern but did not take action.<br><br>A total of 8 deficiencies are being recited as a result of the complaint investigations and the revisit survey. The facility was made aware of concerns on 12/14/22 and did not take appropriate action to correct the deficiencies as evidenced by the ongoing complaints being received.<br><br>This is evidenced by:<br><br>Example 1:<br><br>On 3/8/23 and 3/9/23 Surveyor made contact with the Oak Creek Police Department and requested a log of 911 calls that have been received from the facility.<br><br>In December, there were a total of 12 calls, 9 of which were from family and/or residents alleging abuse/neglect including lack of staff or inability to reach staff.<br><br>In January, there were a total of 14 calls, 11 of which were from family and /or resident alleging abuse/neglect including lack of staff or inability to reach staff.<br><br>In February, there were a total of 13 calls, 8 of which were from family and/or residents alleging abuse/neglect including lack of staff or inability to reach staff.<br><br>A review of the reports finds that with each call, the police made contact with staff either in person or via telephone to follow up on calls received by the residents and/or families.<br><br>Surveyors reviewed resident records and noted that only 3 of the total 28, 911 calls were followed up on including documentation in the resident record. There is no indication staff reported these as allegations of abuse or neglect or completed thorough investigations as required by regulation.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Surveyor reviewed the Facility Assessment with a reviewed date of 2/9/23 and noted facility Administration identified under resources the facility needs to care for their residents. Topics for Staff Education include:<br><br>Topic: Communication - effective communications for direct care staff<br><br>Staff Type and Timing (on hire, annual, [as needed (PRN)], On Demand), How:<br><br>All staff- upon hire, monthly, PRN and on demand if issues are identified<br><br>Topic: Resident's rights and facility responsibilities - ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents<br><br>Staff Type and Timing (on hire, annual, PRN, On Demand), How:<br><br>All staff- upon hire, PRN annually<br><br>Topic: Abuse, neglect, and exploitation - training that at a minimum educates staff on - (1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property; (2) Procedures for reporting incidents, of abuse, neglect, exploitation, or the misappropriation of resident property; and (3)<br><br>The facility policy and procedure entitled Abuse Policy dated 11/2018 states: The facility Administrator will be designated as the facility Abuse Coordinator and is responsible for overseeing all components of the abuse policy . Investigation: Any allegation of abuse must be reported immediately to the facility Director of Nursing and Administrator .Abuse: the infliction of physical, sexual, or emotional injury or harm including financial exploitation by any person, firm, or corporation.<br><br>Neglect: the failure to provide services to an eligible adult by any person, firm, or corporation with a legal or contractual duty to do so, when such failure presents either an imminent danger to the health, safety, or welfare of the client or a substantial probability that death or serious physical harm would result.<br><br>On 3/9/23 at 2:15 pm Surveyors spoke with NHA A (Nursing Home Administrator). NHA A was asked if he was aware of the number of calls that were made to 911 by families and/or residents. NHA A indicated he was not. NHA A was asked if this was something that he should be made aware of. NHA A agreed he should have been made aware and follow up should have occurred.<br><br>Facility administration should have been aware of the alegations of abuse and neglect as staff are required to report all allegations to the Director of Nursing and the Administrator, according to their policy and procedure. Staff were aware of the police prescence in the building as well as the calls made to 911 as the police reports indicate that contact with facility staff was made at the time of each of the calls. These failures contributed to the continued calls to 911 and the continued allegations of abuse and neglect.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 3/8/23 Surveyors returned to the building at 9:34 pm to find the facility staffed with a total of 3 LPNs and 5 CNAs to care for 112 residents. (1 LPN and 2 CNAs on 2 units and 1 LPN and 1 CNA on the third unit) which was not sufficient to meet resident needs. Staff's failure to report allegations of abuse and neglect lead to the facility failing to recognize the allegations were partially related to a lack of staff in the facility to meet resident needs. (Refer to F725.)