STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. BUILDING _____ B. WING _____	08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAUTAUQUA HEALTH AND REHABILITATION	1205 LEITCHFIELD ROAD OWENSBORO, KY 42303

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F 000	INITIAL COMMENTS	F 000		

An Abbreviated Survey investigating Complaint KY00033838 was initiated on 08/23/2021 and was conducted in conjunction with a Recertification Survey initiated on 08/23/2021. The Surveys were concluded on 08/27/2021, with deficiencies cited at the highest Scope and Severity of a "K."

The facility was found not to be in compliance with 42 CFR 483.80 infection control regulations and has not implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.

Total census 111.

Complaint KY00033838 was substantiated with no deficiencies cited.

It was determined the facility's non-compliance with one or more requirements of participation caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.12 (Freedom from Abuse, Neglect, and Exploitation) at a Scope and Severity of "K." The Immediate Jeopardy (IJ) was also related to State Operations Manual, Appendix PP, 483.40 (Behavioral Health) at a Scope and Severity of "J."

The Immediate Jeopardy (IJ) was determined to exist, on 04/01/2021, when Resident #6 was yelling and cursing at another resident and the

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

Electronically Signed | 10/20/2021

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F 000	Continued From page 1 facility failed to investigate the allegation of verbal abuse. The Director of Nursing (DON) and Nursing Home Administrator (NHA) were notified of the IJ and provided with the IJ Template on 08/26/2021 at 12:00 PM. A Removal Plan was requested. The Removal Plan was accepted by the State Survey Agency on 08/27/2021 at 6:00 PM. The IJ was removed on 08/27/2021 at 6:00 PM after the survey team performed onsite verification that the Removal Plan had been implemented. Noncompliance remained at the lower Scope and severity of pattern, no actual harm with potential for more than minimal harm that was not immediate jeopardy for F600, F609, and F610. Noncompliance remained at the lower Scope and Severity of isolated, no actual harm with potential for more than minimal harm that was not immediate jeopardy for F740.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		11/5/21

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F 550	Continued From page 2 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and review of the facility's policy, it was determined the facility failed to ensure dignity for three (3) of three sampled residents (Residents #22, #83 and #67) reviewed for dignity. Resident #22 was observed not dressed or covered. Resident #83 and Resident #67 did not have a privacy bag for their urinary catheter drainage	F 550	F550 1. on 10/13/2021, the Director of Nursing care planned Resident #22 to wear hospital gown when in bed, day clothing when out of bed and room per resident preference. The revised care plan also includes that the Resident prefers to not wear clothing on upper body when in bed.	

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F 550	Continued From page 3 bags. The findings included: Review of the facility's policy, titled, "Quality of Life-Dignity," revised August 2009, revealed, Residents should be treated with dignity and respect at all times. "Treated with dignity" means the resident would be assisted in maintaining and enhancing his or her best self-esteem and self-worth. Residents should be encouraged and assisted to dress in their own clothes rather than hospital gowns. Helping the resident to keep urinary catheter bags covered. 1. Record review revealed the facility admitted Resident #22 on 06/08/2019 with diagnoses that included cerebral infarction, hemiplegia and hemiparesis, contracture to the elbow and wrist, aphasia, muscle weakness, type 2 diabetes, major depressive disorder, dysphagia, lack of coordination, abnormal posture, and essential hypertension. Review of the Annual Minimum Data Set (MDS), dated 06/02/2021, revealed the facility assessed Resident #22 to have a Brief Interview for Mental Status (BIMS) score of six (6) out of fifteen (15), which indicated significant cognitive impairment. Further review revealed Resident #22 required the extensive assistance of two (2) persons with bed mobility, transfer, dressing, and toileting, and required supervision of one (1) person with eating. The resident was totally dependent on staff for bathing. Review of the care plans, dated 07/11/2019, revealed Resident #22 was not care planned for any preference related to clothing or lack of	F 550	Residents #83 and #67 catheter bags were placed in a dignity bag by the Regional Director of Clinical Services on 8/27/2021. 2. All residents were observed on 8/30/2021 by the Regional Director of Clinical Services and MDS Coordinator for proper attire/covered per resident preference. No deficient practice was found. All resident with catheters were observed by the Regional Director of Clinical Services and MDS Coordinator on 8/30/2021 to ensure catheter bags were placed in dignity bags. No deficient practice was found. 3. A Resident Observation round tool was created by the Administrator and initiated 10/20/2021 to include resident dressed in clean clothing of their choosing, resident covered and not exposed, and catheter bags placed in dignity bags. All irregularities will be corrected immediately and reported to the administrative team in the next morning administrative meeting. The administrative team which includes, the Administrator, Director of Nursing, Assistant Director of nursing, Unit Managers, Staff Development Coordinator, Social Services Director, Human resources Director, Business Office Manager, MDS Coordinator, and weekend manager will use the tool daily to observe the use of proper attire/covered per resident preference and that catheter bags will remain in dignity bags. All staff educated by the Regional Director of Clinical Services, Administrator Director of	

