| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675371 | A. Building<br>B. Wing | 03/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Riverview Nursing & Rehabilitation | 1102 River Rd<br>Boerne, TX 78006 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32218<br><br>Based on observation, interview and record review the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced dignity and respect for 1 of 26 Resident (Resident #53) reviewed for resident rights in that:<br><br>The facility failed to promote care in a manner to enhanced dignity for Resident #53 when CNA A and B stood while feeding the resident during the lunch meal.<br><br>This deficient practice could affect residents who required assistance with eating and could contribute to feelings of poor self-esteem and decreased self-worth.<br><br>The findings were:<br><br>Review of Resident #53's face sheet dated 2/7/2023 revealed the resident was admitted to the facility on [DATE] and had diagnoses that included Alzheimer's disease (a progressive brain disorder that slowly destroys memory and thinking skills due to nerve cells in the brain dying), speech and language deficits following unspecified cerebrovascular accident (a condition that affects the supply of blood to the brain), hypertensive disease (heart that occur because of high blood pressure) without heart failure, body mass index 19.9 or less (a bit underweight and can't afford to lose more and dysphagia (difficulty swallowing which often makes it difficult to take in enough calories and fluids to nourish the body).<br><br>Review of Resident #53's physicians orders revealed the resident had an order for a fortified meal plan with a start date of 11/7/2022, add large portions to meals, with a start date of 10/12/2022, add ice cream to lunch and dinner, with a start date of 11/16/2022, and yogurt, pudding, or ice cream two times a day between meals with a start date of 3/26/2021. Resident #53 also had an order to be in the secure unit related to wandering, with a start date of 4/13/2021.<br><br>Review of Resident #53's Quarterly MDS dated [DATE] revealed the resident had a BIMS score of 1, indicating severely impaired cognitive status and required extensive assistance of 1 staff member for dressing, toileting and eating.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident #53's care plans in the resident's electronic record revealed a Nutritional Status care plan that indicated the resident was on a fortified meal plan, with a start date of 7/5/2021. Further review of Resident #53's care plans revealed an additional Nutritional Status care plan that indicated the resident was at risk for weight loss due to dementia, with a start date of 11/30/2020.<br><br>Observation on 2/7/2023 at 12:33 p.m. in the woman's secure unit dining room revealed CNA B was standing while feeding Resident #53 her meal.<br><br>Observation on 2/7/2023 at 12:37 p.m. revealed CNA A took over feeding Resident #53 while CNA B went to another unidentified resident, sat in a chair, and began feeding the unidentified resident. Continued observation of CNA A revealed the CNA stood while she fed Resident #53 until the resident finished eating her meal.<br><br>In an interview on 2/7/2023 at 12:40 p.m. with CNAs A and B, CNA B stated Resident #53 will stand up to leave if staff sat to feed her.<br><br>In an interview on 2/9/2023 at 10:29 a.m. with the DON she stated staff should not stand while feeding residents because it could be intimidating to the resident and would be a dignity issue. The DON went on to say she did not know if there was a potential for physical harm to the resident if staff stood while feeding the residents.<br><br>Observation on 2/9/2023 at 12:30 p.m. revealed the DON was feeding Resident #53 her meal. The DON was sitting while feeding the resident and the resident did not attempt to stand up to leave during the meal.<br><br>Review of the facility policy, Resident Rights, revised October 2009, revealed, 3. Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity.<br><br>44906<br><br>47564 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32218<br><br>Based on observation, interview, and record review the facility failed to provide a clean, comfortable, and homelike environment for daily living for 8 of 26 residents, (Residents # 9, 11, 25, 67, 28, 16, 40, 61) reviewed for environmental conditions, in that:<br><br>1A. The facility failed to repair holes in the bedroom for room [ROOM NUMBER] (Residents #25 and #67's room).<br><br>1B. The facility failed to provide a paper towel holder and paper towels in room [ROOM NUMBER] (Resident #16's room) for 3 days.<br><br>1C. The facility failed to have hot running water in room [ROOM NUMBER] (Resident #28's room) for 3 days.<br><br>1D. The facility failed to repair a light that was out in room [ROOM NUMBER]'s restroom (Residents #40 and #61's room) for 3 days.<br><br>2A. The facility failed to provide Resident #11 with toilet paper when requested.<br><br>2B. The facility failed to provide Resident #11 with adequate clothing storage.<br><br>2C. The facility failed to provide a bedsheet for Resident #11's bed.<br><br>3A.The facility failed to remove soiled personal underwear from Resident #9's personal bed. The facility failed to remove a torn mattress with urine smell from Resident #9's room.<br><br>3B. The facility failed to prevent personal fans from being covered in gray fuzzy matter for Residents #11 and #25.<br><br>3C. The facility failed to maintain clean cloth privacy curtains in Residents #9, #11, #25 rooms.<br><br>These failures could affect residents who reside at the facility and could put them at risk of living in an unsafe, unclean, and a potentially infectious environment .<br><br>Findings included:<br><br>1A. Record review of Resident #25's face sheet reflected Resident #25 was a [AGE] year-old female admitted on [DATE] with diagnosis including End Stage Renal Disease (complete kidney failure) and acquired absence of left leg above knee (leg missing from above knee to foot).<br><br>Record review of Resident #25's MDS reflected a BIMS of 13 indicating cognitively intact.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #67's face sheet reflected Resident #67 was a [AGE] year-old female admitted on [DATE] with diagnosis including Atherosclerotic heart disease (the buildup of fats, cholesterol and other substances in and on the artery walls), and Cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body).<br><br>Record review of Resident #67's MDS reflected a BIMS of 01 indicating severe impairment.<br><br>Record review of facility resident roster reflected Resident #25 and Resident #67 were the only two residents residing in room [ROOM NUMBER].<br><br>Observation on 2/8/2023 at 11:57 AM revealed room [ROOM NUMBER]'s bathroom wall to have an approximately 3-inch-tall, 1-foot-wide hole near the floor next to the toilet.<br><br>Interview and observation on 2/9/2023 at 12:40 p.m., Maintenance Director stated he did not know about the hole in the wall of the bathroom in room [ROOM NUMBER]. MS stated he was not aware of the hole in the wall and stated that it is his expectation to be notified of any sort of damage to the resident's rooms requiring repairs such as drywall holes.<br><br>1B. Review of Resident #16's face sheet dated 12/9/2023 revealed the resident was admitted to the facility on [DATE] and had diagnoses that included schizophrenia unspecified (a diagnosis assigned to individuals who are experiencing symptoms of schizophrenia-experiencing impaired functioning in social, occupational, or other major areas of functioning) but do not meet the full diagnostic criteria for schizophrenia), essential hypertension (a type of high blood pressure that has no clearly identifiable cause but thought to be linked to genetics, poor diet, lack of exercise and obesity), hypertensive heart disease (heart problems that occur because of high blood pressure that is present over a long time) without heart failure, and unspecified dementia with other behavioral disturbance (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems).<br><br>Review of Resident #16's Quarterly MDS dated [DATE] revealed the resident had a BIMS score of 7, severely impaired decision-making, and required extensive assistance of 1 staff member for dressing, toileting, and personal hygiene.<br><br>Review of Resident #16's care plan with a start date of 11/29/2022 revealed the resident would scratch herself and hit her arms on her wheelchair or bedside table when she gets angry. Further review of the resident's care plans revealed a new care plan was created on 2/9/2023 at 1:58 p.m. that revealed Resident #16 had behaviors that included removing/damaging facility furnishings such as window blinds, wall hangings and fixtures.<br><br>In an observation on 2/7/2023 at 11:36 a.m., after HK C had completed cleaning led room [ROOM NUMBER], Resident #16's room, did not have a paper towel dispenser or paper towels in the room.<br><br>In an interview at 2/7/2023 at 11:41 a.m. with HK C the HK confirmed she had already cleaned room [ROOM NUMBER]. The HK stated Resident #16 removed the paper towel holder from the wall in room [ROOM NUMBER]. The HK stated she did not know if she should leave paper towels in the resident's room since there was no paper towel holder.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation on 2/9/2023 at 3:00 p.m. of room [ROOM NUMBER] revealed there was no paper towel holder or paper towels in the restroom.<br><br>Observation on 2/9/2023 at 1:35 p.m. with the Maintenance Director present revealed room [ROOM NUMBER] did not have a paper towel holder or paper towels in the room.<br><br>In an interview on 2/9/2023 at 1:35 p.m. with the Maintenance Director he reported he was not aware there was no paper towel holder in the room. He went on to say Resident #16 would put paper towels in the commode, causing it to clog. The Maintenance Supervisor stated that was probably reason why there was no paper towels in room. This surveyor asked if the facility had considered other options so that the resident could dry her hands after she washes them, and he was not aware. The Maintenance Supervisor stated the CNAs were on the floor to help Resident #16 if she needed anything.<br><br>1C. Record review of Resident #28's face sheet dated 2/9/2023 revealed the resident was admitted on [DATE] and had diagnoses that included hypotension (low blood pressure), schizoaffective disorder, bipolar type (a chronic mental health condition with symptoms of mood disorder, such as mania and depression), and speech and language deficits following cerebrovascular disease (a variety of medical conditions that affect supply of blood to the brain).<br><br>Review of Resident #28's Quarterly MDS dated [DATE] revealed she had a BIMS score of 8, moderately impaired cognitive status and required supervision with setup help only for transfers, ambulation, dressing, toileting, and personal hygiene.<br><br>Review of Resident #28's care plan with a start date of 4/10/2020 revealed the resident had impaired physical mobility related to decrease muscle control at times, cognitive impairment and required supervision with activities of daily living.<br><br>Observation on 2/7/2023 at 11:02 a.m. in room [ROOM NUMBER], where Resident #28 resided, revealed the hot water barely trickled from the faucet and the water was cold.<br><br>Observation on 2/8/2023 at 3:03 p.m. revealed the hot water in room [ROOM NUMBER] only trickled and was cold.<br><br>Observation on 2/9/2023 at 1:38 p.m. with the Maintenance Director present revealed the hot water in room [ROOM NUMBER] trickled and was cold. The Maintenance Director reached under the sink, turned the knob for the hot water on and the hot water began to run. When the Maintenance Director turned off the hot water, the water was dripping.<br><br>In an interview on 2/9/2023 at 1:39 p.m. with the Maintenance Director he stated he was not aware room [ROOM NUMBER] did not have hot water. When the water began leaking after the hot water was turned off the Maintenance Director stated someone must have turned off the hot water because the faucet was leaking. The Maintenance Director stated he did not know why the staff just turned off the hot water and did not notify him. The Maintenance Director reported he had a binder at the nurses' station where staff could write down any issues they may find in the residents' rooms.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 1D. Record review of Resident #40's face sheet dated 2/9/2023 revealed the resident was admitted to the facility on [DATE] and had diagnoses that included Alzheimer's disease (a progressive brain disorder that slowly destroys memory and thinking skills due to nerve cells in the brain dying), bipolar disorder current episode manic severe with psychotic features (a category of mood disorders defined by the occurrence of one or more episodes of abnormally elevated mood), hypertensive heart disease (heart problems that occur because of high blood pressure that is present over a long time) without heart failure and cognitive communication deficit.<br><br>Review of Resident #40's Annual assessment dated [DATE] revealed the resident had a BIMS score of 2, severely impaired cognition, and required supervision with setup help only for transfers, ambulation, dressing, toileting and hygiene.<br><br>Review of Resident #40's care plan with a start date of 1/26/2022 revealed the resident resides in the secure unit and at risk for injury from wandering in an unsafe environment due to poor safety awareness.<br><br>Review of Resident #61's face sheet dated 2/9/2023 revealed the resident was admitted to the facility on [DATE] and had diagnoses that included schizophrenia (a long term serious mental illness that interferes with a person's ability to think clearly, manage emotions, make decisions and relate to others), nonfamilial hypogammaglobulinemia (a disorder caused by low anti-body levels or immunoglobulins, which are main source to help eradicate infectious source) and personal history of non-[NAME] lymphoma (a cancer that starts in the white blood cells called lymphocytes, which are part of the body's immune system).<br><br>Review of Resident #61's Annual MDS dated [DATE] revealed the resident had a BIMS score of 2, severely impaired cognition and required extensive assistance of 1 staff member for transfers, dressing, toileting and personal hygiene.<br><br>Review of Resident #61's care plan with a start date of 3/9/2022 revealed the resident uses a wheelchair but will get herself out of the wheelchair and sit on the floor.<br><br>Observation on 2/7/2023 at 11:37 a.m. in room [ROOM NUMBER], where Resident #40 and Resident #61 resided, revealed there was not a working light in the restroom and the toilet tank lid was off tank and on the floor.<br><br>In an interview on 2/7/2023 at 11:41 a.m. with CNA A revealed she did not know the light was out in the rest room or the toilet tank lid was on the floor. The CNA stated one of the residents in the room may have removed the toilet tank lid and set it on the floor. She placed the lid back on the toilet tank. This surveyor asked CNA A what she did when she finds a light out in the residents' rooms. The CNA stated she would go look for the Maintenance Director or tell housekeeping if housekeeping was on the secure unit at that time.<br><br>Observation on 2/8/2023 at 2:20 p.m. in room [ROOM NUMBER] revealed the light was still out in the restroom.<br><br>Observation on 2/9/2023 at 1:45 p.m. of room [ROOM NUMBER] with the Maintenance Director revealed the light was still out in room [ROOM NUMBER]'s restroom.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 2/9/2023 at 1:45 p.m. with the Maintenance Director if the staff had informed him the light was out, he would have addressed it. The Maintenance Director reported he was not aware the light was out in room [ROOM NUMBER]'s restroom.<br><br>2A. Record review of Resident #11's face sheet reflected Resident #11 was a [AGE] year-old female admitted on [DATE] with diagnosis including rhabdomyolysis (condition of muscle deterioration and kidney damage), diabetes mellitus (disease that affects the body's ability to process glucose), and hypertensive heart disease (heart problems that occur with long term high blood pressure).<br><br>Record review of Resident #11's MDS assessment reflected a BIMS of 10, indicating moderately impaired cognitive status, and that the resident was occasionally incontinent.<br><br>Record review of facility's resident roster reflected Resident #11 was the only resident residing in room [ROOM NUMBER].<br><br>Observation on 2/9/2023 at 8:58 a.m. revealed there was approximately 8 inches of total toilet paper length in room [ROOM NUMBER]'s bathroom.<br><br>Interview on 2/9/2023 at 8:55 a.m. with Resident #11 revealed that she had asked for more toilet paper but was not provided with it.<br><br>During an interview on 2/9/23 at 9:45 a.m., the DON stated the MS was the manager of housekeeping.