<br><br>Example 2:<br><br>Surveyors investigated 26 complaints during this survey. Review of the facility grievance log found that 9 of these complaints had been brought to the facility's attention through their grievance process. However, review of the grievances found that staff did not work towards resolution of the concern, but rather filed them as Unsubstantiated with no further follow up.<br><br>On 3/13/23 at 11:12 AM Surveyor interviewed Director of Care Transitions (DCT)-E; who is part of the facility's administration staff. Surveyor asked who was in charge of grievances. DCT-E stated she was. Surveyor asked about the grievances sent by Power of Attorney (POA)-KK who had submitted all of her grievances via email to facility administration after verbally expressing grievances to staff when in the facility. DCT-E stated that POA-KK does not like the facility, calls it Hell on Earth is rude to staff and is always complaining that no one is helping R12.<br><br>DCT-E stated she offered POA-KK to start the referral process to move R12 to a different facility. DCT-E stated because of all the nasty comments POA-KK makes about the facility. DCT-E stated the conversations they have are not constructive so it may be in her best interest to find alternative placement. Surveyor asked why she would suggest the resident move instead of resolving the grievances. DCT-E stated the grievances were unsubstantiated. Surveyor asked what that meant. Surveyor handed DCT-E the 2/6/23 grievance as an example. DCT-E stated that grievance was unsubstantiated because the staff had just changed R12. Surveyor asked how that is a resolution and were there other interviews or an investigation. DCT-E stated DON-B would have done that and she did interview the aide.<br><br>Surveyor asked if POA-KK keeps filing grievances about the same thing, how is it resolved. DCT-E stated she does not think the issues with POA-KK will ever be resolved. DCT-E stated there are going to be times R12 is wet, she is on a check and change schedule but POA-KK's expectations are just too high. Surveyor asked how the grievances will ever be resolved if the facility cannot address the issues. DCT-E stated all of the grievances from POA-KK came in at once (on 2/25/23 via email.) DCT-E stated we did our best. Surveyor noted that there was no resolution to any of the grievances, no follow-up to the POA and no thorough investigation into any of the allegations. Surveyor asked for any additional information regarding addressing the issues brought forward. No additional information was provided and DON-B was unavailable for interview.<br><br>The facility's Grievances policy with a date of April 2022 indicates:<br><br>The Grievance Official will initiate the appropriate notification and investigation processes per individual circumstance and facility guidelines. The investigation will consist of at least the following:<br><br>- A review of the completed complaint report<br><br>- An interview with the person or persons reporting the grievance<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | - Interviews with any witnesses to the concern<br><br>- A review of the medical record if indicated<br><br>- A search of resident room (with resident permission)<br><br>- Interview with staff members having contact with the resident during the relevant periods or shifts of the alleged incident<br><br>- Interview with the resident roommate, family members and visitors<br><br>- Completion of a root cause analysis of all circumstances surrounding the concern As necessary, the Grievance Official and facility leadership will take immediate action to prevent further potential continuations of any additional and like resident concerns while the grievance is being investigated.<br><br>RESOLUTION<br><br>The Grievance Official will complete a response to the resident and / or resident representative which includes:<br><br>- Date of grievance<br><br>- Summary of grievance<br><br>- Investigation steps<br><br>- Findings<br><br>- Resolution outcome and actions taken with date decision was determined .<br><br>Administration was aware of grievances that existed within the facility as DON B had signed the grievances as being completed. Despite Administration being aware of staffing concerns, care concerns, neglect and abuse concerns within the facility through the grievance process, Administration failed to thoroughly and promptly address grievances and concerns to come to a resolution. Many of these grievances, due to not being addressed, led to complaints being filed with the state agency and the need for an additional complaint survey to investigate unresolved concerns. (Refer to F585.)