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F 550	Continued From page 4 clothing. Further review revealed Resident #22 was not care planned for being resistive to care related to dressing. Observation on 08/23/2021 at 11:11 AM, revealed Resident #22 lying in bed without any clothing on and covered by only a sheet. Further observation revealed the sheet was only partially covering Resident #22, leaving the resident almost fully exposed. Observation on 08/24/2021 at 10:31 AM, revealed Resident #22 lying down in bed covered with only a sheet. Further observation revealed when the sheet was pulled back Resident #22 had nothing on under the sheet other than briefs. Observation on 08/25/2021 at 9:07 AM, revealed Resident #22 lying in bed wearing a hospital gown. Observation on 08/26/2021 at 9:10 AM, revealed Resident #22 lying in bed wearing a hospital gown. Interview with Certified Nurse Aide (CNA) #5, on 08/26/2021 at 9:31 AM, revealed staff complete a spot check in the morning first, then they get breakfast trays and get residents up and ready for breakfast. CNA #5 stated staff go back around at nine o'clock to complete resident bed baths, showers, and clothing changes. The CNA stated Resident #22 typically wore a hospital gown, and she was unsure if Resident #22 had his/her own personal clothing. Further interview revealed Resident #22 would put clothes on if the resident was out of bed. CNA #5 stated she was not aware of any issues with Resident #22 being resistive to care. CNA #5 stated after activities of	F 550	Nursing, Assistant Director of Nursing, or Staff Development Coordinator on resident rights including the right to a dignified existence related to proper attire/covered per resident preference and the use of dignity bags to conceal catheter bags. Education completed by 11/4/21. 4.The issues will be reviewed daily times 2 weeks, weekly times 2 weeks, monthly for 2 months and then quarterly times 9 months by the Administrator, Director of Nursing, Assistant Director of Nursing, or Unit Manager to ensure residents dressed in clean clothing of their choosing, resident covered and not exposed, and catheter bags placed in dignity bags. Results will be reported by the Director of Nursing at the monthly Quality Assurance and Performance Improvement Committee meeting for review and recommendations to ensure continued compliance.	

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F 550	Continued From page 5	F 550		

daily living (ADL) care was provided, all residents would and should have on either clothing or a hospital gown. CNA #5 stated that no resident should ever be left naked or undressed.

Interview with CNA #6, on 08/26/2021 at 10:13 AM, revealed that at 6:30 AM, staff did a walk-through and checked on residents. She stated at that time, staff started incontinent care and wiped residents' faces before breakfast. CNA #6 stated after breakfast, staff started ADL care such as providing bed baths, showers, or partial baths. The CNA stated all residents were provided full ADL care which included providing clean clothes, denture/oral mouth care, washing their faces, and grooming. CNA #6 stated Resident #22 was unable to verbalize and make his/her needs known, and that Resident #22 required staff to turn him/her every two hours. CNA #6 stated Resident #22 did not like ADL care but allowed staff to complete it. Continued interview revealed Resident #22 primarily wore a hospital gown and liked to pull down the arms but had never completely removed the gown. CNA #6 stated Resident #22 would allow staff to adjust the gown when that occurred. She stated there should never be an occasion when Resident #22 was completely naked.

Interview with the Director of Nursing (DON), on 08/26/2021 at 8:15 AM, revealed she would need to check the facility's ADL and dignity policy. No policy was presented. During a follow up interview, on 08/26/2021 at 12:48 PM, revealed the DON stated she still had not had a chance to review the policy.

2. Record review revealed the facility admitted Resident #83 on 10/16/2019 with diagnoses that

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F 550	Continued From page 6	F 550		

included cerebral palsy, chronic obstructive pulmonary disease, contractures, abnormal posture, neuromuscular dysfunction of the bladder, and mild cognitive impairment.

Review of the Significant Change Minimum Data Set, dated 07/27/2021, revealed the facility assessed Resident #83 to have a Brief Interview for Mental Status (BIMS) score of zero (00) out of fifteen (15), which indicated significant cognitive impairment. Resident #83 required extensive assistance of two persons with bed mobility, dressing, and toileting. Further review revealed Resident #83 required limited assistance of one person with eating. The resident was totally dependent on staff for bathing.

Review of Resident #83's care plan, initiated on 10/17/2019, revealed the resident required an indwelling suprapubic catheter due to neurogenic bladder. Further review revealed interventions were to provide a privacy bag.

Observation on 08/23/2021 at 10:25 AM, revealed Resident #83 lying in bed, with a catheter drainage bag on the right side of the bed, exposed and not in a privacy bag.

Interview with CNA #5, on 08/26/2021 at 10:52 AM, revealed the CNA staff were responsible for cleaning a resident's catheter tubing and ensuring that the catheter drainage bag was in a privacy bag. The CNA stated that catheter privacy bags were in central supply, and staff could ask a nurse to get a bag. CNA #5 stated it was staff's responsibility to correct issues such as a catheter bag not placed in a privacy bag.