<br><br>During an interview and observation on 2/9/2023 at 12:34 p.m., the MS stated he was the manager of housekeeping. The MS stated the current toilet paper in room [ROOM NUMBER] was sufficient. The surveyor observed the remaining toilet paper to be approximately 8 inches of total toilet paper length remaining on the roll. The MS stated he was not aware that room [ROOM NUMBER] was not provided additional toilet paper. The MS stated there had been no issues with Resident #11 reported to him. The MS stated it was his expectation that all resident rooms are always evaluated for toilet paper by housekeeping staff in their daily morning rounds.<br><br>Observation on 2/9/2023 at 2:44 p.m. revealed no toilet paper left in room [ROOM NUMBER].<br><br>Observation on 2/9/2023 at 5:20 p.m. revealed no toilet paper in room [ROOM NUMBER].<br><br>2B&C. Observation on 2/9/2023 at 8:55 a.m. in room [ROOM NUMBER] revealed there was clothing on the floor and Resident #11's bed was without bed sheets. Further observation in the room revealed there was an empty, unused bed with a mattress that was fully furnished with bed sheets and a blanket.<br><br>Interview on 2/9/2023 at 8:55 a.m. with Resident #11 revealed she was told by staff that they did not have clean sheets for her bed. Resident #11 stated that there used to be a dresser in her room, and it was removed an unknown time ago by the facility and as a result, she keeps her clothes on the floor. Resident #11 stated she recently reported the lack of bedsheets and storage for her clothes to housekeeping staff.<br><br>During an interview on 2/9/23 at 9:45 a.m., the DON stated the MS was the manager of housekeeping.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview and observation on 2/9/2023 at 12:34 p.m., the MS stated he was the manager of housekeeping. The MS stated there had been no issues with Resident #11 reported to him. The MS did not respond when asked why Resident #11's bed did not have sheets and shook his head. The MS stated he would provide Resident #11 with a dresser to put her clothes in, and that it was housekeeping staff's responsibility to put clothing away after they were cleaned. The MS stated he was not sure why there was no dresser present for Resident #11.<br><br>Observation on 2/9/2023 at 2:44 p.m. revealed a dresser in the room with clothes remaining on the floor, and no bed sheets on Resident #11's mattress.<br><br>Observation on 2/9/2023 at 5:20 p.m. revealed a dresser in the room with clothes remaining on the floor, and no bed sheets on Resident #11's mattress.<br><br>3A-C. During an observation on 2/7/2023 at 11:15 a.m. of Resident #9's room, there was soiled personal underwear with on pillow located on Resident #9's bed. Resident #9 was sitting on his bed on the B side of the room. There was a strong smell of urine in the room during the observation. Observed mattress on the A side of Resident #9's bed to have torn main cover of mattress and had urine smell. Resident #9's privacy curtain had multiple-colored stains of red, brown and yellow substance.<br><br>During an interview on 2/7/2023 at 11:15 a.m., Resident #9 was asked if his bed was cleaned for him. He stated, no it is dirty, and can't you see the underwear they have not cleaned my room, they never do.<br><br>During an observation and interview on 2/7/2023 at 11:30 am, the DON and Administrator observed Resident #9's room urine odor, brief on the bed, dirty curtains, and torn mattress with urine smell. The Administrator stated the torn mattress would be removed and discarded. He further revealed the privacy curtain had multiple-colored stains of red, brown and yellow substance on the lower end of it. The DON stated Resident #9's personal bed would be cleaned, and soiled brief removed. She stated Resident #1 used his privacy curtain to wipe his hands.<br><br>During an observation on 2/9/2023 at 12:21 p.m., Resident #11's room had a personal fan with gray fuzzy matter covering the front and back of the fan.<br><br>During an observation and interview on 2/9/2023 at 1:00 p.m., the Maintenance Supervisor confirmed Resident #11's fan had fuzzy gray matter covering the front and back of the fan. When asked who was responsible for cleaning residents' personal fans, he stated the housekeeping department was responsible. He further revealed not cleaning the residents' personal fans and keeping them free of dust debris could be unsafe to the residents' respiratory health.<br><br>During an observation on 2/9/2023 at 12:25 p.m. Resident #25's room had a personal fan with gray fuzzy matter covering the front and back of the fan.<br><br>During an observation and interview on 2/9/2023 at 1:05 p.m. the facility Maintenance Supervisor confirmed Resident #25's fan had fuzzy gray matter covering the front and back of the fan. When asked who was responsible for cleaning resident's personal fans, he stated the housekeeping department was responsible. He further revealed not cleaning the residents' personal fans and keeping them free of dust debris could be unsafe to the residents' respiratory health.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on 2/9/2023, at 1:07 p.m. Resident #11 and #25's privacy curtains were visibly soiled with a brown substance.<br><br>During an observation and interview on 2/9/2023 at 1:07 p.m., Maintenance Supervisor observed that the privacy curtains were soiled. He stated housekeeping was responsible for changing the privacy curtains in residents' rooms when they are soiled. He stated he did not know why the soiled curtains were not changed, but he would have housekeeping staff change them. When asked if there was a written process on changing privacy curtains in residents room, he stated no.<br><br>Record review of facility policy titled: Cleaning and Disinfection of Environmental Surfaces; 2001 Med-Pass. Inc.(revised June 2009), statement revealed Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OSHA Bloodborne Pathogens Standard. Section 6. A one-step process and an EPA-registered hospital disinfectant designed for housekeeping purposes will be used in resident care areas where: a. uncertainty exists about the nature of the soil on the surfaces (e.g., blood or body fluids contamination versus routine dust or dirt). 11. Walls, blinds, and privacy curtains in residents areas will be cleaned when these surfaces are visibly contaminated or soiled.<br><br>Review of the facility policy, Quality of Life-Homelike Environment, revised February 2014, revealed, 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics included: a. Cleanliness and order; b. Comfortable (minimum glare) yet adequate (suitable to task) lighting.<br><br>42402<br><br>44906<br><br>47564 |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<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** 34957<br><br>Based on observation, interview, and record review, the facility failed to protect a resident's right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 4 of 5 residents (Resident # 3, #11, #27 and #36) reviewed for abuse, in that:<br><br>1. The facility failed to prevent Resident # 11 from being verbally abused by Nurse suffering psychosocial harm<br><br>2. The facility failed to prevent Resident #3 from being verbally abused by Nurse and suffering psychosocial harm<br><br>3. The facility failed to prevent Resident #36 from being verbally abused by Nurse and suffering psychosocial harm<br><br>4. The facility failed to prevent Resident #27 from being spoken to in a harsh, loud manner by Nurse X; and Resident # 27 suffered psychosocial harm<br><br>These failures resulted in an IJ on 03/01/23 at 6:45 PM. While the IJ was removed on 03/03/23 at 12:40 PM., the facility remained out of compliance at a level of actual harm that is not immediate jeopardy with a scope of pattern due to facility's need to evaluate the effectiveness of their plan of removal.<br><br>This deficient practice placed residents at risk of psychosocial harm, feeling disrespected or uncomfortable, decreased self-esteem, impaired quality of life; and abuse.<br><br>The findings were:<br><br>1. Record review of Resident #11's face sheet reflected Resident #11 was a [AGE] year-old female admitted on [DATE] with diagnosis including rhabdomyolysis (condition of muscle deterioration and kidney damage), diabetes mellitus (disease that affects the body's ability to process glucose), and hypertensive heart disease (heart problems that occur with long term high blood pressure). RP was listed as the resident.<br><br>Record review of Resident #11's MDS assessment reflected a BIMS of 10, indicating moderately impaired cognitive status. Also, record review of Resident #11's ADLs included: bed mobility-supervision with set-up; transfer-supervision with set-up; and eating was-supervision with set-up.<br><br>Record review of Resident #11's care plan dated 12/13/22 listed the problem of Behavioral Systems which included the Approach .Approach and speak in a calm manner .<br><br>Record review of Resident #11's signed HHS Form 4825-A (written statement), dated June 2005 read: She (Nurse X) is rude She said that I need to fast and not eat everything She (Nurse X) saw me trying to get past my wheelchair and she laughed at me. [There were no other witnesses to the alleged said incident.]<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Record review of Resident #11's EMR revealed weight of 313 pounds on 02/01/23.<br><br>Record review of Resident #11's nurse note dated 02/20/23 authored by Nurse X read. [Resident #11] can be uncooperative with staff. resident will cover her food at meal time and tell [Nurse X] what are you looking at .resident is disrespectful to staff and other resident.<br><br>In an observation on 2/10/2023 at 7:48 AM, breakfast was being served in the communal dining area with the TV on a loud volume. The communal dining area was brightly lit.<br><br>In an interview on 2/10/2023 at 7:50 AM, Resident #11 stated she was upset because Nurse X refused to let her eat breakfast in her room that morning [A resident's right]. Resident #11 stated she advised Nurse X that she was not feeling well due to a migraine and wanted to eat in her room because it was not as loud or bright. Resident #11 stated she was upset because Nurse X was so rude about it. Resident #11 stated she had also asked the ADON to eat in her room.<br><br>In an interview on 2/10/2023 7:55 AM, Nurse X stated she would prefer residents not eat in their room. Nurse X declined further interview and walked abruptly away from this surveyor and Resident #11.<br><br>In an interview on 2/10/2023 at 7:56 AM, the ADON stated she was aware of the request, and did not know that Nurse X had refused Resident #11's request. The ADON stated she would find Resident #11's breakfast tray and take it to Resident 11's room immediately. The ADON stated some residents preferred to eat in the dining area, and it was unusual for Resident #11 to request to eat in her room. [The ADON honored the resident's request to eat in her room.]<br><br>Observation and interview on 03/01/23 at 08:35 AM , Resident #11 was in room watching TV, cleaned and groomed, alert and oriented.; wheelchair present. The resident did not reveal signs or symptoms of sadness, fear, or anxiety (as a response to verbal abuse). The resident requested door be closed for the interview. Resident was eating her breakfast in the room. The Resident stated, .not that long ago (Nurse X) was rude to me .she said I could not eat in my room on 02/02/23 .I was upset she has always been rude to me .maybe she does not like me .she yells at me and laughs at me .yesterday (02/28/23) she laughed at me .as I struggled with my wheelchair .I complained in the past to the Administrator and he let me eat in my room .I'm not afraid of her I want her to be polite.<br><br>Record review of Resident Council Minutes for the past 9 months ( June 2022 to March 2023) read: on 02/16/23: night staff needs better communications [In reference to Nurse X].<br><br>During an interview on 03/01/23 at 2:13 PM, the ADON stated Nurse X tried to get Resident #11 to eat in the dining room for socialization reasons. Resident #11's tray was in the dining hall and taken to the resident. The ADON was not aware of verbal abuse by Nurse X towards Resident #11. The ADON stated that Resident #11, Resident #27, and Resident #3 told her (ADON) of instances where Nurse X could come across being load. The ADON stated the instances were never recorded as grievances; and she recalled the said residents saying not wanting to file a grievance against Nurse X; but their denial (Resident #11, #27 and #3) was not documented as a grievance or investigated. Regarding the Resident Council minutes dated 08/22/23, the ADON recalled speaking to Nurse X about modulating her volume when speaking to residents. The ADON did not consider the minutes on the concern over communications to be a grievance only to be a concern to be discussed with Nurse X. ADON described Nurse X, as a phenomenal and an excellent nurse in providing nursing care.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | 2. Record review of quarterly MDS dated [DATE], revealed Resident #3 was a [AGE] year-old-male admitted [DATE] with the diagnosis of diffuse traumatic brain injury (widespread traumatic injury to the tissues of the brain, usually mechanical forces such as those that are present in high velocity road traffic accidents). The summary BIMS score of 14 was indicative of intact cognition. ADLs revealed: transfer and bed mobility required limited assistance with one person physical assistance and supervision with set-up for eating.<br><br>Record review of Resident #3's face sheet dated, 03/01/23, revealed the RP was a family member.<br><br>Record review of Resident #3's care plan dated 2/15/23 read, the Problem .Behavioral Symptoms . Approach .maintain calm environment .anticipate behavior and re-direct .ensure staff is aware of resident('s) behaviors and successful interventions.<br><br>Record review of Resident #3's written statement on HHS form 4825-A, [dated 03/01/23] read, (Nurse X) does not speak what is not true [resident had communication and writing deficits during the interview].<br><br>Record review of Resident # 3's nurse notes from 01/01/23 to 03/01/23 authored by Nurse X revealed no negative behaviors by Resident #3 directed at Nurse X.<br><br>Record review of Resident #3's email to a Family Member K dated 11/22/2021 read, [ .(Nurse X)] .called me 'crazy'.<br><br>In an interview on 2/08/2023 at 1:46 PM, Resident #3 stated he would like to talk about something but was afraid he may get in trouble. Resident #3 stated Nurse X treated many people, including him, like mud. He stated every time he came to Nurse (X) for something, she made sure her back was turned toward him so she could quickly walk away from him. Resident #3 stated Nurse X would go into a different room, so he would not know where she was when he needed something. He stated she was nice to some residents and obviously had her favorites. Resident #3 stated Nurse X embarrassed him in the past when she said something about his mother after he asked her a question. Resident #3 stated Nurse X exclaimed, your momma wouldn't like you screaming like that. Resident #3 stated he does not like to be around Nurse X. Resident #3 stated he had mentioned it to staff, but they don't care what I say about Nurse [X] because they like Nurse [X].<br><br>Observation and interview on 03/01/23 at 9:02 AM , Resident #3 was in bed watching TV, cleaned and groomed, alert and oriented but with communication deficits. No signs of anxiety, sadness or fear. The Resident stated, .[Nurse X] treats me like mud .she wants to talk to other residents not me .I want her to become better .I complained to everybody [Administrator and DON] but nothing happens .<br><br>During an interview on 03/02/23 at 3:14 PM, Family Member K stated: Nurse X had been extremely rude to the Family Member K and to Resident #3. Family Member K stated that [Nurse X] threatened to withhold (Resident #3's) medication or give him (Resident #3) extra medication to control (Resident #3). [Family Member did not report the allegation to facility management] Family Member K stated that about 6 months ago (November 2022), she told former Administrator O about Nurse X's verbal abuse and former Administrator O said he would check; but never informed Family Member K of any internal investigation outcomes. Family Member K stated they received numerous emails from (Resident #3) complaining about Nurse X's behavior.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | [Record review of email from Resident #3 dated 11/22/21 read Nurse X called Resident #3 crazy.<br><br>Record review of email from Resident #3 dated 03/02/23 read [Nurse X ] lied.<br><br>During an interview on 03/02/23 at 3:48 PM, former Administrator O stated, I do not remember a verbal complaint from a family member about six months ago involving Nurse (X) and a resident (Resident #3) . The former Administrator O the residents may have mis-interpreted Nurse X's tone [speaking loudly].