<br><br>Example 3:<br><br>On 1/4/2023 the facility was issued the 2567 - Statement of Deficiencies for a survey that concluded on 12/14/23. On 1/13/2023 the facility administration submitted a plan of correction indicating steps they would be taking to achieve substantial compliance, to include audits and QAPI review. Through implementation of the facility audit and QAPI process, the facility should have been aware of continued existing concerns within the facility to include deficiencies uncorrected at the time of revisit:<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 1. The facility was made aware of concern with the lack of thorough investigation into an allegation of neglect following the 12/14/22 survey. Administration was aware of the issued identified during the 12/14/22 survey through the issuance of the Statement of Deficiencies. The awareness is further confirmed by the signing of the Statement of Deficiencies as well as the writing and submission of the Plan of Correction. During the 3/23/22 survey, this deficiency was not corrected as the facility had 3 allegations of abuse that were not thoroughly investigated. (Refer to F610.)<br><br>* R66 and R67 were involved in a resident to resident altercation on 3/8/2023 that was not thoroughly investigated including putting interventions in place on R66 and R67's care plan to prevent further resident to resident abuse. The facility investigation determined the injury sustained by R66 was not as a result of a resident to resident altercation but did not investigate further to determine the cause of the injury of unknown origin.<br><br>* R12 has 2 grievances filed by R12's Power of Attorney (POA) with allegations of abuse/neglect that were not investigated by the facility.<br><br>2. The facility was made aware of concerns that residents were not receiving ADL (activities of daily living) cares following the 12/14/22 survey. Since that survey, the state agency has received 12 complaints with allegations that residents are not receiving cares. During the 3/23/23 survey, Surveyors found the Oak Creek Police Department responded to a number of 911 calls they received from residents and/or family related to residents not receiving needed cares including transfers to bed, assessments, oxygen, showers, etc. Concerns were again identified that 3 residents did not receive the assistance with ADL cares they needed. (Refer to F677)<br><br>* R47 and R61 are dependent on staff assistance for showers/ bathing. Both R47 and R61 were not provided with scheduled showers/ baths per the plan of care.<br><br>* R60 is dependent on staff for bathing/ showers as well as incontinence cares. R60 was not provided with showers or incontinence care per the plan of care.<br><br>3. The facility was made aware of concerns that residents were not receiving appropriate care to prevent the development of pressure injuries resulting in actual harm to the residents following the 12/14/22 survey. Administration was aware of the issued identified during the 12/14/22 survey through the issuance of the Statement of Deficiencies. The awareness is further confirmed by the signing of the Statement of Deficiencies as well as the writing and submission of the Plan of Correction. Since the completion of that survey, the state agency has received 3 additional complaints. During the 3/23/23 survey, the deficiency was found to be uncorrected as 2 residents developed pressure injuries as appropriate measures to prevent the development of pressure injures were not implemented. (Refer to F686.)<br><br>* R58 was admitted to the facility 12/16/22 with no pressure injuries and at high risk for skin breakdown due to pressure, arterial and diabetic comorbidities. R58 had a plan of care in place but no resident specific interventions to prevent skin breakdown.<br><br>R58 was hospitalized [DATE] through 1/4/23. Upon readmission, R58 was assessed by a Licensed Practical Nurse (LPN) and not a Registered Nurse (RN) and bruising, dry flaky feet and a scab to left pinky toe was noted but was not assessed comprehensively or reported to the Nurse Practitioner (NP).<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | R58 developed a skin tear to his buttocks on 1/13/23 that was not assessed comprehensively by an RN or reported to the NP. R58's family noted a wound causing pain to R58's right ankle on 1/15/23 and alerted the LPN on duty. The LPN charted the wound as a necrotic pressure injury and reported it to the Unit Manager RN. LPN stated the wound was 3 to 4 inches in length and 2 to 3 inches long when she saw it on 1/15/23. There was no RN assessment of the wound and it was not reported to the NP.