Interview with CNA #6, on 08/26/2021 at 11:24

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F 550	Continued From page 7	F 550		

AM, revealed the CNA staff were responsible for emptying catheter bags, checking the color of output, ensuring the catheter bag were placed in a privacy bag, tubing was never on the floor, and the bag was not overflowing or leaking.
3. Record review revealed the facility admitted Resident #67 on 01/18/2021 and readmitted the resident on 02/14/2021 with diagnoses that included disruption of a surgical wound, obstructive uropathy and morbid obesity.

Review of the Quarterly Minimum Data Set, dated 07/19/2021, indicated Resident #67 was cognitively intact with a Brief Interview for Mental Status score of fourteen (14) out of fifteen (15). The assessment further indicated the resident had an indwelling urinary catheter and surgical wounds.

Review of the 08/2021 Treatment Administration Record (TAR), revealed an entry to check placement of the privacy bag for the indwelling urinary catheter every shift. Further review revealed each day had been checked and initialed which indicated the privacy bag was in place.

Review of the care plan for Resident #67, last reviewed on 08/12/2021, indicated a privacy bag should be provided for the resident's indwelling urinary catheter.

Observation of Resident #67 on 08/23/2021 at 2:47 PM, revealed the drainage bag for the indwelling urinary catheter did not have a privacy bag. Further observation revealed urine was visible to anyone in the hall as the door to the room was opened.

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F 550	Continued From page 8 Observation on 08/24/2021 at 2:00 PM, revealed no privacy bag was seen covering the urinary drainage bag. Interview with the resident, at that time, revealed the last time he/she remembered the bag being covered was about three (3) weeks ago. Interview with Certified Nursing Assistant (CNA) #2, on 08/25/2021 at 10:33 AM, revealed Resident #67 should have a privacy bag covering the urinary drainage bag. CNA #2 added she had served breakfast to the resident and had not noticed the drainage bag was not covered. Interview with Registered Nurse (RN) #1, on 08/25/2021 at 10:34 AM, revealed the urinary drainage bag should be always covered to maintain privacy. The nurse stated she was uncertain about the facility's policy for covering catheter drainage bags. RN #1 added she was unaware if Resident #67's catheter drainage bag was covered since she had not been in the resident's room yet that shift. Interview with the Director of Nursing (DON), on 08/26/2021 at 8:15 AM, revealed the standard of care was to cover the urinary drainage bag, but to be sure she needed to review the facility policy. The DON did not return a policy for covering the urinary drainage bag.	F 550		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This	F 600		11/5/21

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F 600	Continued From page 9 includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews and facility policy review, it was determined that the facility failed to protect residents from physical, sexual, and verbal abuse for five (5) (Residents #35, #8, #58, #54, and #87) of five (5) sampled residents reviewed for abuse by Resident #85 and Resident #6. Specifically, Resident #85 knocked down Resident #35 down on 08/21/2021, and knocked Resident #8 down on 08/22/2021, resulting in a femur fracture. Resident #6 had multiple episodes of verbal and physical aggression towards other residents. Resident #6 exposed himself/herself, sexually during an activity, to Resident #58 and Resident #87. Staff reported that when Resident #6 came into the common area, other residents left due to the resident's behaviors. Staff indicated they were fearful Resident #6 would hurt another resident. The Director of Nursing (DON) indicated	F 600	1. Resident #85 was reported to push Resident #8 resulting in a fractured femur. The incident was reported on 08/26/21 and the follow up investigation was finalized and reported 08/27/21. Resident #6 was reported to have exposed himself in a group activity on 08/14/21. This event reported to OIG 08/27/21 and investigation and follow up submitted on 8/28/21. 2. All residents with BIMs of 8 or above were interviewed by social services on 8-25-2021 and 8-26-2021 to ensure there were no concerns of safety, or feelings of abuse while in this facility. None were noted. MDS nurse and SS assistant reviewed residents with BIMS of 7 and below for any signs of change in baseline mood or behavior and normal daily	

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Resident's #6's behaviors created a stressful environment for the other residents.

It was determined the facility's non-compliance with one or more requirements of participation caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was identified at 483.12 (Freedom from Abuse, Neglect, and Exploitation) at a scope and severity of "K."

The Immediate Jeopardy (IJ) was determined to exist on 04/01/2021 when Resident #6 was yelling and cursing at another resident and the facility failed to investigate the allegation of verbal abuse. The Director of Nursing (DON) and Nursing Home Administrator (NHA) were notified of the IJ and were provided the IJ Template on 08/26/2021 at 12:00 PM. AN acceptable Removal Plan was received on 08/27/2021. The IJ was determined to be removed on 08/27/2021, before exit. after the survey team performed onsite verification that the Removal Plans had been implemented. Noncompliance remained at the lower scope and severity of pattern "E", no actual harm with potential for more than minimal harm that was not immediate jeopardy.

The findings included:

Review of the Abuse Prevention Program, revised 09/2020, indicated in Paragraph #1 that as part of the resident abuse prevention, administration would protect residents from abuse by anyone including, but not necessarily limited to staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individuals.

routine. No changes or concerns were identified.