<br><br>3. Record review of the quarterly Minimum Data Set, dated dated dated [DATE] revealed Resident #36 was a [AGE] year-old male admitted [DATE]. Active diagnosis included hip fracture; cerebral palsy (impaired muscle coordination); moderate intellectual disabilities; Lack of coordination. Brief Interview for Mental Status score of 13 indicative of intact cognition. ADL for bed mobility and transfer was limited assistance with one person physical help; eating was supervision with set-up.<br><br>Record review of Resident #36's care plan, dated 09/03/21 read, Problem .Behavioral Symptoms .Approach . Provide opportunities for expression of feelings related to situational stressor .<br><br>Record review of Resident #36's written statement, transcribed by the Surveyor L, on 03/01/23 at 09:47 AM read, I do not feel comfortable with [Nurse X]. She yells at me and screams at people. She tells me to sit down in a loud voice. Get rid of her (Nurse X) Hire someone else.<br><br>Record review of Resident # 36' nurse notes from 01/01/23 to 03/01/23 authored by Nurse X revealed no negative behaviors by Resident #36 directed at Nurse X.<br><br>In an interview on 2/08/2023 at 11:53 AM Resident #36 stated Nurse X was frequently rude to him and other residents. Nurse X frequently yells and hollers. Resident #36 stated he did not like to ask Nurse X for assistance. Resident #36 stated, It doesn't do any good to complain about staff here when asked to whom he had reported his concerns.<br><br>Observation and interview on 03/01/23 at 9:38 AM , Resident #36 was in his room sitting on a wheelchair listening to country music. The resident displayed no signs of distress, anxiety, fear or sadness. Resident #36 stated, Nurse X had the habit of yelling at him. He complained the Administrator and the DON about Nurse X's yelling but no changed occurred.<br><br>4. Record review of quarterly MDS dated [DATE] revealed Resident #27 was a [AGE] year-old female with an admitted [DATE] . Active diagnosis included cerebral palsy (impaired muscle movements); cellulitis (bacterial skin infection) of left and right lower limb; lymphedema (swelling); and lack of coordination. The BIMS summary score of 13 was indicative of intact cognition. ADLs revealed: bed mobility and transfer were limited assistance with one person physical assist; eating was supervision with set-up.<br><br>Record review of Resident #27's care plan, dated 01/03/23 revealed that Resident #27 had to be approached in a calmed manner.<br><br>Record review of Resident #27's written statement on Form 4827-A dated 3/1/27 at 10:19 AM read, [Nurse X] talks to us like we are babies Don't do this like a slap on the hand Take a lot of food from peoples plates to feed her cats.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Record review of Resident # 27' nurse notes from 01/01/23 to 03/01/23 authored by Nurse X revealed no negative behaviors by resident directed at Nurse X.<br><br>In an interview on 02/08/2023 at 3:23 PM, Resident #27 stated Nurse X was often rude to her. Resident #27 stated Nurse X frequently speaks to her in a harsh tone. Resident #27 stated it made her feel bad and Resident #27 wished she was not at this facility when spoken to in that manner. Resident #27 further stated [Nurse X] does not pay my bills, and I am not her child so she shouldn't speak to me like that! Resident #27 stated it made her feel bad and she would return to her room to cry when Nurse X spoke to her condescendingly. Resident #27 stated she had previously told other aides and the ADON that she did not like Nurse X, but Nurse X continued to act bossy over me.<br><br>Observation and interview on 03/01/23 at 10:12 AM , Resident #27 was attending a church service; sitting on a wheelchair, alert and oriented. There were no signs of sadness, anxiety or fear . The Resident stated, she told the surveyor that Nurse X treated her like a child. Resident #27 added that she once cried after being treated as a child by Nurse X. Resident #27 complained to the Administrator about Nurse X's tone and behaviors but no actions were taken against Nurse X.<br><br>Record review of Resident # 27's nurse notes from 01/01/23 to 03/01/23 authored by Nurse X revealed no negative behaviors by Resident#27 directed at Nurse X.<br><br>In a group interview on 2/09/2023 at 9:30 AM, with the DON, the Regional Nurse, and the ADON, the ADON stated she did the facility staffing. She further revealed Nurse X was the only full-time nurse on staff, other than the DON. The ADON stated Nurse X worked 12 hour shifts 6:00 AM to 6:00 PM Monday through Saturday and Sundays off. When asked if she felt this was ok for RN to work this many hours, ADON stated, yes, she is one of our best nurses. She does just fine. When the DON was asked if she was aware of any issues or complaints concerning Nurse X being rude to residents, she replied No, that's just the way Nurse X talks to people. The DON stated Nurse X knew which residents needed a firmer approach. The DON stated that Nurse X really cared for the residents at the facility. When asked if the DON felt Nurse X was able to maintain a therapeutic relationship working that many hours each week she replied yes. The DON further explained that Nurse X had been offered more money to go to another facility but would not leave her people.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | In an interview on 2/10/2023 at 4:00 PM, Nurse X stated she was the primary (nurse) that worked Monday through Saturday 6:00 a.m. to 6:00 p.m. When asked if she knew what abuse and neglect of a resident was, she stated yes, this can be verbal or physical abuse like talking ugly to a person. She further revealed that staff including herself should speak respectfully to residents. She stated the facility had presented many in-services about abuse and neglect and she had attended several of them. When asked how she would feel if she was spoken to in an aggressive or disrespectful way she stated, I would not like that. When asked if she ever recalled speaking disrespectful or less than polite to a resident or family member, she stated no. During the interview, Nurse X was asked what the negative outcome would be if a resident was spoken to in a harmful or disrespectful manner. Nurse X revealed the resident could become agitated, frustrated, or even depressed. She said she felt it could hurt the resident mentally. When asked if residents are allowed to decline services, Nurse X stated yes, they do have the right. She stated they should be encouraged to proceed with the service if it benefits them. Nurse X further revealed she wanted all of her residents to get the services that they needed. She stated she felt that they needed to get out of their rooms and be social. When asked if the resident did not want to go out of their room and you were their nurse, what would you do. She stated, I would ask them questions like 'why do you not want to go?' and then go from there, meaning see what was wrong.<br><br>During an interview on 03/01/23 at 10:59 AM, the facility physician stated: Nurse X was direct .and does not cuddle residents. The physician added this was the first time he heard about Nurse X possibly verbally abusing residents. Nurse X was described as a dedicated nurse that was sometimes misunderstood by residents because of her directness and need for a different bedside manner. The physician stated he never received any complaints of verbal abuse from residents or families about Nurse X when he visited the facility.<br><br>During an interview on 03/01/23 at 2:43 PM, The DON stated: Nurse X was outstanding and you would not find a better nurse. The DON stated that Nurse X was sometimes firm with residents; meaning more direct but not abusive. The DON added that at staff meetings, administration addressed communications and speaking to a resident in a better tone. No resident filed a complaint about verbal abuse involving Nurse X or any other staff to the DON. No formal investigations were done or HHS was not contacted. I have verbally counseled [Nurse X about one month ago in February 2023, but did not document it as part of the disciplinary process. The QAPI monthly minutes, per DON, had not developed an action plan dealing with communication. Per the DON, Nurse X was allowed to continue to work after the survey entrance (02/07/23) until the present because she (DON) did not believe that verbal abuse was present perpetrated by Nurse X. [Procedure for allegation of abuse was to report to the Abuse Coordinator, document the allegation or grievance and investigate. The DON was made aware in the interview that four residents and a family member had alleged verbal abuse by Nurse X.]<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview on 03/01/23 at 3:02 PM, the Administrator stated: he assumed the role of administrator on 01/16/23. He stated that there had been no documented grievances for the past 9 months involving verbal abuse or staff speaking loudly or rudely to residents. The Administrator was made aware of alleged rude tones by Nurse X by the Activity Director in the month of February 2023. The Administrator stated his response to the allegation of rudeness by Nurse X in February 2023 was: I am encouraging structure in meetings .I have visited with the residents and heard their concerns about rudeness .just information as I was transitioning not an official complaint .no actions plans have been developed and have not reported to HHS any verbal abuse by any staff or done any formal investigations. The Administrator stated that no action plan at the monthly QAPI meeting had been developed for communications. The Administrator stated that per abuse policy if there was an allegation of abuse the alleged perpetrator would be suspended pending an investigation. The Administrator stated, I did not suspend her (Nurse X) because rude tone did not rise to verbal abuse level requiring a suspension and a formal investigation .I read the minutes from the Resident Council meeting but did not see it as formal grievance .<br><br>During an interview on 03/01/22 at 3:25 PM, Nurse X stated: she worked Monday to Saturday 6:00 AM to 6:00 PM. She received abuse training on 02/11/23 and the highlights of the training were: report abuse to the Administrator, keep residents safe, and not engage in any abuse. Verbal abuse was defined as belittling the resident and being disrespectful. Nurse X stated that a loud voice or tone is not abuse. For residents that cannot hear, Nurse X stated that 'sometimes you need to raise voice to be heard. Regarding Resident # 27, Nurse X stated: she might have spoken loud to Resident #27 but not in a rude manner. Nurse X there were no issues of communication between her/him and Resident #3 except Resident #3 had communication deficits. As for Resident #36, Nurse X stated there were no issues. Nurse X added that Resident #11 had a weight problem; but she (Nurse X denied ever laughing or belittling the resident. Nurse X stated she was not soft spoken and the residents might misunderstand her tone as abuse. Nurse X stated that the ADON spoke to her about her loud tone; and encouraged her to use a softer tone. Nurse X recalled that after the state visit (02/10/23) the DON spoke to her about her tone and that residents might misunderstand; and to speak softer. I have apologized to [Resident #3] around January (2023) because we could not understand each other . Nurse X concluded that she had not verbally abused any resident and denied her interactions with any resident constituted willful verbal abuse or rudeness.<br><br>During an interview on 03/01/23 at 1:58 PM, Activity Director stated: regarding the Resident Council Minutes (February 2023) , communication involved the tone of staff at night; and the staff were loud. The Activity Director could not comment on the 08/11/22 and 06/09/22 minutes because she was not an employee at the facility. She attended training on abuse and neglect. She added, I told the Administrator and DON about the tone issue (raised at the February 2023 Resident Council Minutes in morning meeting around 02/17/23 and no new interventions were instituted .we just talked about having better communications .<br><br>During an interview on 03/03/23 at 8:36 AM, Anonymous Party P stated they heard about allegations of verbal abuse involving Nurse X in January 2023 and conveyed the allegation to the DON. The DON did not contact Anonymous Party P with results involving any investigation of Nurse X. At a resident council meeting in February, Anonymous Party P heard allegations of verbal abuse by staff and Nurse X. The verbal abuse was not intentional by Nurse X, but she would come across as verbally abusing residents and not caring.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Record review of Nurse X's training record revealed Nurse X attended Abuse/Neglect training on 02/23/23.<br><br>Record review of facility's sign-in sheet on facility's Abuse and Neglect policy revised April 2013 revealed Nurse X signed the sheet.<br><br>Record review of Nurse X's time card revealed she worked 6 days per week (Monday to Saturday) 06:00 AM to 6:00PM from 01/29/23 to 03/01/23.<br><br>Record review of Nurse X's annual competency evaluation dated 09/01/2019 revealed she was rated as satisfactory for Knowledge of Abuse/Neglect Protocol; and Nurse X signed the evaluation on 09/01/2019.<br><br>Record review of Nurse X's Skills checklist dated 01/03/23 read, the Role of Charge Nurse .Receives and gives pertinent care reports to .the DON .Documents and reports changes of condition and unusual occurrences to the MD, Family, and DON . Nurse X was rated as demonstrating said competencies on 01/03/23.<br><br>Record review of facility's in-service sign in sheet for the training on Abuse & Neglect dated 02/23/23 revealed Nurse X attended the training and signed the attendance sheet.<br><br>Record review of facility's Reporting Abuse to Facility Management revised February 2014 read, Abuse is defined as the willful infliction of injury, unreasonable confinement. intimidation, or punishment with resulting physical harm, pain or mental anguish . Further the said policy defined verbal abuse as .any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents . The policy further read, .The staff, with the physician's input (as needed), will investigate alleges occurrences of abuse and neglect to clarify what happened and identify possible causes.<br><br>The Administrator was given the IJ template and was notified of the Immediate Jeopardy {IJ} on 03/01/23 at 6:45 PM; and a plan of removal was requested.<br><br>On 03/02/23 at 4:45 PM, the facility's provided a plan of removal that was accepted. It was documented as follows:<br><br>SURVEY TYPE: Annual Survey<br><br>SURVEY DATE: 3/1/2023<br><br>Plan for REMOVAL<br><br>Plan to remove immediate jeopardy.<br><br>F600<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Residents #3, 11, 27, and 36 were assessed by DON and support was provided as accepted, physician was notified of the alleged deficiency on 3/1/23. There were no new orders obtained. Affected residents' responsible parties were notified by DON and ADON of alleged deficiencies and plan of correction.<br><br>On 3/1/2023 Administrator reported allegations of abuse to THHS and initiated investigation immediately.<br><br>Nurse X was immediately suspended by DON and Administrator on 3/1/23.<br><br>On 3/1/2023 the DON (director of nursing) and Administrator interviewed all residents in the facility to determine if any other residents experienced any psychosocial harm from verbal abuse from Nurse X or from any other staff. There was no concern identified. The interviews were completed before midnight on 3/1/2023.<br><br>Ad-Hoc QAPI meeting was held on 3/1/2023, with the Medical Director, NHA (Nursing Home Administrator), RDO (Regional Director of Operations) and DON to review the alleged deficiencies, policy and procedure, and the plan for removal of immediacy.<br><br>On 3/1/2023 the RDO completed 1:1 in-service on Abuse, grievances, and communication with Administrator, DON, and ADON.<br><br>Starting on 3/1/2023, the facility leadership (Administrator, DON, and ADON) will complete education with all staff on Verbal Abuse, grievances process, and communication, to ensure that each resident receives the services consistent with the professional standards of practice, comprehensive person-centered care plan and the residents' goals and preferences. The training was initiated on 3/1/2023 and will be completed on 3/2/2023. Staff will not be allowed to work until they receive the training.<br><br>The policy pertaining to Abuse and Grievances were reviewed on 3/1/2023 by the DON, NHA (Nursing Home Administrator) and Medical Director.<br><br>Starting on 3/1/2023, IDT (Interdisciplinary team), including Administrator, DON, ADON, Activity Director, MDS Coordinator, HR, BOM) will meet with residents daily Monday to Friday, and Manager on Duty Saturday and Sunday to determine if any allegations of abuse or grievances toward staff members arise. The findings will be immediately brought up to Administrator for further action, if necessary. Grievances will be reviewed during morning meeting with Administrator and IDT team members for any follow up needed. All grievances will be entered into Grievance log by Administrator and investigation form will be filled out accordingly.