<br><br>Diabetic foot checks were recorded as completed but no nurse could recall or remember checking R58's feet the week leading up to the family reporting the wound and no Certified Nursing Assistant (CNA) could recall or remember looking at R58's feet. R58 was transferred to the hospital on 1/16/23 at approximately 11:15 AM and the wound was noted in the emergency room documents by a Wound MD at 4:35 PM as an Unstageable Pressure Injury along with numerous other diabetic wounds and a Stage 2 Pressure Ulcer to his sacrum. R58's wounds continued to worsen, needing debridement and eventually causing osteomyelitis. R58 passed away 2/11/23.<br><br>* R22 did not have a comprehensive skin assessment, along with treatment orders, upon readmission to the facility from a hospital stay.<br><br>4. Following the 12/14/22 survey, the facility was made aware that there were concerns related to supervision to prevent accidents including falls and safe consumption of food and beverages. Since that survey, the state agency received 6 complaints alleging concerns with falls. Administration was aware of the issued identified during the 12/14/22 survey through the issuance of the Statement of Deficiencies. The awareness is further confirmed by the signing of the Statement of Deficiencies as well as the writing and submission of the Plan of Correction. During the 3/23/22 survey, surveyors identified a concern with a resident who was not assessed by an RN or physician following 2 falls. (Refer to F689.)<br><br>The facility was made aware of concerns with nutrition/hydration status following the 12/14/22 survey. Since that survey, the state agency received 2 complaints related to nutrition/hydration. During the 3/23/22 survey, surveyors identified a concern with a resident who experienced profound dehydration. The facility was not monitoring the resident's fluid intake or assisting with fluids. (Refer to F692.)<br><br>* On 3/8/23 R68 was transferred to the hospital due to a change in condition. The hospital record dated 3/8/23 indicated R68 was severely dehydrated and needed 14 liters of lactated ringers to rehydrate.<br><br>R68 was receiving pureed foods and nectar thick liquids and the facility was not monitoring R68's fluid intake.<br><br>Assistant Chief Nursing Officer CC stated R68 would refuse to drink at times. There is no evidence of R68 refusing to drink. There is no evidence R68 was educated on the importance of nectar thick liquids, options to the diet or discussion of possible waiver to the diet.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 5. The facility was made aware of concerns related to behavioral health services following the 12/14/22 survey. Administration was aware of the issued identified during the 12/14/22 survey through the issuance of the Statement of Deficiencies. The awareness is further confirmed by the signing of the Statement of Deficiencies as well as the writing and submission of the Plan of Correction. During the 3/23/22 survey, Surveyors identified a concern that 1 person who had been followed by psychiatric services for medication and behavior monitoring did not receive services after a change in psychiatric service providers. The resident requested to see a provider related to medication changes.<br><br>* R60 had been receiving active psychological services for medication and behavior monitoring. When the facility changed medical practitioners/services R60 was not transitioned to the new medical group to receive continued psychological services.<br><br>Administration was aware that psychological service provider was no longer practicing at the facility, and did not ensure that residents were provided with the needed and requested services. (Refer to F740.)<br><br>6. Following the 12/14/22 survey, the facility was made aware of concerns with breaks in infection control practices. During the 3/23/22 survey, Surveyors identified breaks in infection control when staff did not practice hand hygiene at appropriate intervals while providing cares.<br><br>7. The facility was made aware of concerns related to infection control following the 12/14/22 survey. Administration was aware of the issued identified during the 12/14/22 survey through the issuance of the Statement of Deficiencies. The awareness is further confirmed by the signing of the Statement of Deficiencies as well as the writing and submission of the Plan of Correction. During the 3/23/22 survey, staff did not wash hands or change gloves in accordance with standards of practice for hand hygiene during incontinence cares for R12; potentially exposing her to infection. (Refer to F880) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>40533<br><br>UNCORRECTED ON REVISIT<br><br>Based on observation, record review and interview, the facility did not ensure facility staff utilized hand hygiene in accordance with acceptable standards of practice during incontinence care for 1 (R12) of 3 residents reviewed for incontinence care.