3. Administrator, Director of Nursing, Unit Managers, Assistant Director of Nursing, MDS, Business office, Payroll, Activities, Maintenance, Therapy, Scheduling were educated per regional director of Clinical services on 8-26-2021 pm on What is abuse, how to prevent abuse and neglect, when to report abuse and neglect, and to report all abuse to the LNHA immediately. The licensed Nursing Home Administrator will make the initial report to the Office of the Inspector General, Department of Community Based Services, the State Ombudsman and Local Ombudsman, the responsible parties and the MD or Nurse practitioner within two hours. All other staff educated on how to Identify types of Abuse and Neglect, when to report suspected abuse and neglect, Reporting of abuse and neglect directly to the administrator immediately on 8/26/21 by the Administrator and Director of Nursing. Behavior monitoring is reviewed in the morning clinical meeting and the trigger word report is reviewed daily and all concerns will be immediately addressed.

4. The Abuse Quality Assurance and Performance Improvement tool and the reportable events logs will be completed monthly by the LNHA. Events will be audited weekly x 3 months and then quarterly x 12 months. Any concerns documented, corrected immediately, and staff educated accordingly. Findings/trends will be reported at the

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F 600	Continued From page 11 Review of the facility's policy, titled, "Abuse and Neglect - Clinical Protocol," revised July 2017, revealed Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well-being. The management and staff, with the support of the physicians, will address situations of suspected or identified abuse and report them in a timely manner to appropriate agencies, consistent with applicable laws and regulations. Review of the Unmanageable Resident policy, revised 04/2010, indicated that if a resident's behavior became abusive, hostile, assaultive, or unmanageable in any way that would jeopardize his or her safety or the safety of others, the Nurse Supervisor/Charge Nurse must immediately provide for the safety of all concerned, notify the attending physician for instruction, and notify the Director of Nursing and the resident's representative. The policy further indicated complete documentation of the incident must be recorded in the resident's medical record, and an incident report must be filed with the Administrator. Additionally, unmanageable residents may not be retained by the facility. 1. Record review revealed the facility admitted Resident #6 on 01/19/2017 with diagnoses of dementia with behavioral disturbances, anxiety/agitation, schizophrenia, adult failure to thrive, intellectual disability, and depression. Review of the annual Minimum Data Set (MDS) dated 02/16/2021, revealed Resident #6's	F 600	monthly quality assurance and performance improvement committee meeting by the Director of Nursing or designee for a minimum of six months for review and recommendations to ensure continued compliance.	

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cognition was severely impaired with a Brief Interview for Mental Status (BIMS) score of three (3) out of fifteen (15). The resident required supervision with ambulation using a walker. The MDS indicated the resident had no behaviors. The most recent Quarterly MDS, dated 05/19/2021 indicated diagnoses of impulse disorder and physical and verbal aggression directed toward others occurred one (1) to three (3) days during the seven (7) day assessment period.

Review of a care plan, dated 02/02/2017, indicated Resident #6 exhibited or had the potential to exhibit or demonstrate verbal behaviors such as the use of abusive and sexually inappropriate language.

Review of a care plan, dated 10/26/2020, indicated Resident #6 exhibited or had the potential to exhibit physical behaviors related to poor anger management, poor impulse control, and public masturbation.

Review of a Progress Note, dated 03/26/2021, indicated Resident #6 had a resident-to-resident altercation. Resident #6 continued to curse other residents and threatened to harm self and other residents.

Review of a Progress Note, dated 04/01/2021, indicated Resident #6 was cursing and yelling at another resident. There was no evidence provided that showed this incident was investigated.

Review of a Progress Note, dated 04/03/2021, indicated Resident #6 was cursing other residents and making multiple verbal threats. There was no

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evidence provided that this incident was investigated.

Review of a Progress Note, dated 04/04/2021 at 5:20 PM, indicated Resident #6 was extremely agitated and yelling at other residents. There was no evidence provided that this incident was investigated.

Review of a Progress Note, dated 04/09/2021 at 10:04 AM, indicated Resident #6 was verbally aggressive with other residents, threatening harm, and cursing. There was no evidence provided that this incident was investigated.

Review of a Progress Note, dated 04/13/2021 at 7:50 AM, indicated Resident #6 was cursing and threatening to harm other residents. There was no evidence provided that this incident was investigated.

Review of a Progress Note, dated 04/16/2021, indicated Resident #6 was yelling and cursing at other residents, and the facility had the Director of Nursing come back to the unit. There was no evidence provided that this incident was investigated.

Review of a Progress Note, dated 04/18/2021, indicated Resident #6 was yelling, throwing stuff, and cussing at other residents. There was no evidence provided that this incident was investigated.

Review of a Progress Note, dated 04/30/2021, indicated Resident #6 was publicly masturbating during an activity. There was no evidence provided that this incident was investigated.

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Review of a Progress Note, dated 05/08/2021, indicated Resident #6 was yelling and cussing at other residents. There was no evidence provided that this incident was investigated.

Review of a Progress Note, dated 05/29/2021, indicated Resident #6 had been cursing, yelling, and threatening other residents. There was no evidence provided that this incident was investigated.

Review of a Progress Note, dated 06/05/2021, indicated Resident #6 was verbally aggressive with another resident. There was no evidence provided that this incident was investigated.