<br><br>On 3/2/2023 the RDO will start reviewing Grievance log and investigation forms weekly for four (4) weeks followed by monthly reviews after.<br><br>3/2/2023 RDO will provide physical oversight at facility weekly x4 weeks and then monthly reviews after.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | The DON/designee will monitor compliance by completing audit of ten (10) residents per week for four (4) weeks. This was initiated on 3/2/2023. Any identified concern will be addressed immediately and if trends and patterns are identified, the facility will conduct an Ad-Hoc QAPI meeting to discuss if additional interventions are needed to ensure compliance.<br><br>The Administrator will be responsible to ensure this plan is completed on 3/2/2023.<br><br>The RDO will provide oversight of DON and Administrators to ensure that the items on the plan of removal are reviewed and completed.<br><br>Monitoring of the implementation of the POR:<br><br>Plan to remove immediate jeopardy.<br><br>Observation and interview on 03/02/23 at 2:57 PM, Resident #3 was in his room listening to music waiting for his smoke break. The resident stated he had no fears, did not feel anxious, was not sad, and felt happy. The resident had no complaints to make to the surveyor.<br><br>Observation and interview on 03/03/23 at 11:14 AM, Resident #36 was in his room listening to music sitting on a wheelchair . The resident revealed no signs or symptoms of anger, fear, anxiety or sadness. The resident stated he felt happy because she is not here (Nurse X). The resident denied any other abuse by staff and would report any verbal abuse to the nursing staff.<br><br>During an observation and interview on 03/03/23 at 11:21 AM, Resident # 27 was wondering the hallways sitting on her wheelchair. The resident revealed no signs or symptoms of anger, fear, anxiety or sadness. The resident smiled and stated ,I am happy and feel safe that Nurse (X) is not here. The resident added no other staff have verbally abused her and she would report abuse to the administrator and nursing staff.<br><br>During an observation and interview on 03/03/23 at 11:28 AM, Resident #11 was in bed watching TV. The resident revealed no signs or symptoms of anger, fear, anxiety or sadness. The resident smiled and stated, I feel good that she (Nurse X) is not here and something had to be done. The resident added that there has been no other verbal abuse by other staff and she felt safe.<br><br>During an observation and interview on 03/03/23 at 11:33 AM, Resident #3 was in his room. The resident revealed no signs or symptoms of anger, fear, anxiety or sadness. The resident stated, I feel good she is not here .staff needs to be kind to everyone .she was mean and never said anything nice . The resident responded that he felt safe. If abused occurred again the resident stated he would tell (a family member).<br><br>Record review of facility's self report to HHS on 03/02/23 revealed HHS assigned the intake numbers.<br><br>During an interview on 03/03/23 at 10:55 AM, the Administrator stated, with approval from his corporate headquarters his intention was to terminate Nurse (X).<br><br>Record review of facility's interview of 67 residents on 03/01/23 revealed checklists were completed for 67 residents; and no resident made any new allegations of abuse to include verbal abuse.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Record review of facility's Ad-Hoc QAPI meeting held on 3/1/2023 revealed signatures for Medical Director, NHA (Nursing Home Administrator), RDO (Regional Director of Operations) and DON.<br><br>During an interview on 03/02/23 at 5:07 PM, the RDO stated: the highlights of the training were: administrative staff to be familiar with reporting guidelines, verbal abuse, and all abuse.<br><br>During a Joint interview on 03/02/23 at 5:10 PM with Admin, DON, and ADON, the DON stated: the highlight of the training was to report verbal abuse and any suspected abuse. The ADON added: the highlight to report and investigate all abuse. The Administrator: the main highlight was to report alleged or suspect abuse; and to adhere to the reporting guidelines.<br><br>Record review of facility's in-service on 03/02/23 on the topic of Process for reporting abuse/Neglect revealed 46 paid employees signed the sign-in sheet, 100% completion rate. [total paid staff on 03/2/23 was 46]<br><br>Record review of facility's in-service on 03/01/23 on the topic of Abuse/Neglect-Verbal Abuse revealed 45 paid employees signed the sign-in sheet, 98% completion rate. [total paid staff on 03/2/23 was 46; Nurse X was suspended and did not attend the training]<br><br>1.During an interview on 03/02/23 at 10:12 AM, LVN M stated: LVN M received training on Abuse/Neglect on 02/11/ [TRUNCATED] |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34957<br><br>Based on observation, interview and record review, the facility failed to provide evidence that all alleged violations of neglect, abuse, misappropriation of property were thoroughly investigated in order to prevent further potential neglect, abuse, misappropriation while the investigation was in progress for 4 of 5 residents (Resident #3, #11, #27 and #36 ) reviewed for investigation of abuse, in that:<br><br>The facility did not thoroughly investigate complaints that Residents #3, #11, #27 and # 36 were verbally abused by Nurse X and suffered psychosocial harm.<br><br>These failures resulted in an IJ on 03/01/23 at 6:45 PM. While the IJ was removed on 03/03/23 at 12:40 PM., the facility remained out of compliance at a level of actual harm that is not immediate jeopardy with a scope of pattern due to facility's need to evaluate the effectiveness of their plan of removal and complete training.<br><br>This deficient practice could place residents at risk for harm, a diminished quality of life, and psychosocial harm.<br><br>The findings were:<br><br>1. Record review of Resident #11's face sheet reflected Resident #11 was a [AGE] year-old female admitted on [DATE] with diagnosis including rhabdomyolysis (condition of muscle deterioration and kidney damage), diabetes mellitus (disease that affects the body's ability to process glucose), and hypertensive heart disease (heart problems that occur with long term high blood pressure). RP was listed as the resident.<br><br>Record review of Resident #11's MDS assessment reflected a BIMS of 10, indicating moderately impaired cognitive status. Also, record review of Resident #11's ADLs included: bed mobility-supervision with set-up; transfer-supervision with set-up; and eating was-supervision with set-up.<br><br>Record review of Resident #11's care plan dated 12/13/22 listed the problem of Behavioral Systems which included the Approach .Approach and speak in a calm manner .<br><br>Record review of Resident #11's signed HHS Form 4825-A (written statement), dated June 2005 read: She (Nurse X) is rude She said that I need to fast and not eat everything She (Nurse X) saw me trying to get past my wheelchair and she laughed at me. [There were no other witnesses to the alleged said incident.]<br><br>Record review of Resident #11's EMR revealed weight of 313 pounds on 02/01/23.<br><br>Record review of Resident #11's nurse note dated 02/20/23 authored by Nurse X read. [Resident #11] can be uncooperative with staff. resident will cover her food at meal time and tell [Nurse X] what are you looking at .resident is disrespectful to staff and other resident.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | In an observation on 2/10/2023 at 7:48 AM, breakfast was being served in the communal dining area with the TV on a loud volume. The communal dining area was brightly lit.<br><br>In an interview on 2/10/2023 at 7:50 AM, Resident #11 stated she was upset because Nurse X refused to let her eat breakfast in her room that morning [A resident's right]. Resident #11 stated she advised Nurse X that she was not feeling well due to a migraine and wanted to eat in her room because it was not as loud or bright. Resident #11 stated she was upset because Nurse X was so rude about it. Resident #11 stated she had also asked the ADON to eat in her room.<br><br>In an interview on 2/10/2023 7:55 AM, Nurse X stated she would prefer residents not eat in their room. Nurse X declined further interview and walked abruptly away from this surveyor and Resident #11.<br><br>In an interview on 2/10/2023 at 7:56 AM, the ADON stated she was aware of the request, and did not know that Nurse X had refused Resident #11's request. The ADON stated she would find Resident #11's breakfast tray and take it to Resident 11's room immediately. The ADON stated some residents preferred to eat in the dining area, and it was unusual for Resident #11 to request to eat in her room. [The ADON honored the resident's request to eat in her room.]<br><br>Observation and interview on 03/01/23 at 08:35 AM , Resident #11 was in room watching TV, cleaned and groomed, alert and oriented.; wheelchair present. The resident did not reveal signs or symptoms of sadness, fear, or anxiety (as a response to verbal abuse). The resident requested door be closed for the interview. Resident was eating her breakfast in the room. The Resident stated, .not that long ago (Nurse X) was rude to me .she said I could not eat in my room on 02/02/23 .I was upset she has always been rude to me .maybe she does not like me .she yells at me and laughs at me .yesterday (02/28/23) she laughed at me .as I struggled with my wheelchair .I complained in the past to the Administrator and he let me eat in my room .I'm not afraid of her I want her to be polite.<br><br>Record review of Resident Council Minutes for the past 9 months ( June 2022 to March 2023) read: on 02/16/23: night staff needs better communications [In reference to Nurse X].<br><br>During an interview on 03/01/23 at 2:13 PM, the ADON stated Nurse X tried to get Resident #11 to eat in the dining room for socialization reasons. Resident #11's tray was in the dining hall and taken to the resident. The ADON was not aware of verbal abuse by Nurse X towards Resident #11. The ADON stated that Resident #11, Resident #27, and Resident #3 told her (ADON) of instances where Nurse X could come across being load. The ADON stated the instances were never recorded as grievances; and she recalled the said residents saying not wanting to file a grievance against Nurse X; but their denial (Resident #11, #27 and #3) was not documented as a grievance or investigated. Regarding the Resident Council minutes dated 08/22/23, the ADON recalled speaking to Nurse X about modulating her volume when speaking to residents. The ADON did not consider the minutes on the concern over communications to be a grievance only to be a concern to be discussed with Nurse X. ADON described Nurse X, as a phenomenal and an excellent nurse in providing nursing care.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | 2. Record review of quarterly MDS dated [DATE], revealed Resident #3 was a [AGE] year-old-male admitted [DATE] with the diagnosis of diffuse traumatic brain injury (widespread traumatic injury to the tissues of the brain, usually mechanical forces such as those that are present in high velocity road traffic accidents). The summary BIMS score of 14 was indicative of intact cognition. ADLs revealed: transfer and bed mobility required limited assistance with one person physical assistance and supervision with set-up for eating.<br><br>Record review of Resident #3's face sheet dated, 03/01/23, revealed the RP was a family member.<br><br>Record review of Resident #3's care plan dated 2/15/23 read, the Problem .Behavioral Symptoms . Approach .maintain calm environment .anticipate behavior and re-direct .ensure staff is aware of resident('s) behaviors and successful interventions.<br><br>Record review of Resident #3's written statement on HHS form 4825-A, [dated 03/01/23] read, (Nurse X) does not speak what is not true [resident had communication and writing deficits during the interview].<br><br>Record review of Resident # 3's nurse notes from 01/01/23 to 03/01/23 authored by Nurse X revealed no negative behaviors by Resident #3 directed at Nurse X.<br><br>Record review of Resident #3's email to a Family Member K dated 11/22/2021 read, [ .(Nurse X)] .called me crazy.<br><br>In an interview on 2/08/2023 at 1:46 PM, Resident #3 stated he would like to talk about something but was afraid he may get in trouble. Resident #3 stated Nurse X treated many people, including him, like mud. He stated every time he came to Nurse (X) for something, she made sure her back was turned toward him so she could quickly walk away from him. Resident #3 stated Nurse X would go into a different room, so he would not know where she was when he needed something. He stated she was nice to some residents and obviously had her favorites. Resident #3 stated Nurse X embarrassed him in the past when she said something about his mother after he asked her a question. Resident #3 stated Nurse X exclaimed, your momma wouldn't like you screaming like that. Resident #3 stated he does not like to be around Nurse X. Resident #3 stated he had mentioned it to staff, but they don't care what I say about Nurse [X] because they like Nurse [X].<br><br>Observation and interview on 03/01/23 at 9:02 AM , Resident #3 was in bed watching TV, cleaned and groomed, alert and oriented but with communication deficits. No signs of anxiety, sadness or fear. The Resident stated, .[Nurse X] treats me like mud .she wants to talk to other residents not me .I want her to become better .I complained to everybody [Administrator and DON] but nothing happens .<br><br>During an interview on 03/02/23 at 3:14 PM, Family Member K stated Nurse X had been extremely rude to the Family Member K and to Resident #3. Family Member K stated that [Nurse X] threatened to withhold (Resident #3's) medication or give him (Resident #3) extra medication to control (Resident #3). [Family Member did not report the allegation to facility management] Family Member K stated that about 6 months ago (November 2022), she told former Administrator O about Nurse X's verbal abuse and former Administrator O said he would check; but never informed Family Member K of any internal investigation outcomes. Family Member K stated they received numerous emails from (Resident #3) complaining about Nurse X's behavior.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Record review of email from Resident #3 dated 11/22/21 read Nurse X called Resident #3 crazy.<br><br>Record review of email from Resident #3 dated 03/02/23 read [Nurse X ] lied.<br><br>During an interview on 03/02/23 at 3:48 PM, former Administrator O stated, I do not remember a verbal complaint from a family member about six months ago involving Nurse (X) and a resident (Resident #3) . The former Administrator O the residents may have mis-interpreted Nurse X's tone [speaking loudly].<br><br>3. Record review of the quarterly Minimum Data Set, dated dated dated [DATE] revealed Resident #36 was a [AGE] year-old male admitted [DATE]. Active diagnosis included hip fracture; cerebral palsy (impaired muscle coordination); moderate intellectual disabilities; Lack of coordination. Brief Interview for Mental Status score of 13 indicative of intact cognition. ADL for bed mobility and transfer was limited assistance with one person physical help; eating was supervision with set-up.<br><br>Record review of Resident #36's care plan, dated 09/03/21 read, Problem .Behavioral Symptoms .Approach . Provide opportunities for expression of feelings related to situational stressor .<br><br>Record review of Resident #36's written statement, transcribed by the Surveyor, on 03/01/23 at 09:47 AM read, I do not feel comfortable with [Nurse X]. She yells at me and screams at people. She tells me to sit down in a loud voice. Get rid of her (Nurse X) Hire someone else.<br><br>Record review of Resident # 36' nurse notes from 01/01/23 to 03/01/23 authored by Nurse X revealed no negative behaviors by Resident #36 directed at Nurse X.<br><br>In an interview on 2/08/2023 at 11:53 AM Resident #36 stated Nurse X was frequently rude to him and other residents. Nurse X frequently yells and hollers. Resident #36 stated he did not like to ask Nurse X for assistance. Resident #36 stated, It doesn't do any good to complain about staff here when asked to whom he had reported his concerns.<br><br>Observation and interview on 03/01/23 at 9:38 AM , Resident #36 was in his room sitting on a wheelchair listening to country music. The resident displayed no signs of distress, anxiety, fear or sadness. Resident #36 stated, Nurse X had the habit of yelling at him. He complained the Administrator and the DON about Nurse X's yelling but no changed occurred.<br><br>4. Record review of quarterly MDS dated [DATE] revealed Resident #27 was a [AGE] year-old female with an admitted [DATE] . Active diagnosis included cerebral palsy (impaired muscle movements); cellulitis (bacterial skin infection) of left and right lower limb; lymphedema (swelling); and lack of coordination. The BIMS summary score of 13 was indicative of intact cognition. ADLs revealed: bed mobility and transfer were limited assistance with one person physical assist; eating was supervision with set-up.