<br><br>Staff did not wash hands or change gloves in accordance with standards of practice for hand hygiene during incontinence cares for R12; potentially exposing her to infection.<br><br>Findings include:<br><br>Surveyor reviewed the facility's Handwashing policy with a date of November 2018. Documented was:<br><br>1. Handwashing is done before and after resident contact, before and after any procedure, after using a Kleenex or the rest room, before eating and handling food, when hands are obviously soiled and regardless of glove use.<br><br>2. If using waterless system, put alcohol based hand rinse on hands and rub hands together for approximately 10-15 seconds or until hand sanitizer has absorbed on hands.<br><br>3. If using a system with soap and water, turn water on to desired temperature.<br><br>4. Do not touch inside of sink or front of sink if possible.<br><br>5. Wet hands with water and apply soap.<br><br>6. Rub hands together for about 20 seconds, making sure to wash between fingers.<br><br>7. Rinse hand thoroughly under running water.<br><br>8. Obtain paper towel. If paper towel dispenser needs to be pushed down, do so with forearm or prior to washing hands.<br><br>9. Dry hands using paper towels. Use paper towel to turn off faucet.<br><br>10. Discard paper towel.<br><br>Surveyor reviewed the facility's Gloves policy with a date of November 2018. Documented was:<br><br>1. Gloves are worn when there is a chance of coming into contact with excretions, secretions, blood, body fluids, mucous membranes, non-intact skin or other potentially infective material.<br><br>2. Gloves are discarded in the waste receptacle in the resident's room.<br><br>(continued on next page) |

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| | 525730 | A. Building<br>B. Wing | 03/23/2023 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3. Staff should not walk in the hall or from room to room with the same gloves on their hands.<br><br>4. Hands should always be washed after removing the gloves.<br><br>5. Gloves are one time use only item.<br><br>R12 was admitted to the facility 6/24/22 with diagnoses that included Unspecified Dementia without Behavioral Disturbances, Encounter for Surgical Aftercare Following Surgery on the Digestive System and Adult Failure to Thrive. R12 had designated her Power of Attorney (POA) to be POA-KK.<br><br>Surveyor reviewed R12's MDS (Minimum Data Set) Quarterly Assessment with an assessment reference date of 2/5/23. Documented under Cognition was a BIMS (brief interview mental status) score of 03 which indicated cognitively impaired. Documented under Functional Status for Bed Mobility was 2/2 which indicated Limited assistance - resident highly involved in activity; staff provide guided maneuvering of limbs or other non weight-bearing assistance; One person physical assist. Documented under Functional status for Toilet Use was 4/2 which indicated Total dependence; One person physical assist.<br><br>On 3/8/23 at 10:57 AM, Surveyor entered R12's room who stated she needed to get off the bedpan because it was in the wrong place. Surveyor instructed her to push her call light. At 10:59 AM, Certified Nursing Assistant (CNA)-Q entered the room. R12 stated the bed pan was in the wrong place. CNA-Q donned gloves without washing hands. CNA-Q lifted the blanket off R12 and instructed her to roll to the left. CNA-Q moved the bedpan with left hand and held on to R12's hip with the right hand. CNA-Q instructed R12 to roll back to a seated position. R12 stated that the bedpan was positioned better. CNA-Q doffed gloves and discarded, did not sanitize hands. CNA-Q asked R12 if she wanted her Prevalon boots on. R12 stated yes. CNA-Q did not sanitize hands and proceeded to lift the blanket. CNA-Q placed Prevalon boots to both of R12's feet. CNA-Q replaced blanket and stated to R12 to push call light when she was ready to get off the bedpan. CNA-Q walked to roommates' (R63) bed without sanitizing hands. CNA-Q asked if R63 needed anything and R63 responded no. CNA-Q exited room without washing or sanitizing hands. Surveyor left room and waited in hallway to allow for privacy for R12.