Review of a Progress Note, dated 06/14/2021, indicated Resident #6 had been cursing and yelling at other residents and throwing items in the resident's room. There was no evidence provided that this incident was investigated.

Review of a Physician's Progress Note, dated 06/16/2021, indicated Resident #6 was noted to have the potential to harm staff, other residents, or self.

Review of a Physician's Progress Note, dated 06/17/2021, indicated Resident #6 had a long history with physical aggression related to schizoaffective bipolar disorder.

Review of a Progress Note, dated 06/29/2021, indicated Resident #6 was threatening to hit, was cursing, and was being verbally aggressive with other residents. There was no evidence provided that this incident was investigated.

Review of a Progress Note, dated 07/27/2021,

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indicated Resident #6 was cursing and threatening to hit other residents. There was no evidence provided that this incident was investigated.

Review of a Progress Note, dated 08/11/2021, indicated Resident #6 was being verbally aggressive with other residents and was threatening to harm other residents. There was no evidence provided that this incident was investigated.

Review of a Progress Note, dated 08/14/2021, indicated Resident #6 had exposed himself/herself and touched himself/herself inappropriately in front of other residents during an activity. The DON went to the unit to talk to the resident regarding his/her behaviors. There was no evidence provided that this incident was investigated.

Review of a Physician's Progress Note, dated 08/18/2021 at 12:00 PM, indicated Resident #6 was verbally and physically aggressive, was throwing things, trying to break things, slamming the walker, and yelling and cursing. Record review revealed Haldol 2.5 mg (milligrams) was given.

During an interview on 08/24/2021 at 3:15 PM, Licensed Practical Nurse (LPN) #3 indicated Resident #6 threatened to kill other residents, and it was "just a matter of time" before the resident hurt another resident. She indicated the facility's administration was aware of Resident #6's aggressive physical and verbal behaviors.

During an interview on 08/24/2021 at 2:16 PM, Resident #54 indicated Resident #6 had kicked

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him/her in the leg with three (3) staff members present who witnessed the incident.

During an interview on 08/24/2021 at 3:30 PM, the Activity Assistant (AA) indicated she had witnessed Resident #6 kick Resident #54.

During an interview on 08/26/2021 at 12:15 PM, the AA indicated Resident #6 exposed himself/herself to two residents during an airshow while outside in the courtyard.

During an interview on 08/26/2021 at 12:20 PM, Resident #58 indicated Resident #6 had exposed himself/herself to Resident #58 during the airshow, and that it made the resident feel uncomfortable, "wondering what [Resident #58] did to provoke this."

During an interview on 08/26/2021 at 12:30 PM, Resident #87 indicated Resident #6 had their genitals in his/her hand and was exposing himself/herself to Resident #58. Resident #87 indicated (he/she) felt "bad" for Resident #58.

During an interview on 08/25/2021, the DON indicated allegations of abuse were to be reported to their immediate supervisor, and it would then be reported to the DON or NHA. She indicated she was not aware of the allegations of physical, verbal, and sexual abuse. The DON indicated she would report verbal allegations of abuse depending on how the other residents felt about it. She indicated the incident of Resident #6 exposing self during an activity should have been reported.

During an interview with the Administrator, on 8/26/2021 at 2:30 PM, she stated she was aware

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of behaviors that Resident #58 had been displaying and that the resident was "like a child." She indicated she had not been notified that the resident kicked another resident or that the resident had exposed themself in front of female residents during the outside activity for the air show.

2. Record review revealed the facility admitted Resident #85 on 01/27/2020 and last re-admitted him/her on 04/22/2021. The resident's diagnoses included schizoaffective disorder, vascular dementia with behaviors, early onset Alzheimer's disease, anxiety, and depression. Record review revealed Resident #85 was also readmitted on 03/22/2021, and on readmission experienced agitation, restlessness, hyperactivity, and sought companionship.

Review of the most recent Quarterly Minimum Data Set (MDS), dated 07/30/2021, revealed the resident had moderately impaired cognition with a Brief Interview for Mental Status (BIMS) of nine (9) out of fifteen (15). The resident's behaviors included physical aggression toward others occurring one (1) to three (3) days during the seven (7) day assessment period; other behaviors not directed toward others were documented as occurring one (1) - three (3) days; and, rejection of care one (1) to three (3) days during the assessment period. No verbal behaviors were identified as occurring during the assessment period.

Review of Resident 85's medical record revealed the resident had previously been discharged from another skilled nursing facility due to two (2) resident-to-resident altercations in two (2) days with behaviors that had become more aggressive

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leading up to the transfer.

Review of the Nurse's Progress Notes and/or incident reports indicated Resident #85 had physical or verbal altercations with other residents on the following days: 05/05/2021, 06/13/2021, 07/07/2021, 07/09/2021, 07/24/2021, 08/21/2021, and 08/22/2021.

A review of the Nursing Progress Notes dated 03/10/2021 at 2:51 PM indicated Resident #85 was transferred to the hospital for geriatric psychiatric services due to anxiousness, agitation, and endangering self and others. The documentation did not reveal how the resident endangered self or others.