<br><br>Record review of Resident #27's care plan, dated 01/03/23 revealed that Resident #27 had to be approached in a calmed manner.<br><br>Record review of Resident #27's written statement on Form 4827-A dated 3/1/27 at 10:19 AM read, [Nurse X] talks to us like we are babies Don't do this like a slap on the hand Take a lot of food from peoples plates to feed her cats.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Record review of Resident # 27' nurse notes from 01/01/23 to 03/01/23 authored by Nurse X revealed no negative behaviors by resident directed at Nurse X.<br><br>In an interview on 02/08/2023 at 3:23 PM, Resident #27 stated Nurse X was often rude to her. Resident #27 stated Nurse X frequently speaks to her in a harsh tone. Resident #27 stated it made her feel bad and Resident #27 wished she was not at this facility when spoken to in that manner. Resident #27 further stated [Nurse X] does not pay my bills, and I am not her child so she shouldn't speak to me like that! Resident #27 stated it made her feel bad and she would return to her room to cry when Nurse X spoke to her condescendingly. Resident #27 stated she had previously told other aides and the ADON that she did not like Nurse X, but Nurse X continued to act bossy over me.<br><br>Observation and interview on 03/01/23 at 10:12 AM , Resident #27 was attending a church service; sitting on a wheelchair, alert and oriented. There were no signs of sadness, anxiety or fear . The Resident stated, she told the surveyor that Nurse X treated her like a child. Resident #27 added that she once cried after being treated as a child by Nurse X. Resident #27 complained to the Administrator about Nurse X's tone and behaviors but no actions were taken against Nurse X.<br><br>Record review of Resident # 27's nurse notes from 01/01/23 to 03/01/23 authored by Nurse X revealed no negative behaviors by Resident#27 directed at Nurse X.<br><br>In a group interview on 2/09/2023 at 9:30 AM, with the DON, the Regional Nurse, and the ADON, the ADON stated she did the facility staffing. She further revealed Nurse X was the only full-time nurse on staff, other than the DON. The ADON stated Nurse X worked 12 hour shifts 6:00 AM to 6:00 PM Monday through Saturday and Sundays off. When asked if she felt this was ok for RN to work this many hours, ADON stated, yes, she is one of our best nurses. She does just fine. When the DON was asked if she was aware of any issues or complaints concerning Nurse X being rude to residents, she replied No, that's just the way Nurse X talks to people. The DON stated Nurse X knew which residents needed a firmer approach. The DON stated that Nurse X really cared for the residents at the facility. When asked if the DON felt Nurse X was able to maintain a therapeutic relationship working that many hours each week she replied yes. The DON further explained that Nurse X had been offered more money to go to another facility but would not leave her people.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | In an interview on 2/10/2023 at 4:00 PM, Nurse X stated she was the primary (nurse) that worked Monday through Saturday 6:00 a.m. to 6:00 p.m. When asked if she knew what abuse and neglect of a resident was, she stated yes, this can be verbal or physical abuse like talking ugly to a person. She further revealed that staff including herself should speak respectfully to residents. She stated the facility had presented many in-services about abuse and neglect and she had attended several of them. When asked how she would feel if she was spoken to in an aggressive or disrespectful way she stated, I would not like that. When asked if she ever recalled speaking disrespectful or less than polite to a resident or family member, she stated no. During the interview, Nurse X was asked what the negative outcome would be if a resident was spoken to in a harmful or disrespectful manner. Nurse X revealed the resident could become agitated, frustrated, or even depressed. She said she felt it could hurt the resident mentally. When asked if residents are allowed to decline services, Nurse X stated yes, they do have the right. She stated they should be encouraged to proceed with the service if it benefits them. Nurse X further revealed she wanted all of her residents to get the services that they needed. She stated she felt that they needed to get out of their rooms and be social. When asked if the resident did not want to go out of their room and you were their nurse, what would you do. She stated, I would ask them questions like 'why do you not want to go?' and then go from there, meaning see what was wrong.<br><br>During an interview on 03/01/23 at 10:59 AM, the facility physician stated Nurse X was direct .and does not cuddle residents. The physician added this was the first time he heard about Nurse X possibly verbally abusing residents. Nurse X was described as a dedicated nurse that was sometimes misunderstood by residents because of her directness and need for a different bedside manner. The physician stated he never received any complaints of verbal abuse from residents or families about Nurse X when he visited the facility.<br><br>During an interview on 03/01/23 at 2:43 PM, The DON stated Nurse X was outstanding and you would not find a better nurse. The DON stated that Nurse X was sometimes firm with residents; meaning more direct but not abusive. The DON added that at staff meetings, administration addressed communications and speaking to a resident in a better tone. No resident filed a complaint about verbal abuse involving Nurse X or any other staff to the DON. No formal investigations were done or HHS was not contacted. I have verbally counseled [Nurse X about one month ago in February 2023, but did not document it as part of the disciplinary process. The QAPI monthly minutes, per DON, had not developed an action plan dealing with communication. Per the DON, Nurse X was allowed to continue to work after the survey entrance (02/07/23) until the present because she (DON) did not believe that verbal abuse was present perpetrated by Nurse X. [Procedure for allegation of abuse was to report to the Abuse Coordinator, document the allegation or grievance and investigate. The DON was made aware in the interview that four residents and a family member had alleged verbal abuse by Nurse X.]<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview on 03/01/23 at 3:02 PM, the Administrator stated he assumed the role of administrator on 01/16/23. He stated that there had been no documented grievances for the past 9 months involving verbal abuse or staff speaking loudly or rudely to residents. The Administrator was made aware of alleged rude tones by Nurse X by the Activity Director in the month of February 2023. The Administrator stated his response to the allegation of rudeness by Nurse X in February 2023 was: I am encouraging structure in meetings .I have visited with the residents and heard their concerns about rudeness .just information as I was transitioning not an official complaint .no actions plans have been developed and have not reported to HHS any verbal abuse by any staff or done any formal investigations. The Administrator stated that no action plan at the monthly QAPI meeting had been developed for communications. The Administrator stated that per abuse policy if there was an allegation of abuse the alleged perpetrator would be suspended pending an investigation. The Administrator stated, I did not suspend her (Nurse X) because rude tone did not rise to verbal abuse level requiring a suspension and a formal investigation .I read the minutes from the Resident Council meeting but did not see it as formal grievance .<br><br>During an interview on 03/01/22 at 3:25 PM, Nurse X stated she worked Monday to Saturday 6:00 AM to 6:00 PM. She received abuse training on 02/11/23 and the highlights of the training were: report abuse to the Administrator, keep residents safe, and not engage in any abuse. Verbal abuse was defined as belittling the resident and being disrespectful. Nurse X stated that a loud voice or tone is not abuse. For residents that cannot hear, Nurse X stated that 'sometimes you need to raise voice to be heard. Regarding Resident # 27, Nurse X stated: she might have spoken loud to Resident #27 but not in a rude manner. Nurse X there were no issues of communication between her/him and Resident #3 except Resident #3 had communication deficits. As for Resident #36, Nurse X stated there were no issues. Nurse X added that Resident #11 had a weight problem; but she (Nurse X denied ever laughing or belittling the resident. Nurse X stated she was not soft spoken and the residents might misunderstand her tone as abuse. Nurse X stated that the ADON spoke to her about her loud tone; and encouraged her to use a softer tone. Nurse X recalled that after the state visit (02/10/23) the DON spoke to her about her tone and that residents might misunderstand; and to speak softer. I have apologized to [Resident #3] around January (2023) because we could not understand each other . Nurse X concluded that she had not verbally abused any resident and denied her interactions with any resident constituted willful verbal abuse or rudeness.<br><br>During an interview on 03/01/23 at 1:58 PM, Activity Director stated regarding the Resident Council Minutes (February 2023), communication involved the tone of staff at night; and the staff were loud. The Activity Director could not comment on the 08/11/22 and 06/09/22 minutes because she was not an employee at the facility. She attended training on abuse and neglect. She added, I told the Administrator and DON about the tone issue (raised at the February 2023 Resident Council Minutes in morning meeting around 02/17/23 and no new interventions were instituted .we just talked about having better communications .<br><br>During an interview on 03/03/23 at 8:36 AM, Anonymous Party P stated they heard about allegations of verbal abuse involving Nurse X in January 2023 and conveyed the allegation to the DON. The DON did not contact Anonymous Party P with results involving any investigation of Nurse X. At a resident council meeting in February, Anonymous Party P heard allegations of verbal abuse by staff and Nurse X. The verbal abuse was not intentional by Nurse X, but she would come across as verbally abusing residents and not caring.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Record review of Nurse X's training record revealed Nurse X attended Abuse/Neglect training on 02/23/23.<br><br>Record review of facility's sign-in sheet on facility's Abuse and Neglect policy revised April 2013 revealed Nurse X signed the sheet.<br><br>Record review of Nurse X's time card revealed she worked 6 days per week (Monday to Saturday) 06:00 AM to 6:00PM from 01/29/23 to 03/01/23.<br><br>Record review of Nurse X's annual competency evaluation dated 09/01/2019 revealed she was rated as satisfactory for Knowledge of Abuse/Neglect Protocol; and Nurse X signed the evaluation on 09/01/2019.<br><br>Record review of Nurse X's Skills checklist dated 01/03/23 read, the Role of Charge Nurse .Receives and gives pertinent care reports to .the DON .Documents and reports changes of condition and unusual occurrences to the MD, Family, and DON . Nurse X was rated as demonstrating said competencies on 01/03/23.<br><br>Record review of facility's in-service sign in sheet for the training on Abuse & Neglect dated 02/23/23 revealed Nurse X attended the training and signed the attendance sheet.<br><br>Record review of facility's Reporting Abuse to Facility Management revised February 2014 read, Abuse is defined as the willful infliction of injury, unreasonable confinement. intimidation, or punishment with resulting physical harm, pain or mental anguish . Further the said policy defined verbal abuse as .any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents . The policy further read, .The staff, with the physician's input (as needed), will investigate alleges occurrences of abuse and neglect to clarify what happened and identify possible causes.<br><br>The Administrator was given the IJ template and was notified of the Immediate Jeopardy {IJ} on 03/01/23 at 6:45 PM; and a plan of removal was requested.<br><br>On 03/02/23 at 4:45 PM, the facility's provided a plan of removal that was accepted. It was documented as follows:<br><br>SURVEY TYPE: Annual Survey<br><br>SURVEY DATE: 3/1/2023<br><br>Plan for REMOVAL<br><br>Plan to remove immediate jeopardy.<br><br>F610<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Residents #3, 11, 27, and 36 were assessed by DON and support was provided as accepted, physician was notified of the alleged deficiency on 3/1/23. There were no new orders obtained. Affected residents' responsible parties were notified by DON and ADON of alleged deficiencies and plan of correction.<br><br>On 3/1/2023 Administrator reported allegations of abuse to THHS and initiated investigation immediately.<br><br>Nurse X was immediately suspended by DON and Administrator on 3/1/23.<br><br>On 3/1/2023 the DON (director of nursing) and Administrator interviewed all residents in the facility to determine if any other residents experienced any psychosocial harm from verbal abuse from Nurse X or from any other staff. There was no concern identified. The interviews were completed before midnight on 3/1/2023.<br><br>Ad-Hoc QAPI meeting was held on 3/1/2023, with the Medical Director, NHA (Nursing Home Administrator), RDO (Regional Director of Operations) and DON to review the alleged deficiencies, policy and procedure, and the plan for removal of immediacy.<br><br>On 3/1/2023 the RDO completed 1:1 in-service on Abuse, grievances, and communication with Administrator, DON, and ADON.<br><br>Starting on 3/1/2023, the facility leadership (Administrator, DON, and ADON) will complete education with all staff on Verbal Abuse, grievances process, and communication, to ensure that each resident receives the services consistent with the professional standards of practice, comprehensive person-centered care plan and the residents' goals and preferences. The training was initiated on 3/1/2023 and will be completed on 3/2/2023. Staff will not be allowed to work until they receive the training.<br><br>The policy pertaining to Abuse and Grievances were reviewed on 3/1/2023 by the DON, NHA (Nursing Home Administrator) and Medical Director.<br><br>Starting on 3/1/2023, IDT (Interdisciplinary team), including Administrator, DON, ADON, Activity Director, MDS Coordinator, HR, BOM) will meet with residents daily Monday to Friday, and Manager on Duty Saturday and Sunday to determine if any allegations of abuse or grievances toward staff members arise. The findings will be immediately brought up to Administrator for further action, if necessary. Grievances will be reviewed during morning meeting with Administrator and IDT team members for any follow up needed. All grievances will be entered into Grievance log by Administrator and investigation form will be filled out accordingly.<br><br>On 3/2/2023 the RDO will start reviewing Grievance log and investigation forms weekly for four (4) weeks followed by monthly reviews after.<br><br>3/2/2023 RDO will provide physical oversight at facility weekly x4 weeks and then monthly reviews after.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | The DON/designee will monitor compliance by completing audit of ten (10) residents per week for four (4) weeks. This was initiated on 3/2/2023. Any identified concern will be addressed immediately and if trends and patterns are identified, the facility will conduct an Ad-Hoc QAPI meeting to discuss if additional interventions are needed to ensure compliance.<br><br>The Administrator will be responsible to ensure this plan is completed on 3/2/2023.<br><br>The RDO will provide oversight of DON and Administrators to ensure that the items on the plan of removal are reviewed and completed.<br><br>Monitoring of the implementation of the POR:<br><br>Plan to remove immediate jeopardy.<br><br>Observation and interview on 03/02/23 at 2:57 PM, Resident was in his room listening to music waiting for his smoke break. The resident stated he had no fears, did not feel anxious, was not sad, and felt happy. The resident had no complaints to make to the surveyor.<br><br>Observation and interview on 03/03/23 at 11:14 AM, Resident #36 was in his room listening to music sitting on a wheelchair . The resident revealed no signs or symptoms of anger, fear, anxiety or sadness. The resident stated he felt happy because she is not here (Nurse X). The resident denied any other abuse by staff and would report any verbal abuse to the nursing staff.<br><br>During an observation and interview on 03/03/23 at 11:21 AM, Resident # 27 was wondering the hallways sitting on her wheelchair. The resident revealed no signs or symptoms of anger, fear, anxiety or sadness. The resident smiled and stated ,I am happy and feel safe that Nurse (X) is not here. The resident added no other staff have verbally abused her and she would report abuse to the administrator and nursing staff.