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | At 11:20 AM R12's call light was lit and visible from hallway. Surveyor entered room and at 11:21 AM CNA-Q entered R12's room and asked her if she was done on the bedpan. R12 stated yes. CNA-Q did not wash or sanitize hands and donned gloves. CNA-Q picked up the garbage can with gloved hands and moved to the side of the bed. CNA-Q picked up the bed remote with gloved hand and reclined the head of bed. CNA-Q removed the blanket and held bedpan with their right hand and instructed R12 to roll to left side. CNA-Q placed both hands on bedpan, that was half full of urine, and slid bedpan out from under R12. CNA-Q placed bedpan on top of the garbage can on the floor and returned to R12. CNA-Q did not change gloves or sanitize hands. CNA-Q opened a drawer at the bedside and removed a disposable wipe. CNA-Q wiped the backside and buttocks of R12. CNA-Q discarded the wipe and removed gloves, but did not sanitize hands. CNA-Q entered the bathroom, turned on water and filled a basin with soap and water. CNA-Q returned to R12 at bedside and set down basin and donned new gloves. CNA-Q did not wash or sanitize hands. CNA-Q washed R12's peri area in front with washcloth and dried with towel. CNA-Q did not change gloves or sanitize hands. CNA-Q applied barrier cream to front peri area with gloved hand and instructed R12 to roll to the left side. CNA-Q applied barrier cream to buttocks. CNA-Q did not remove gloves or sanitize hands. CNA-Q replaced the brief and attached it on the right side, then left side. CNA-Q pulled up R12's pants and replaced blanket. CNA-Q picked up bedpan from the garbage can and walked to the bathroom. CNA-Q emptied the bedpan in toilet, turned on the water with gloved hand, ran water into bedpan and emptied into the water into the toilet. CNA-Q then set the bedpan down, removed their gloves and washed hands with soap and water. Surveyor noted CNA-Q did not sanitize or wash hands before start of cares, did not change gloves or sanitize hands in-between cares and cleaning resident and touching the bedpan with urine in it and did not sanitize hands or change gloves before touching patient and multiple other surfaces.<br><br>On 3/13/23 at 10:38 AM Surveyor interviewed Assistant Chief Nursing Officer (ACNO)-D. Surveyor asked when CNA's should be sanitizing or washing hands when providing incontinence care. ACNO-D stated before starting cares, upon entering room, with glove changes. Surveyor asked when CNA's should be changing gloves during incontinence care. ACNO-D stated after removing dirty brief, anytime gloves are dirty. Surveyor noted CNA-Q did not sanitize or wash hands before start of cares, did not change gloves or sanitize hands in-between cares and cleaning resident and touched bedpan with urine in it and did not sanitize hands or change gloves before touching patient and multiple other surfaces. ACNO-D stated I will have to do some education. ACNO-D stated CNA-Q should have changed her gloves in between any dirty to clean and washed or sanitized her hands between glove changes. |

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| F 0947<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.<br><br>40533<br><br>Based on interview and record review the facility did not ensure 5 Certified Nursing Assistants (CNA-L, CNA-ZZ, CNA-AAA, CNA-BBB and CNA-CCC) of 5 reviewed received the required in-service training for nurse aides. The in-service training must be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year.<br><br>Findings include:<br><br>Surveyor reviewed the facility's Training Requirements policy with a date of July 2020. Documented was:<br><br>Policy:<br><br>This facility has developed, implemented, and maintains an effective training program for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with defined and expected roles. The facility determines the amount and types of training necessary based on the Facility Assessment and individual training needs based on each staff member's performance evaluation. Competencies and skill sets for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers will be consistent with expected roles.<br><br>It is the policy of this facility that all certified personnel including but not limited to Certified Nurse Aides and Certified Medication Aides participate in regularly scheduled in-service training classes based on Federal Rules of Participation and on identified educational needs of each individual staff member through competency evaluation .<br><br>Required training with demonstration of competency on topics for all staff including but are not limited to:<br><br>o Communication<br><br>o Resident Rights and Facility Responsibilities<br><br>o QAPI<br><br>o Infection Prevention and Control<br><br>o Prevention of Abuse, Neglect, Exploitation and Mistreatment<br><br>o Dementia Management and Resident Abuse<br><br>o Behavioral Health as identified in Facility Assessment<br><br>o Compliance and Ethics<br><br>(continued on next page) |