A review of the care plan, did not indicate behavior interventions were put into place after readmission.

On 08/21/2021 at 2:40 PM, a review of the Nursing Progress Notes, revealed Licensed Practical Nurse (LPN) #6, observed Resident #85 grab Resident #35 by the shirt. Resident #35 attempted to pull away, and Resident #85 pulled Resident #35 closer. When Resident #85 let go of the resident's shirt, Resident #35 fell to the floor. Resident #35 sustained no apparent injury.

Review of a Facility Reported Incident, 08/22/2021, revealed on 08/22/2021, Resident #85 pushed Resident #8 down, resulting in a fracture requiring surgery. Resident #8 remained in the hospital.

Record review revealed a verbal aggression behavior care plan, created 08/23/2021, had a goal of decreased impulsive behaviors.

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Continued review revealed no care plan for physical behaviors of grabbing residents, pushing residents down, or stealing food.

Observation at 9:15 AM on 08/23/2021, this Surveyor overheard the Nurse Practitioner ask Resident #85, in the hallway, why the resident had pinched and pushed another resident during the past weekend. The resident's response was not heard.

A telephone interview was conducted on 08/23/2021 at 1:43 PM, with Resident #85's Responsible Party (RP). The RP stated staff had called that weekend because Resident #85 had gotten into it with another resident. The RP added Resident #85 had been sent to inpatient behavioral health services multiple times.

Interview with the Director of Nursing (DON), on 08/25/2021 at 9:53 AM, revealed she was aware that Resident #85 appeared to have had an altercation with Resident #8. The DON acknowledged Resident #85 grabbed at other residents, but she did not think Resident #85 meant this as an aggressive act.

Interview with Certified Nursing Assistant (CNA) #1, on 08/25/2021 at 9:16 AM, revealed at the present time Resident #85 was on a special observation schedule of every 15 minutes due to an incident over the weekend. CNA #1 stated she had worked the weekend and added on Saturday, 08/21/2021, Resident #85 had pushed Resident #35 down in the living area. The CNA added Resident #85 had grabbed Resident #35 by the shirt and then as Resident #35 tried to get away, Resident #85 let go of the shirt causing Resident #35 to fall. On Sunday, 08/22/2021,

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Resident #85 hit Resident #8 with the left hand. Resident #8 fell and was transferred to the hospital for a fracture. The CNA stated the only thing done on Saturday to protect other residents was taking Resident #85 to the resident's room and turning on the television. After the incident on Sunday, the CNA stated Resident #85 was taken to the bedroom, where the resident stayed until dinner. The CNA added the 15-minute checks were started on Sunday afternoon after Resident #8 had been transferred to the hospital. CNA #1 stated she worked three (3) twelve (12)-hour shifts per week, and usually at least one day during her three (3) days working, Resident #85 would slap another resident's hand, spit on other residents, and pinch or push other residents.

Interview with CNA #2 on 08/25/2021 at 10:19 AM, revealed she had worked on the secure unit on Saturday 08/21/2021. At around 1:00 PM - 1:30 PM, she stated Resident #85 had a hold on Resident #35. When Resident #85 let go, Resident #35 fell, but there was no apparent injury. The CNA stated staff took Resident #85 to his/her bedroom for rest. CNA #2 stated she also worked on Sunday 08/22/2021. The CNA stated that after breakfast (10:30 AM) she had been at the nurse's station and heard Resident #85 making sounds. When she looked up, she saw Resident #85 push Resident #8 with his/her hand and saw Resident #8 fall. At that time, 15-minute checks were started for Resident #85. The CNA added she worked three (3) twelve (12) hour shifts per week, and Resident #85 usually got into an altercation with another resident at least one (1) of the three (3) days. The altercations included grabbing or poking other residents, running over other residents with the wheelchair, pinching other residents, and taking the food of

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other residents. The CNA indicated she reported the incidents but could not remember exact dates or who the nurse was at the time.

Interview with LPN #6, on 08/25/2021 at 11:43 AM revealed that on 08/21/2021 she was sitting at the nurse's station when she heard a CNA yell Resident #85's name. LPN #6 added Resident #85 was pulling Resident #35 close by grabbing Resident #35's clothing. When Resident #85 let go of Resident #35, Resident #35 fell to the floor. LPN #6 stated Resident #85 was put to bed and stayed in the resident's room until dinner. LPN #6 stated staff was not assigned to monitor Resident #85, adding that if another resident had wandered into the room, staff would have to have waited to see if anything happened. LPN #6 stated on Sunday, 08/22/2021, Resident #85 was sitting in the common area of the unit and Resident #8 was also in the area. The LPN stated she heard Resident #8 yell and hit the floor. She stated CNA #1 and CNA #2, who were working, reported to LPN #6 that Resident #85 had pushed Resident #8 down. LPN #6 stated that while she did not see the incident first-hand, she knew Resident #8 had no history of falls and she believed what the two CNAs reported. The LPN stated she averaged working three (3) twelve (12)-hour shifts per week. Of those three (3) days, Resident #85 had a negative interaction with another resident on at least one (1) day. She cited negative interactions to include yelling at other residents and stealing food off other residents' trays. LPN #6 stated the 15-minute check sheets started on Sunday after Resident #8 was transferred to the hospital. On 08/21/2021, when Resident #85 had the aggressive interaction with Resident #35, staff had kept an eye on Resident #85, but had no documentation to support this. LPN #6 stated

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both incidents were reported to the weekend supervisor.