<br><br>During an observation and interview on 03/03/23 at 11:28 AM, Resident #11 was in bed watching TV. The resident revealed no signs or symptoms of anger, fear, anxiety or sadness. The resident smiled and stated, I feel good that she (Nurse X) is not here and something had to be done. The resident added that there has been no other verbal abuse by other staff and she felt safe.<br><br>During an observation and interview on 03/03/23 at 11:33 AM, Resident #3 was in his room. The resident revealed no signs or symptoms of anger, fear, anxiety or sadness. The resident stated, I feel good she is not here .staff needs to be kind to everyone .she was mean and never said anything nice . The resident responded that he felt safe. If abused occurred again the resident stated he would tell (a family member).<br><br>Record review of facility's self report to HHS on 03/02/23 revealed HHS assigned the intake numbers.<br><br>During an interview on 03/03/23 at 10:55 AM, the Administrator stated, with approval from his corporate headquarters his intention was to terminate Nurse (X).<br><br>Record review of facility's interview of 67 residents on 03/01/23 revealed checklists were completed for 67 residents; and no resident made any new allegations of abuse to include verbal abuse.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Record review of facility's Ad-Hoc QAPI meeting held on 3/1/2023 revealed signatures for Medical Director, NHA (Nursing Home Administrator), RDO (Regional Director of Operations) and DON.<br><br>During an interview on 03/02/23 at 5:07 PM, the RDO stated the highlights of the training were: administrative staff to be familiar with reporting guidelines, verbal abuse, and all abuse.<br><br>During a Joint interview on 03/02/23 at 5:10 PM with Admin, DON, and ADON, the DON stated: the highlight of the training was to report verbal abuse and any suspected abuse. The ADON added: the highlight to report and investigate all abuse. The Administrator: the main highlight was to report alleged or suspect abuse; and to adhere to the reporting guidelines.<br><br>Record review of facility's in-service on 03/02/23 on the topic of Process for reporting abuse/Neglect revealed 46 paid employees signed the sign-in sheet, 100% completion rate. [total paid staff on 03/2/23 was 46]<br><br>Record review of facility's in-service on 03/01/23 on the topic of Abuse/Neglect-Verbal Abuse revealed 45 paid employees signed the sign-in sheet, 98% completion rate. [total paid staff on 03/2/23 was 46; Nurse X was suspended and did not attend the training]<br><br>1.During an interview on 03/02/23 at 10:12 AM, LVN M stated: LVN M received training on Abuse/Neglect on 02/11/23. The highlights of the training included: bedside manners, voice tone, and identifying abuse and to report to the Administrator.[shift was 6AM-6PM]<br><br>2.During an interview on 03/02/23 at 10:25 AM, CNA N stated: received abuse/neglect training on 2/11/23 and the highlights of the tr [TRUNCATED] |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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** 42402<br><br>44906<br><br>Based on observation, interview, and record review the facility failed to ensure residents who were unable to carry out activities of daily living were provided with the necessary services to maintain good personal hygiene for 5 of 9 residents (Residents #36, #27, #25, #43 and #11) reviewed for assistance with ADL care, in that:<br><br>1. The facility failed to prevent Resident # 36 from missing 7 of 9 scheduled showers between 1/19/2023 - 2/08/2023.<br><br>2. The facility failed to prevent Resident #27 from missing 7 of 9 scheduled showers between 1/19/2023 - 2/08/2023.<br><br>3. The facility failed to prevent Resident #25 from missing 15 of 17 showers between 1/01/2023 - 2/08/2023.<br><br>4. The facility failed to prevent Resident #43 from missing 14 of 17 scheduled showers between 1/1/2023 - 2/08/2023.<br><br>5. The facility failed to prevent Resident # 11 from missing 12 of 17 scheduled showers between 1/1/2023 - 2/08/2023.<br><br>This deficient practice could place residents who require assistance from staff for personal hygiene at risk of not receiving care and services contributing to overall poor hygiene, risk of experiencing a diminished quality of life, and possible skin infections.<br><br>The findings included:<br><br>1. Record review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #36 was a [AGE] year-old male admitted [DATE] with fractures and other multiple trauma indicated as the primary medical condition for admission. Active diagnosis included hip fracture; cerebral palsy [group of disorders that affect a person's ability to move and maintain balance and posture]; moderate intellectual disabilities [developmental disability affecting cognitive and adaptive functioning; and lack of coordination. The Brief Interview for Mental Status score of 13 was indicative of intact cognition. Resident #36 was clinically assessed as being at risk for developing pressure injuries with included treatments indicated as pressure reducing device for bed. Functional status for bathing coded as level 3 -physical help in part of bathing activity with one staff physical assist.<br><br>Record review of care plan revealed a problem area of self-care deficit with a start date of 7/21/2021 and associated approaches: provide/assist with bath or showers as per schedule and as needed.<br><br>Record review of undated Shower Schedule list, posted in shower rooms, revealed Resident #36 was on the schedule for afternoon showers on Mondays-Wednesdays-Fridays.<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 - Some | Record review of Nursing Assistant Daily Body Observation forms, for the months of January 2023 and through 2/08/23 revealed documentation of showers given for Resident #36 on the following dates: 1/21/2023, 1/25/2023, 1/31/23, 2/02/23, and 2/06/2023. Extrapolating from this, Resident #36 missed scheduled showers on the following dates: 1/20/23, 1/23/2023, 1/27/2023, 1/30/2023, 2/01/2023, 2/03/2023 and 2/08/2023. Resident # 36 missed 7 of 9 scheduled showers between 1/19/2023 - 2/08/2023. There were no documented refusals in electronic health record or on the Nursing Assistant Daily Body Observation forms.<br><br>In an interview on 2/08/2023 at 11:52 AM, Resident #36 stated he preferred his shower scheduled for Mondays-Wednesdays-Fridays, later in the evenings and had requested showers for later in the evenings instead of in the afternoons. Resident #36 stated he does not get showers three times per week regularly. Resident #36 stated there are various reasons why he does not get his showers as scheduled such as not enough staff, no clean towels, or if some other resident is having an issue, such as an emergency. Resident #36 stated he would like to have showers every day but would be happy with three times per week. Resident #36 stated he did not like missing showers. Resident #36 stated he had never refused a shower when offered.<br><br>2. Record review of quarterly MDS dated [DATE] revealed Resident #27 was a [AGE] year-old female with an admitted [DATE] with progressive neurological condition coded as the primary medical condition for admission, other active diagnosis included cerebral palsy; cellulitis [serious bacterial infection of the skin, usually swollen, red, and painful]of left and right lower limb; lymphedema[swelling, usually in the arm or leg, due to blockage in the lymphatic system]; lack of coordination. The BIMS summary score of 13 was indicative of intact cognition. Resident #27 was clinically assessed as being at risk of developing pressure injuries with two venous and arterial ulcers [open sores, usually on the legs, from poor circulation] present; associated treatments included pressure reducing device for bed, application of non-surgical dressings, application ointments and medications. Functional status for bathing coded as level three - physical help in part of bathing with one staff physical assist.<br><br>Record for review of care plan revealed Resident #27 had a problem area of self-care deficit with a problem start date of 10/06/2022; associated approaches included: Provide/assist with bath or shower as per schedule and as needed.<br><br>Record review of undated Shower Schedule list, posted in shower rooms, revealed Resident #27 was on the schedule for afternoon showers on Tuesdays-Thursdays-Saturdays.<br><br>Record review of Nursing Assistant Daily Body Observation forms, for the months of January 2023 through 2/08/23, revealed documentation of showers for Resident #27 on the following dates: 1/31/23, and 2/02/23. Extrapolating from this, Resident #27 missed scheduled showers on the following dates: 1/19/23, 1/21/2023, 1/24/2021, 1/26/23, 1/28/2023, 2/04/2023, and 02/07/2023. In the previous 3 weeks, Resident #27 received 2 of 9 scheduled showers between 1/19/2023 - 2/08/2023. There were no documented refusals.<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 - Some | In an interview on 02/08/2023 at 3:23 PM, Resident #27 stated she did not get a shower 02/07/2023. Resident #27 speculated that she did not get her shower because there were no towels due to the dryer being broken, and the facility must go off site to do laundry. Resident #27 stated the dryer has been broken for several months. Resident #27 stated she missed showers frequently and does her best to keep clean between showers. Resident #27 stated she would like to have showers 3-4 times per week. Resident #27 stated she felt dirty when showers were not provided as per the schedule.<br><br>3. Record review of quarterly MDS dated [DATE] revealed Resident #25 was a [AGE] year-old female admitted [DATE] with medically complex conditions coded as the primary medical condition for admission. Other active diagnosis included cerebrovascular accident [occurs when blood supply to brain is reduced preventing brain tissues from getting oxygen and nutrients]and mild cognitive impairment [memory or thinking problems] of uncertain or unknown cause. The BIMS summary score of 13 was indicative of intact cognition. Resident #25 was clinically assessed as being at risk for developing pressure injuries; associated treatments included pressure reducing device for bed, application of dressing to feet. Functional status coded as level 4 - total dependence with one staff physical assist for bathing.<br><br>Record review of care plan revealed Resident #25 had a problem area of self-care deficit/requires assistance with the start date of 9/21/2021; associated approaches included: provide/assist with bath or showers per schedule and as needed.<br><br>Record review of undated Shower Schedule list, posted in shower rooms, revealed Resident #25 was not listed.<br><br>Record review of Nursing Assistant Daily Body Observation forms, for the months of January 2023 and through 2/08/23, revealed documentation of showers for Resident #25 on the following dates: 1/2/2023, and 1/08/2023. There were no documented refusals.<br><br>In an observation on 02/07/2023 at 12:08 PM, Resident #25's hair was uncombed and greasy.<br><br>In an interview on 2/14/2023 at 4:00 PM, Resident #25 stated she felt better after a shower. Resident #25 stated she frequently missed showers due to not having enough female staff available. Resident #25 stated she did not like missing showers, and not knowing when the next shower was going to happen.<br><br>4. Record review a quarterly MDS dated [DATE] revealed Resident #43 was a [AGE] year-old female admitted ,d+[DATE] medically complex conditions coded as the primary medical condition for admission. Other active diagnosis included cerebrovascular accident, unspecified symptoms and signs involving cognitive functions, lack of coordination, and lymphedema. Resident #43 was clinically assessed as being at risk for developing pressure injuries with one stage three pressure injury and one stage 4 pressure injury and three veinous or ulterior ulcers present. Treatments included pressure reducing device for bed, pressure entry care, application of dressings to feet. BIMS summary score of 13 [indicative of intact cognition]. Functional status coded as level 4 total dependence with one staff physical assist for bathing.<br><br>Record review of care plan revealed Resident #43 had a problem area of self-care deficit/requires assistance with the start date of 10/20/2021; associated approaches included: provide/assist with bath or showers per schedule and as needed.<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 - Some | Record review of undated Shower Schedule list, posted in shower rooms, revealed Resident #43 was on the schedule for afternoon showers on Mondays-Wednesdays-Fridays.<br><br>Record review of nursing assistant daily body observation forms, for the months of January 2023 and through 2/08/23, revealed documentation of showers for Resident #43 on the following dates: 1/03/23, 1/09/2023,1/27/2023, 1/31/2023, and 2/06/2023.<br><br>Record review of Nursing Assistant Daily Body Observation forms, for the months of January 2023 and through 2/08/23, revealed documentation of showers for Resident #43 on the following dates: 1/03/2023, 1/09/2023, 1/27/2023, 1/31/2023 and 2/06/23. Extrapolating from this, Resident #43 missed scheduled showers on the following dates: 1/02/2023, 1/04/2023, 1/06/2023, 1/11/2023, 1/13/2023, 1/16/2023, 1/18/2023, 1/20/2023, 1/25/2023, 1/30/2023, 2/01/2023, 2/03/2023, and 02/08/2023. Resident #43 received 3 of 17 scheduled showers between 1/1/2023 - 2/08/2023. There were no documented refusals.<br><br>In an interview on 2/09/2023 at 5:40 PM, Resident #43 stated she received 1 or maybe 2 showers per week. Resident #43 stated she frequently feels itchy and cannot sleep because she has not had a shower. Resident #43 stated it bothers her when she goes too long without a shower. Resident #43 stated she would like to have a shower more frequently.<br><br>5. Record review of Resident #11's face sheet reflected Resident #11 was a [AGE] year-old female admitted on [DATE] with diagnosis including Rhabdomyolysis [condition of muscle deterioration and kidney damage], Diabetes Mellitus [disease that affects the body's ability to process glucose], and Hypertensive heart disease [heart problems that occur with long term high blood pressure].<br><br>Record review of Resident #11's MDS reflected a BIMS of 10, indicating moderately impaired.<br><br>Record review of shower logs indicate Resident #11 received a shower on 1/3/2023, 1/5/2023, 1/16/2023, 1/22/2023, 1/24/2023, 1/31/2023, and 2/2/2023. This record review indicates that Resident #11 missed 6 showers on the following dates: 1/7/2023, 1/10/2023, 1/14/2023, 1/19/2023, 1/26/2023, and 1/28/2023.<br><br>Interview on 2/10/2023 at 12:38 PM, Resident #11 stated she was supposed to get showers every Tuesday, Thursday, and Saturday and she did not remember the last time she got a shower, but she estimated it was about a week and a half ago. Resident #11 stated she did not know why they skipped her showers. Resident #11 stated that missing her shower makes her feel bad and dirty. Resident #11 stated that she sometimes gets rashes on her buttock if she is not regularly showered.<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 - Some | In an interview on 02/10/2023 at 4:24 PM CNA H stated they normally work 6:00 AM to 6:00 PM. CNA H stated there was no checklist for who has and has not been showered that day and the CNA's use shower sheets [Nursing Assistant Daily Body Observation] to document showers provided. CNA H stated sometimes CNAs forget to do the shower sheets. The CNA stated they talk with other CNAs, they work with, to see who has and has not been showered. CNA H stated usually it is two people who help. CNA H stated they might have forgotten to shower some people at times, but it sometimes takes a lot of time when there are a lot of call lights. CNA H stated CNAs must respond to call lights and shower the residents at the same time. CNA H stated it is not more difficult to shower people on the weekends. CNA H stated there are supposed to be three staff on the evening shift but sometimes there are only two. [when shown the shower sheets] she stated the dates between showers show a long time between showers. CNA H stated that if there is a lot going on, sometimes they are unable to shower all residents who need showers and will try to do them either the next day or on the residents next shower day.<br><br>In an interview on 2/9/2023 at 4:45 PM, the DON stated the stack of hard copy Nursing Assistant Daily Body Observation provided, are the only documents the facility had from January 1st, 2023 through 2/08/2023 for documentation of showers provided to residents. The DON stated some of the agency CNAs do not always complete the forms. The DON stated the expectation was for the CNA to fill out and submit to the charge nurse on duty a Nursing Assistant Daily Body Observation form on every resident on the shower schedule for their shift, to include an indication if the resident refused. The charge nurse was then to notate any new wounds, skin issues or patterns in not getting showers. The DON stated she was not aware of any resident frequently missing showers.<br><br>Record review of Resident Rights policy, revised October 2009, revealed statements that Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity.<br><br>A facility policy on showers or ADLs was requested but none was provided prior to exit.<br><br>47564 |