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| F 0947<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | o HIPAA and Confidentiality<br><br>o Emergency Preparedness and Safety Procedures<br><br>o Missing Resident Protocol .<br><br>All direct care staff are required to attend twelve (12) hours of continuing education and demonstrate competency annually including but not limited to:<br><br>o Dementia<br><br>o Infection Control including bloodborne pathogens and Antibiotic Stewardship<br><br>o HIPAA and confidentiality<br><br>o Resident rights and facility responsibilities<br><br>o Prevention of abuse, neglect, exploitation and mistreatment of residents<br><br>o Compliance and ethics<br><br>o Advance directives and the Patient Self Determination Act<br><br>o Emergency preparedness<br><br>o Quality Assurance/Performance Improvement (QAPI)<br><br>o Communication<br><br>o Safety and hazard training program Behavioral Health including but not limited to Trauma-Informed Care and Substance Use Disorder as identified in Facility Assessment<br><br>o Non-Pharmacological Interventions .<br><br>o The facility will keep a record of all trainings for each staff member<br><br>o Training requirements will be met prior to staff and volunteers independently providing services to residents, annually and as necessary based on but not limited to:<br><br>- The Facility Assessment<br><br>- Training based on individual staff member needs identified on the staff member's performance evaluation(s) .<br><br>Surveyor reviewed the Facility Assessment with a reviewed date of 2/9/23 to identify resources the facility needs to care for their residents. Documented under Staff Education was:<br><br>Topic:<br><br>(continued on next page) |

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| F 0947<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Communication - effective communications for direct care staff<br><br>Staff Type and Timing (on hire, annual, [as needed (PRN)], On Demand), How:<br><br>All staff- upon hire, monthly, PRN and on demand if issues are identified<br><br>Face to Face<br><br>Topic:<br><br>Resident's rights and facility responsibilities - ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents<br><br>Staff Type and Timing (on hire, annual, PRN, On Demand), How:<br><br>All staff- upon hire, PRN annually<br><br>Face to Face, written materials given<br><br>Topic:<br><br>Abuse, neglect, and exploitation - training that at a minimum educates staff on - (1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property; (2) Procedures for reporting incidents, of abuse, neglect, exploitation, or the misappropriation of resident property; and (3) Education related to responsibilities as mandated reporters<br><br>Staff Type and Timing (on hire, annual, PRN, On Demand), How:<br><br>All staff- upon hire, PRN annually<br><br>Face to Face, written materials given<br><br>Topic:<br><br>Infection control - a facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program<br><br>Staff Type and Timing (on hire, annual, PRN, On Demand), How:<br><br>All staff<br><br>Upon hire, annually, PRN<br><br>Face to Face, return demonstration, written materials given<br><br>Topic:<br><br>Culture change (that is, person-centered and person-directed care)<br><br>(continued on next page) |

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| F 0947<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Staff Type and Timing (on hire, annual, PRN, On Demand), How:<br><br>All staff<br><br>Upon hire, annually, PRN<br><br>Face to Face, written materials given .<br><br>Topic:<br><br>Identification of resident changes in condition, including how to identify medical issues appropriately, how to determine if symptoms represent problems in need of intervention, how to identify when medical interventions are causing rather than helping relieve suffering and improve quality of life<br><br>Staff Type and Timing (on hire, annual, PRN, On Demand), How:<br><br>All staff on components of this, but primarily clinical staff<br><br>Topic:<br><br>Cultural competency (ability of organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of residents)<br><br>Staff Type and Timing (on hire, annual, PRN, On Demand), How:<br><br>See Resident's Rights and Cultural Change .<br><br>Surveyor reviewed facility's Certified Nursing Assistant Annual Training Hours January - December 2022. Documented was the Training/Inservice to be completed, the time amount it would take to complete the training and the due date. Documented was:<br><br>Residents Rights - 45 Minutes - June 2022 Quiz<br><br>QAPI - 1 Hour - June 2022 Inservice<br><br>Abuse & Neglect - 45 Minutes - December 2022 Quiz<br><br>Dementia Training - 30 Minutes - December 2022 Quiz<br><br>Hand Hygiene (Infection Control) - 15 Minute - June 2022 Demonstration<br><br>PPE (Infection Control) - 1 Hour - June 2022 Demonstration<br><br>Ethics & Culture (Customer Service Video) - 1.5 Hour - June 2022 Quiz<br><br>Body Mechanics & Transfers - 30 Minutes - December 2022 Demonstration<br><br>Transfers & Bed Mobility - 30 Minutes - December 2022 Demonstration<br><br>(continued on next page) |