During an interview with LPN #7 on 08/25/2021 at 1:20 PM, he stated that while he was a contract nurse, he had worked in the facility many times and was familiar with Resident #85. LPN #7 described Resident #85 as combative with other residents and believed Resident #85 was aware of the incidents. He supported his position by saying that when asked why another resident had been hit, Resident #85 would respond, "Because I wanted to." LPN #7 stated he had not seen Resident #85 hit anyone, but he had seen the resident trying to push other residents down, grabbing other residents, and grabbing other residents' food and drink. The nurse stated he had complained to the DON about the resident's aggressive behavior, but nothing had been done.

Interview with the Director of Nursing (DON), on 08/25/2021 at 2:26 PM, revealed if one resident placed their hands on another, to include pushing, kicking, and hitting, it would be considered resident-to-resident abuse and would be reported to the State. The DON stated she had not read the 08/21/2021 Nurse's Note nor talked with any of the staff that were there. She added that based on what had been reported to her by the weekend supervisor, she had not thought aggression was a part of the incident and therefore had not been abuse.

Further interview on 08/26/2021 at 8:21 AM, with the DON, revealed she was unaware of Resident #85's history of aggression toward other residents. She acknowledged there should have been a care plan revision and interventions placed on 08/21/2021, when Resident #85

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grabbed Resident #35 causing him/her to fall. The DON stated she was unsure if placing interventions on Saturday would have prevented the fracture to Resident #8 on 08/22/2021.

The facility provided an acceptable credible Action Plan that alleged removal of the Immediate Jeopardy (IJ). The facility's Action Plan included:

1. Resident #85 was reported to push Resident #8 resulting in a fractured femur. The incident was reported on 08/26/2021 and the follow up investigation was finalized and reported 08/27/2021. Resident #6 was reported to have exposed himself/herself in a group activity on 08/14/2021. This event was reported to the State Survey agency/OIG (Office of the Inspector General) 08/27/2021.

Investigations going forward will include:

2. Conducting observations of the alleged victim, identification of any injuries as appropriate, location where the situation occurred, interaction and relationships between staff and other residents.

3. Interviews conducted with the alleged victim representative, perpetrator, witness, practitioner, outside agencies as needed. The facility conducted a record review for pertinent information such as progress notes, social services notes, physician, therapist and consultant notes, financial records, incident reports, reports from hospital, lab or x ray, medication records and any other agencies as deemed necessary.

4. Depending on the nature of the allegation, the

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CHAUTAUQUA HEALTH AND REHABILITATION	1205 LEITCHFIELD ROAD OWENSBORO, KY 42303

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facility put effective measures in place to ensure that further abuse, neglect or exploitation or mistreatment does not occur while the investigation is in progress. The facility will monitor the alleged victim and monitor the other residents at risk, by conducting management visits at different times and shifts. The facility will evaluate if the alleged victim feels safe. If they do not, immediate action will be taken to alleviate fear, i.e. room relocation, increased supervision, etc., immediate notification of the victim's practitioner and the family or the victims responsible party. The facility will oversee the implementation of corrective action and evaluate effectiveness through the QAPI process. All alleged abuse, neglect or exploitation will be monitored and recorded on a reportable event log. The investigation is in progress.

5. All residents with BIMs of 8 or above were interviewed by Social Services on 08-25-2021 and 08-26-2021 to ensure there were no concerns of safety, or feelings of abuse while in this facility. None were noted. The MOS Nurse and SS (Social Services) assistant reviewed residents with BIMS of 7 and below for any signs of change in baseline mood or behavior and normal daily routine. No changes or concerns were identified.

6. The LNHA, DON, Unit Managers, ADON, MOS, Business office, Payroll, Activities, Maintenance, Therapy, Scheduling were educated per the Regional Director of Clinical services on 08-26-2021 at 2:15 PM, on "What is abuse, how to prevent abuse and neglect, when to report abuse and neglect, and to report all abuse to the LNHA immediately." The licensed Nursing Home Administrator will make the initial

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report to the Office of the Inspector General, Department of Community Based Services, the State Ombudsman and local Ombudsman, the responsible parties and the MD or Nurse practitioner within two hours.

7. IDT meting was held on 08-27-2021, the team met and all residents with behaviors affecting others; have interventions and care plans in place. All interventions and care plans were communicated to the floor staff on 08-27-2021. Referrals were made to psychiatric services as appropriate by assistant the Social Services Director.

DON, and LNHA, and or designee educated all staff on the following:
- Identify types of Abuse and Neglect.
- When to report suspected abuse and neglect
- Reporting of abuse and neglect directly to the administrator immediately
- This education completed by 8/27/2021
- In addition, a list of all staff has been developed and no persons will be allowed to work without having completed this education prior to assuming the floor.