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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>32218<br><br>Based on observation and interview the facility failed to ensure the residents environment remains as free of accident hazards as is possible for 1 of 1 shower room on the female secure unit reviewed for accidents, hazards, and supervision in that:<br><br>1. The facility failed to ensure the female secure unit shower room, which had medicated and regular shampoo and body wash, and a sharps container accessible, was not locked.<br><br>This failure could place residents at risk of harm or injury and contribute to avoidable accidents.<br><br>The findings were:<br><br>Observation on 02/9/23 at 2:09 p.m. on the secure unit revealed the shower room door was unlocked. Observation inside the shower room revealed there was an open bottle of medicated shampoo on a shelf on the left side. Above the shelf was a cabinet that had a lock on it, but it was unlocked. Continued observation revealed there was a sharps container on the wall that was not secured and could be easily removed from the wall. Additional observation in the shower room where the shower was revealed there was a large open bottle of shampoo/body wash in the shower area, and two additional bottles of shampoo with residents' names on them on a handrail inside the shower area.<br><br>In an interview on 2/9/2023 at 2:11 p.m. with CNA A, she reported she was not certain if the shampoos needed to be locked in the locked cabinet. The CNA reported she must have left the door unlocked earlier in the day, before lunch. CNA A began looking for the keys to the shower room to assure she had them before she locked the door. The CNA could not locate the keys, so she called out to the nurses' station outside the unit to have someone bring her a key to the shower room.<br><br>In an interview on 2/9/2023 at 2:39 p.m. with the Maintenance Director he stated each of the CNAs should have a key to the shower rooms on their unit and that there was a key on all the nurses key rings.<br><br>During an interview on 2/10/2023 at 4:30 p.m., the DON and Regional Nurse stated there was not a policy regarding keeping doors locked in any of the memory care units. When asked if there was a process in place or if the staff who worked in the memory care units knew to keep shower doors locked for residents' safety, the DON stared, There is no real process, we all know to keep the doors locked. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42402<br><br>Based on observation, interview, and record review the facility failed to ensure a resident who is fed by enteral means receives appropriate treatment for services for 1 of 1 resident (Resident #56) reviewed for enteral feeding tubes, in that:<br><br>The facility failed to ensure Resident #56 had two 60 cc syringes for enteral feeding which were labeled with a date of 2/5/2023 and the other one with 2/6/2023 and the date of investigation was 2/7/2023. Both syringes had been opened and had residual moisture in the syringes.<br><br>This deficient practice could place residents who receive enteral feedings at risk for dehydration, weight loss, and/or metabolic abnormalities(A metabolic disorder occurs when abnormal chemical reactions disrupt the body's metabolism. This could affect how well the body can break down large molecules for energy.)<br><br>The findings were:<br><br>Record review of Resident #56's face sheet undated, revealed an admitted [DATE] with diagnoses of: unspecified intracranial injury with loss of consciousness (Moderate to severe traumatic brain injury), hemiplegia affecting left dominant side (paralysis or inability to move), gastrostomy status (surgery performed by a general surgeon to give an external opening into the stomach and inserted a tube to receive formula for nutrition.), and dysphagia (a condition with difficulty in swallowing food or liquid.).<br><br>Record review of resident #56's consolidated physician orders dated 2/1/2023 for: Administer Jevity 1.5 bolus feeding of 350 ml at meals and at bedtime to equal 1400 ml per day. Check tube placement by auscultation(listening for air) and aspirating(pulling back on syringe to see if gastric juices are present) stomach contents before administration of formula/water/medications. Return stomach contents to stomach.<br><br>Record review of Resident #56's consolidated physician orders dated 2/1/2023, revealed no physician order for enteral syringe to be changed every 24 hrs.<br><br>Record review of Resident #56's resident assessment and care screening MDS, dated [DATE], revealed the resident had a BIMS score of 11, which indicated the resident was moderately cognitively impaired. Further review revealed Resident #56's MDS in section G revealed dependence on staff for eating via gastrostomy tube.<br><br>During an observation and interview on 2/7/2023 at 10:55 a.m., Resident #56 was awake in bed in his room. Further observation revealed Resident #56's had two 60 cc syringes for enteral feeding which were labeled and had moisture in syringes with a date of 2/5/2023 and the other one with 2/6/2023 and date of investigation was 2/7/2023, on his bedside table. Resident #56 stated, the nurses use the syringes to feed me in my stomach tube. He said he did not know when they would throw the syringes away or if they wash them. When asked why he had 2 syringes on his bedside table he said, I don't know.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 2/7/2023 at 11:00 a.m. with LVN F, she confirmed Resident #56 had two 60 cc syringes for enteral feeding on Resident #56's bedside table. She stated she was not sure why they had not been changed. She stated she worked with agency, and she was not in the facility very often. She further revealed it is best practice as a nurse to change the enteral feeding syringes every 24 hours and if the syringes were not clean, so the residents do not get sick from contamination.<br><br>During an interview on 2/9/2023 at 9:30 am, the ADON stated enteral syringes for feeding residents per gastrostomy tubes should be changed q 24hrs and that is done on night shift.<br><br>The facility DON stated the facility did not have a policy on changing enteral tube feeding syringes.<br><br>Review of Piston Irrigation Syringe mfr#904, manufacture label revealed 60cc, suggested procedure: 1. Tear open package and remove syringe. 2. Perform enteral irrigation procedure. 3. Discard after single use. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42402<br><br>Based on observation, interviews, and record review, the facility failed to ensure that a resident needs for respiratory care, was provided such care, consistent with professional standards of practice for 1 of 1 resident (Resident #13) reviewed for respiratory care in that:<br><br>The facility failed to prevent Resident 13#'s CPAP machine(Continuous positive airway pressure - one of the most common treatments for obstructive sleep apnea) and CPAP mask from having a white and brown flaky substance present.<br><br>This deficient practice could affect residents who receive respiratory treatment and result in infection and respiratory compromise.<br><br>The findings were:<br><br>Record review of Resident 13#'s face sheet, computer dated 2/7/2023, revealed an [AGE] year-old male with an admitted to the facility on [DATE] with diagnoses of unspecified dementia without behavioral disturbance (A group of symptoms that affects memory, thinking and interferes with daily life.), Type 2 Diabetes Mellitus (impairment in the way the body regulates and uses sugar (glucose) as a fuel.), Hypertensive heart disease (a long-term condition that develops over many years in people who have high blood pressure. Heart disease may cause difficulty in breathing.), Sleep apnea (a potentially serious sleep disorder in which breathing repeatedly stops and starts), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest.), recurrent with psychotic symptoms.<br><br>Record review of Resident 13#'s Quarterly MDS assessment dated [DATE] revealed a BIMS score of 9, which indicated a moderate mental impairment.<br><br>Record review of Resident 13 #'s Care plan dated 5/23/2017 with review 12/12/2022, Problem: Disturbed sleep pattern related to diagnosis of sleep apnea. Goal: Resident will state feeling rested over the next 90 days. Approach: Encourage/remind resident to use CPAP machine for sleep apnea when in bed at the prescribed settings. There were no approaches for maintaining CPAP and/or cleaning.<br><br>Record review of Resident #13's consolidated physician orders dated 2/1/2023 revealed physician orders dated 8/29/2022: Clean CPAP mask and tubing every Tuesday and Friday 6p-6a shift. Clean CPAP filter Q week on Sunday.6pm-6a, Let air dry. CPAP mask-change mask q 3 months and PRN.(on the 12th of Every month)<br><br>Observation and interview on 2/7/2023 at 10:30 a.m. revealed Resident #13 sitting in wheel chair in his room beside bed. Observed CPAP machine and facemask with tubing at bedside. During interview with Resident #13 he was asked by investigator if he used his cpap. He stated, yes every night. They put it on me. When asked if the machine and mask and tubing are cleaned, he stated I don't do it, so I don't know. He could not continue with appropriate answers. Resident 13#'s CPAP machine and CPAP mask was observed to have thick white and brown flaky substance present.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 2/7/2023 at 10:35 a.m. with CNA E,. he confirmed the CPAP machine and mask of Resident #13 had white and brown flaky substance present. He further stated he did not know who cleaned it.<br><br>During an interview on 2/8/2023 at 10:15 a.m., the DON stated the nurses on night shift would clean and maintain the CPAP for Resident #13. She stated she did not know why the CPAP machine and mask of Resident #13 had white and brown flaky substance present. She further revealed it was important for respiratory safety for the residents and they should have clean equipment.<br><br>During an interview on 2/8/2023 at 10:15 a.m., the DON stated, we do not have a policy for CPAP cleaning. DON further revealed she could not recall any in services for training or competency for CPAP cleaning and maintenance.<br><br>Record review of CPAP manufacture recommendations for model {resmed airsense} 10 autoset(https://www.resmed.com/en-us/sleep-apnea/cpap-parts-support/cleaning-cpap-equipment/). To clean the tube, we recommend using warm soapy water. Rinse with fresh water and then air dry. With the {ResMed AirSense} 10 heated tubing, it is ok for the electrical component of his to get wet. There are tube brushes available should you wish to get inside your tube and give it a good scrub. Cleaning mask: Unplug your CPAP machine from the power source. Disconnect the mask and air tubing from the CPAP machine. Disassemble your mask into 3 parts (headgear, cushion, and frame). In a sink or tub, clean your mask cushion and headgear to remove any oils. Gently rub with soap and warm, drinking-quality water. Avoid using stronger cleaning products, including dish detergents, as they may damage the mask or leave harmful residue. Rinse again thoroughly with warm, drinking-quality water. Place the cushion and frame on a flat surface, on top of a towel, to dry. Avoid placing them in direct sunlight. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42402<br><br>Based on observation, interview and record review, the facility failed to ensure ointments and biologicals were labeled in accordance with currently accepted professional principles for 1 of 1 nursing supply closets near the A hall reviewed for nursing supplies storage in that:<br><br>The facility failed to ensure 1 tube of diclofenac sodium topical gel 1% with an expiration date of ,d+[DATE] had an opened date written on it.<br><br>The facility failed to ensure 1 tube of derma skin wound dressing with open date of [DATE] and expiration date of ,d+[DATE].<br><br>The facility failed to ensure 1 sealed package of hydrogel absorbent sheet with expiration of [DATE]<br><br>The facility failed to ensure 7 sealed packages with expiration date of ,d+[DATE] hydrogel gauze 2x2 wound gauze.<br><br>This deficient practice could affect residents prescribed multi use over the counter biologicals and could result in ineffective ingredients.<br><br>The findings were:<br><br>During an observation on [DATE] at 8:45 am, of nurses supply closet near the A hall, 1 tube of diclofenac sodium topical gel 1% with an expiration date of ,d+[DATE] had no opened date written on it, 1 tube of derma skin wound dressing with open date of [DATE] and expired ,d+[DATE], 1 sealed package of hydrogel absorbent expired [DATE], and 7 sealed packages of hydrogel gauze 2x2 wound gauze expired ,d+[DATE].<br><br>During an observation and interview on [DATE] at 9:30 am, ADON confirmed there were expired products which included: 1 tube of diclofenac sodium topical gel 1%, 1 tube of derma skin wound dressing, 1 sealed package of hydrogel absorbent sheet, and 7 sealed packages of hydrogel gauze 2x2 wound gauze. She further revealed all products with an expiration date would be removed and disposed of properly. She stated residents could not receive the full benefit for treatment of an expired ointment or wound care product. When asked who was responsible for making sure the products had not expired, she stated , we all are, which includes myself, the person who orders products (human resource employee, and nurses.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation and interview on [DATE] at 10:45 am with Human Resource/ supplies confirmed there were expired products which included: 1 tube of diclofenac sodium topical gel 1%, 1 tube of derma skin wound dressing, 1 sealed package of hydrogel absorbent sheet, and 7 sealed packages of hydrogel gauze 2x2 wound gauze. She further revealed all products with an expiration date would be removed and disposed of properly. She stated residents should not receive expired ointments or wound care products. When asked who was responsible for making sure the products had not expired, she stated , we all are, which includes myself. She stated when she receives supplies, she rotates them, and checks the expiring products then will remove them. She stated she did not know why the expired products were not removed.<br><br>During an observation and interview on [DATE] at 11:00 a.m. with DON , she confirmed there were expired products which included: 1 tube of diclofenac sodium topical gel 1%, 1 tube of derma skin wound dressing, 1 sealed package of hydrogel absorbent sheet, and 7 sealed packages of hydrogel gauze 2x2 wound gauze. She further revealed all products with an expiration date would be removed and disposed of properly. She stated residents should not receive expired ointments or wound care products because they would not get the full benefit of the treatment. When asked who was responsible for making sure the products had not expired, she stated , we all are, which includes the nurses, the person who orders, the treatment nurse and myself. She stated she did not know why the expired products were not removed.<br><br>During the survey a policy was requested for storage room. The DON stated there was not a policy in place. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675371 | A. Building<br>B. Wing | 03/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Riverview Nursing & Rehabilitation | 1102 River Rd<br>Boerne, TX 78006 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32218<br><br>Based on observation, interview and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen observed for sanitation and storage, in that:<br><br>1. The facility failed to ensure a pitcher of house shake in the refrigerator was labeled and dated.<br><br>2. The facility failed to ensure a pitcher of red juice in the refrigerator was labeled and dated<br><br>3. The Dietary Supervisor failed to wash his hands between tasks.<br><br>These deficient practices could place residents who receive food and snacks from the kitchen at-risk of foodborne illness.<br><br>Findings included:<br><br>1. Observation on 2/7/2023 at 10:42 a.m. in the facility kitchen revealed there was a refrigerator to the left side of the kitchen when entering from the dining room. Observation inside the refrigerator revealed there was a gallon size picture in the refrigerator that was a 1/4 filled with house shake. Closer observation of the pitcher revealed it was not labeled or dated.<br><br>2. Observation on 2/7/2023 at 10:43 AM in the facility kitchen revealed there was a refrigerator to the left side of the kitchen when entering from the dining room. Observation inside the refrigerator revealed there was a gallon size pitcher 1/2 filled with a red juice that was not label or dated. in the refrigerator that was a 1/4 filled with house shake. Closer observation of the pitcher revealed it was not labeled or dated.<br><br>In an interview on 2/7/2023 at 10:44 a.m. with the Dietary Supervisor revealed staff should have labeled and dated the items to know when they should be discarded.<br><br>3. a. Observation on 2/9/2023 at 4:40 p.m. revealed the Dietary Supervisor was preparing food for the evening meal. Continued observation revealed while the Dietary Supervisor was waiting for the time to begin plating food, the Dietary Supervisor took his cell phone from his pocket and began texting with his ungloved hands. Observation revealed the Dietary Supervisor then returned his phone to his pocket, retrieved an empty container with his ungloved hands, walked to the refrigerator, filled the container with butter packets from the refrigerator, walked to the door that led to the dining room, opened the door with right hand, gave the container of butter to an unidentified staff member and then shut the door again. Continued observation revealed the Dietary Supervisor walked towards the steam table, rubbed his ungloved hands on his pants, and then began plating food with his ungloved hands. Observation at 5:13 p.m., after all the trays for the 2 secure units and hall trays had been plated by the Dietary Supervisor and delivered to the residents, the Dietary Supervisor then washed his hands before continuing to plate the remaining food for the residents in the main dining room.<br><br>(continued on next page) |