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| F 0947<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Dysphagia - 45 Minutes - December 2022 Quiz<br><br>Dining Experience - 30 minutes - December 2022 competency<br><br>Infection Control (PowerPoint follow up) - 1 hour - December 2022 competency<br><br>Fall Prevention (PowerPoint) - 30 minutes - June 2022 Competency<br><br>Standard Precautions - 45 Minutes - June 2022 Competency<br><br>Dietary Process - 15 Minutes/15 Minutes - June/ December Competency<br><br>Resident Right (Grievance Process) - 30 minutes - December 2022 competency<br><br>Blood Born Demonstration - 1 hour - December 2022 Quiz / competency.<br><br>On 3/22/23, Surveyor requested Abuse/Neglect, Dementia, Infection Control, QAPI, Ethics and Compliance, Resident Rights and other trainings to total over 12 hours from 2022 and 2023 for CNA-L, CNA-ZZ, CNA-AAA, CNA-BBB and CNA-CCC. Staffing Coordinator (SC)-YY provided the paperwork that documented the following:<br><br>CNA-L was rehired on 12/16/21 and had documented Abuse/Neglect, Dementia, Infection Control, Ethics and Compliance, Resident Rights training. There was no documentation of QAPI or required 12 hour annual training.<br><br>CNA-ZZ was hired on 8/11/20 and had documented Abuse/Neglect, Dementia, Infection Control, QAPI, Ethics and Compliance, Resident Rights training. There was no documentation of required 12 hour annual training.<br><br>CNA-AAA was hired on 5/4/21 and had documented Abuse/Neglect, Dementia, Infection Control, QAPI, Ethics and Compliance, Resident Rights training. There was no documentation of required 12 hour annual training.<br><br>CNA-BBB was hired on 8/18/20 and had documented Abuse/Neglect, Dementia, Infection Control, QAPI, Ethics and Compliance, Resident Rights training. There was no documentation of QAPI or required 12 hour annual training.<br><br>CNA-CCC was hired on 5/11/21 and had documented Abuse/Neglect, Dementia, Infection Control, QAPI, Ethics and Compliance, Resident Rights training. There was no documentation of required 12 hour annual training.<br><br>(continued on next page) |

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| F 0947<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 3/22/23 at 3:28 PM, Surveyor interviewed CNA-CCC. Surveyor showed CNA-CCC the paper quiz for Resident Rights and Cultural Competence with her name and date of 6/22/22 on it. Surveyor asked if she remembered the training. CNA-CC stated no. Surveyor asked if she remembers completing the quizzes. CNA-CC stated no, not at all and that is not my handwriting. Surveyor noted the write-in answers for 2 questions on the Cultural Competence quiz. Surveyor asked if she was sure she did not complete the training. CNA-CC stated yes she was sure, noting the answer to question 6 as being misspelled as Compliance Officar instead of Officer. CNA-CC stated I know how to spell. Surveyor asked if she knew who the Compliance Officer was at the facility. CNA-CC stated no, she does not know what that is.<br><br>On 3/22/23 at 2:22 PM Surveyor interviewed Assistant Chief Nursing Officer (ACNO)-D. Surveyor asked how training was completed for the staff. ACNO-D stated there were competencies, verbal trainings, annual and quarterly trainings in meetings and other as needed trainings. Surveyor asked how trainings were tracked. ACNO-D stated once they are completed a hard copy is placed in their employee file.<br><br>On 3/22/23 at 4:06 PM Surveyor interviewed Staffing Coordinator (SC)-YY who oversaw Human Resources and employee files. Surveyor asked who instructed the trainings for Resident Rights and Cultural Compliance in June 2022. SC-YY stated the 2 former social workers. The former Social Workers were no longer employed at the facility and unable to be interviewed. Surveyor requested the 12 hour CNA training documentation for the 5 CNAs from their employee files.<br><br>On 3/23/23 at 7:30 AM Surveyor interviewed Nursing Home Administrator (NHA)-A. Surveyor asked if the 12 hour CNA training documentation had been found. NHA-A stated they were not able to produce any other documentation. Surveyor asked how the training was tracked/completed. NHA-A stated the facility does not have them sign-off on anything. Surveyor asked how the facility knows each staff member completed the training if they do not sign-off that it was completed. NHA-A stated that was something the facility would be working on. Surveyor asked about the Certified Nursing Assistant Annual Training Hours January - December 2022 sheet that was reviewed. NHA-A stated that was the plan for the training but they have no documentation that it was completed. |