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|---|---|---|---|
| | 675371 | A. Building<br>B. Wing | 03/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Riverview Nursing & Rehabilitation | 1102 River Rd<br>Boerne, TX 78006 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | b. Observation on 2/10/2023 at 11:03 a.m. revealed the dietary supervisor had opened the door to the dining room with his ungloved hand to leave the kitchen and then returned. Continued observation revealed the Dietary Supervisor walked over to his office that was connected to the kitchen, sat at his computer touching the keys and the computer mouse, drank some fluid from a coffee cup he had on the desk, then returned to the kitchen area and using a large spoon, he stirred the salsa he was cooking on the stove with his ungloved hands. The Dietary Supervisor was then observed opening and closing the door to the dining room with his ungloved hand, walked to the oven, placed an oven glove on his left hand, removed a large pan of fish from the oven, used tongs with his right ungloved hand and placed the pieces of fish into a pan he had on the steam table. Continued observation revealed the Dietary Supervisor took the large pan the fish had been cooked in to a 3-compartment sink in the back of the kitchen, using the tongs, remove wax paper from the large pan the fish had been cooked on, and with his ungloved hand, opened the lid of a large garbage can and threw the wax paper into the can. The Dietary Supervisor then retrieved a marker from his office, walked to the stack of trays that were ready to have plated food placed on, wrote on a ticket on one of the trays, then placed the marker in his pocket. The Dietary Supervisor then took an empty plastic container, mixed powder chicken broth and water in the container using a wire [NAME] and poured the broth into a food processor to prepare puree mash potatoes. The Dietary Supervisor was then observed taking the plastic container to the 3-compartment sink, returned to the stove again, took a large spoon with his ungloved hand and stirred salsa he had been cooking on the stove. After the Dietary Supervisor stirred the salsa, he placed oven gloves on his hands, took the pot of salsa from the stove and poured it into a metal container he had placed on the steam table. The Dietary Supervisor then covered the metal container of salsa with cellophane and placed it into the steam table. Afterwards, the Dietary Supervisor took the pot he had cooked the salsa in to the 3-compartment sink, then walked to the hand washing sink and washed his hands.<br><br>Observation on 2/10/2023 at 11:40 a.m. revealed the Dietary Supervisor began checking temperatures of food on the steam table. The Dietary Supervisor was observed using a thermometer to check checked the temperature of a food item and then using a pen, he wrote down the temperature on a piece of paper on a clip board. Continued observation revealed the Dietary Supervisor opened a single wrap, small alcohol pad, wiped the thermometer with the pad, walked toward a large garbage can with a lid, lift the lid with his ungloved hand, threw the wrapper and used alcohol pad into the can, then return to the steam table to check the temperature of the next food item. The Dietary Supervisor continued this process for 9 additional items, lifting the lid of the large garbage can with his ungloved hand to throw away the alcohol pad and wrapper. When the Dietary Supervisor finished checking the food temperatures, he put the clip board in his office, then washed his hands.<br><br>In an interview on 2/10/2023 at 4:38 p.m. with the Dietary Supervisor he revealed he failed to wash his hands between tasks because he was nervous with this surveyor observing him prepare and plate the meals.<br><br>Review of the facility policy, Food receiving and Storage, revised December 2008, revealed, 7. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date).<br><br>Review of the facility policy, Handwashing/Hand Hygiene, revised April 2012, revealed, 5. Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: f. Before and after eating or handling food (hand washing with soap and water). |

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|---|---|---|---|
| | 675371 | A. Building<br>B. Wing | 03/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Riverview Nursing & Rehabilitation | 1102 River Rd<br>Boerne, TX 78006 |

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|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42402<br><br>Based on interviews and record review, the facility failed to maintain medical records on each resident that are complete and accurately documented for 3 of 7 residents(resident # 13, 56 & 9) reviewed for pharmaceutical services in that;<br><br>The facility failed to prevent EMARs from having blanks in the time slots for physician ordered medications and procedures with no documentation of chart codes that indicated reasons for the medication or treatments given or not given for Resident #13,#56 and #9.<br><br>This deficient practice place residents at risk of not taking medication for chronic diseases leads to decreased productivity and increase disease morbidity, physician office visits, and death.<br><br>The findings were:<br><br>Record review of Resident #13's face sheet, dated 2/7/2023, revealed an [AGE] year-old male with an admitted to the facility on [DATE] with diagnoses of unspecified dementia without behavioral disturbance(a term used to describe a group of symptoms affecting memory, thinking and social abilities severely enough to interfere with your daily life.), Type 2 Diabetes Mellitus(an impairment in the way the body regulates and uses sugar (glucose) as a fuel. This long-term (chronic) condition results in too much sugar circulating in the bloodstream. Eventually, high blood sugar levels can lead to disorders of the circulatory, nervous and immune systems.), Hypertensive heart disease(refers to heart conditions caused by high blood pressure. The heart working under increased pressure causes some different heart disorders. Hypertensive heart disease includes heart failure, thickening of the heart muscle, coronary artery disease, and other conditions. ), Sleep apnea(A sleep disorder where breathing is interrupted repeatedly during sleep. Characterized by loud snoring and episodes of stop breathing.)and major depressive disorder, recurrent with psychotic symptoms(psychotic symptoms in depression include voices saying negative things or delusions of not being sure if they are alive or dead.)<br><br>Record review of Resident #13's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 9, which indicated a moderate mental impairment.<br><br>Record review of Resident #13's order summary report dated 1/1/2023-1/30/2023 revealed orders for: Accu checks AC and HS, offer snack every night 8:00 p.m., pain evaluation every shift, aspirin tablet delayed release 81 mg I tablet by mouth daily, carvedilol tablet 12.5mg give 1 tablet by mouth twice a day, Eliquis 5mg 1 tab by mouth twice a day, furosemide 40 mg give 1 tablet by mouth daily, levothyroxine 25mcg tablet 1 by mouth daily, polyethylene glycol 3350 powder 17 gram/dose give 17 gm by mouth three times a day, senna 8.6 mg tablet give 1 by mouth daily, tamulosin 0.4mg give 1 tablet by mouth daily, Trulicity pen injector 0.75mg/0.5ml administer 1 unit subcutaneous once a day on Fridays.<br><br>Record review of Resident #13's EMAR for 1/1/2023-1/30/2023 had blank spaces for Resident #13's medication administration with no documentation of chart codes for the following:<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 |
|---|---|---|---|
| | 675371 | A. Building<br>B. Wing | 03/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Riverview Nursing & Rehabilitation | 1102 River Rd<br>Boerne, TX 78006 |

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|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Accu checks AC and HS- 1/5/2023 at 7:00 am and 12 noon, 1/7/2023 at 9:00 p.m, 1/9/2023 at 12 noon and 5:00 p.m.,1/10/2023 at 12pm and 5:00 p.m.,1/12/2023 at 12 noon and 5:00 p.m., 1/18/2023at 7:00 a.m. and 12 noon, 1/19/2023 at 7:00 a.m. and 12 noon, 1/23/2023 at 12 noon and 5:00 p.m., 1/24/2023 at 7:00 a.m., 12 noon,5:00 p.m., 1/26/2023 at 7:00 a.m. and 12 noon., 1/30/2023 at 12 noon, 5:00p.m. and 9:00 p.m.<br><br>offer snack every night 8:00 p.m. - 1/3,1/4,1/5,1/6,1/7,1/8,1/9,1/10,1/11,1/12,1/13,1/14,1/15,1/16,1/17,1/18, 1/19,1/20,1/22,1/23,1/24,1/25,1/26,1/27,1/28,1/29,1/30/2023.<br><br>pain evaluation every shift -1/1/ day ,1/3,1/4,1/5 day and night, 1/7 night, 1/8,1/9,1/10,1/11 day and night , 1/12 night,1/13-1/20 day and night,1/22 night,1/23-1/29 day and night, 1/30/2023 night.<br><br>aspirin tablet delayed release 81 mg I tablet by mouth daily-1/26/2023 7:00 a.m.<br><br>carvedilol tablet 12.5mg give 1 tablet by mouth twice a day- 1/6/2023 at 7:00 p.m., 1/26/2023 at 7:00 a.m.<br><br>Eliquis 5mg 1 tab by mouth twice a day-1/6/2023 at 7:00 p.m., 1/26/2023 at 7:00 a.m.<br><br>furosemide 40 mg give 1 tablet by mouth daily-1/26/2023 at 7:00 a.m.<br><br>levothyroxine 25mcg tablet 1 by mouth daily - 1/16/2023 at 5:00 a.m.<br><br>polyethylene glycol 3350 powder 17 gram/dose give 17 gm by mouth three times a day- 1/6/2023 at 7:00 p.m. , 1/9 at 1:00 p.m.,1/10 at 1:00 p.m.,1/23 at 1:00 p.m.,1/26 at 7:00 a.m., 1/30/2023 at 1:00 p.m.<br><br>senna 8.6 mg tablet give 1 by mouth daily- 1/6/2023 at 7:00 p.m.<br><br>tamulosin 0.4mg give 1 tablet by mouth daily-1/6/2023 at 7:00 p.m.<br><br>Trulicity pen injector 0.75mg/0.5ml administer 1 unit subcutaneous once a day on Fridays. - 1/6/2023 at 7:00 a.m.<br><br>Record review of Resident #13's order summary report dated 2/1/2023-2/8/2023 revealed orders for: Accuchecks AC and HS, offer snack every night 8:00 p.m., pain evaluation every shift, aspirin tablet delayed release 81 mg I tablet by mouth daily, carvedilol tablet 12.5mg give 1 tablet by mouth twice a day, Eliquis 5mg 1 tab by mouth twice a day, furosemide 40 mg give 1 tablet by mouth daily, levothyroxine 25mcg tablet 1 by mouth daily, polyethylene glycol 3350 powder 17 gram/dose give 17 gm by mouth three times a day, senna 8.6 mg tablet give 1 by mouth daily, tamulosin 0.4mg give 1 tablet by mouth daily, Trulicity pen injector 0.75mg/0.5ml administer 1 unit subcutaneous once a day on Fridays.<br><br>Accuchecks AC and HS- 2/1 for 9:00 p.m.,2/3 for 7:00 a.m and 12 noon.2/5 for 7:00 a.m. and 12 noon,2/6 for 7:00 a.m., 2/7 for 7:00 a.m.<br><br>Levimir U-100 insulin administer 30 units subcutaneous- 2/1/2023 for 7:00 p.m., 2/5/2023 for 7:00 p.m.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675371 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/03/2023 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Riverview Nursing & Rehabilitation | 1102 River Rd Boerne, TX 78006 |

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|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Offer snack every night- 2/1,2/2,2/5 for 8:00 p.m.<br><br>Pain evaluation every shift- 2/1,2/2 day and night,2/5-night,2/6 for day,2/7 for day and night.<br><br>Levothyroxine 25mcg tablet 1 by mouth daily- 5:00 a.m.<br><br>Record review of Resident #56's face sheet undated, revealed an admitted [DATE] with diagnoses of: unspecified intracranial injury with loss of consciousness(A head injury causing damage to the brain by external force or mechanism. It causes long term complications or death.), hemiplegia affecting left dominant side(Hemiplegia can affect either the left or right side of your body. People can have different symptoms from hemiplegia depending on its severityomuscle weakness or stiffness on one side), gastrostomy status(is surgery performed by a general surgeon to give an external opening into the stomach)., and dysphagia(A condition with difficulty in swallowing food or liquid. This may interfere in a person's ability to eat and drink.).<br><br>Record review of Resident #56's resident assessment and care screening MDS, dated [DATE], revealed the resident had a BIMS score of 11, which indicated the resident was moderately cognitively impaired. Further review revealed Resident #56's MDS in section G revealed dependent of staff for eating via gastrostomy tube.<br><br>Record review of Resident #56's EMAR for 1/1/2023-1/31/2023 had blank spaces for Resident #56's medication administration with no documentation of chart codes for the following:<br><br>Lamictal 25 mg tablet give one by gastric tube at bedtime. 1-7-2023 at 7:00 p.m.<br><br>Loratadine 10 mg by gastric tube once a day.-1/26/2023 at 8:00 a.m.<br><br>Risperdal 1mg tablet by gastric tube daily.- 1/26/2023 at 7:00 a.m.<br><br>Trazadone 100mg by gastric tube at bedtime.-1/7/2023 at 7:00 p.m.<br><br>Trazodone 50 mg tablet give 1/2 tablet per gtube in morning.- 1/9,1/10,1/23,1/30 at 12:00 noon.<br><br>Check tube placement by auscultation and aspirating stomach contents before administration of formula/water/medications. Return stomach contents to stomach. If aspirate greater than greater 100cc , hold formula/water/medication and notify physician. 1/1 for day,1/3 for day,1/4 for day, 1/8,1/9,1/10,1/11,1/13, 1/17,1/23,1/26,1/28,1/30 1/31 for day and 1/31 for night.<br><br>Record review of Resident #9's face sheet, computer dated 2/7/2023, revealed an [AGE] year-old male with an admitted to the facility on [DATE] with diagnoses of Alzheimer's disease, other seizures, unspecified dementia and major depressive disorder, recurrent with psychotic symptoms.<br><br>Record review of Resident #9's Quarterly MDS dated [DATE] revealed a BIMS score of 9, which indicated a moderate mental impairment.<br><br>Record review of Resident #9's EMAR for 1/1/2023-1/31/2023 had blank spaces for Resident #9's medication administration with no documentation of chart codes for the following:<br><br>(continued on next page) |

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| | 675371 | A. Building<br>B. Wing | 03/03/2023 |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Depakote Sprinkles capsule delayed 125mg give 6 caps (to total 750 mg) once a day- 1/26/23 for 7:00 a.m.<br><br>Depakote sprinkles capsule delayed 125 mg give 2 tabs once a day-1/23/2023 for 12:00 p.m. and 1/30/2023 for 12:00 p.m.<br><br>Folic acid 400mcg 1 tablet by mouth daily- 1/26/2023 for 7:00 a.m.<br><br>Furosemide 40 mg tablet give 1 by mouth twice daily- 1/26/2023 for 7:00 a.m.<br><br>Gabapentin 100 mg 1 capsule by mouth twice a day- 1/26/2023 for 7:00 a.m.<br><br>During an interview on 2/10/2023 at 5:56 p.m., the DON confirmed staff did not document on Resident #56's, #13's, or #9's EMAR or the reason why medications were not administered for Residents #13's, #56's, or #9's EMAR. She stated there should not be any blanks on the EMAR and stated that staff are to document the reason the medications were not given. She further revealed if residents do not get there medications as ordered , they could have health changes that could lead to illness.<br><br>Record review of the facility's policy titled Charting and Documentation, dated 2001 MED-PASS, Inc., with revision date April 2008, revealed: 1. All observations, medications administered, services performed, etc., must be documented in the resident's clinical records.6. Documentation of procedures and treatments shall include care-specific details and shall include at a minimum: a. The date and time the procedure/treatment was provided. e. Whether the resident refused the procedure/treatment. |