1. Facility system changes:
i. behavior monitoring added to TAR to be completed Q shift by [name redacted] RN/Clinical Support services.
ii. Facility is reviewing TAR daily in morning clinical meeting. TAR reviewed by DON on 08/27/2021.
iii. A trigger report was run by RDO on 08/27/2021 and all concerns were addressed immediately.
iv. The facility identified characteristics that could increase the risk for abuse such as attitudes, increase in resident behaviors, reports of shame,

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fear or retaliation, change in psychological, behavioral or psychosocial outcomes.
v. allegations including staff to resident, resident to resident, visitor to resident, neglect, or exploitation facility is to report immediately and immediately start investigation and protect residents.
vi. The LNHA had reported all investigations 08-27-2021

2. DON, LNHA, and or designee will audit:
i. The Abuse QAPI tool and the reportable events logs completed monthly by the LNHA. Events audited weekly x 3 months and then quarterly x 12 months. Any concerns documented, corrected immediately, and staff educated accordingly.
ii. Findings/trends reported at the monthly quality assurance and performance improvement committee by the Director of Nursing or designee for a minimum of six months.
iii. QAPI meetings will occur weekly for four weeks to monitor progress and then monthly thereafter."

The IJ was removed on 08/27/2021 at 6:00 PM after the survey team performed onsite verification that the Removal Action Plans had been implemented.

Onsite verification of the implementation of the Removal Plan was conducted during the survey. On 08/27/2021 between the hours of 11:00 AM and 6:00 PM. Review of the educational materials indicated 100% of staff to include all departments had been completed on 08/26/2021.

Twelve interviews were conducted to verify in-service training had been completed on the facility's Abuse Policy and Procedure training to

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include the types of abuse, what to report, to whom to report the allegations of abuse and when to report. Of those interviewed included certified nursing assistants (CNAs), licensed practical nurses (LPNs), registered nurses (RNs), housekeeping and scheduling staff. The staff interviewed revealed knowledge of what constituted abuse, what to do if abuse was observed, both staff to resident abuse and in the event of resident-to-resident abuse, when to report abuse and to whom the abuse should be reported.

The interviews revealed a consistent message that staff understood not only the different types of abuse, but that resident-to-resident altercations also constituted abuse. Staff indicated that through training they understood the need to intercede immediately and to always protect the resident before reporting any incident of abuse to the Administrator. Staff also acknowledged that after assuring resident safety, the abuse should be reported immediately.

Observations during the survey revealed Resident #85 was receiving 1:1 supervision. Record review for Resident #85 indicated the care plan had been revised to include exhibited physical behaviors and stealing food from other residents' trays. Interventions for Resident #85 included 1:1 supervision, psychiatric referral, laboratory testing and a care conference with family members to determine the resident's past interest.

Resident #6 had been placed on every 15 minute checks, and the care plan had been updated on measures to address behaviors, and an IDT meeting was held on 08/27/2021. Resident #6

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F 600	Continued From page 28 was seen by psych services on 08/25/2021. Surveyors verified 54 Residents with BIMS 8 or above were interviewed and indicated they felt safe. The LNHA, DON, Unit Managers, ADON, MDS, business office, payroll department, activities, maintenance, therapy, scheduling received education on what constitutes abuse and when to report.	F 600		
F 609 SS=K	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 609		11/5/21

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F 609	Continued From page 29 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and facility policy review, it was determined the facility failed to report abuse allegations and injuries of unknown origin to the State Survey Agency for six (6) (Residents #35, #8, #58, #54, #83, and #87) out of six (6) residents reviewed for abuse. Resident #6 had multiple occurrences of cursing, yelling, throwing things, threatening other residents, and publicly masturbating in front of other residents. These incidents were not reported. Resident #85 had physical or verbal altercations with other residents and the incidents were not reported. One of the physical altercations with Resident #85 caused Resident #8 to fall, and Resident #8 sustained a hip fracture. Resident #83 had injuries of unknown origin, including bruising and a hip fracture, that were not reported to the State Survey Agency. It was determined the facility's non-compliance with one or more requirements of participation caused, or was likely to cause, serious injury,	F 609	1. Resident #85 was reported to push Resident #8 resulting in a fractured femur. The incident was reported on 08/26/21 and the follow up investigation was finalized and reported 08/27/21. Resident #6 was reported to have exposed himself in a group activity on 08/14/21. This event reported to OIG 08/27/21 and investigation and follow up was submitted 8/28/21. 2. All incidents identified during the survey were reported on 8/27/2021. 3. All alleged violations involving abuse, neglect, exploitation, mistreatment, including injuries of unknown source and misappropriation reported immediately but not later than two hours after the allegation if they result in serious bodily injury but not later than 24 hours if they do not involve abuse and do not result in	

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harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was identified at 483.12 (Freedom from Abuse, Neglect, and Exploitation) at a scope and severity of "K."

The Immediate Jeopardy (IJ) determined to exist on 04/01/2021 when Resident #6 was yelling and cursing at another resident and the facility failed to investigate the allegation of verbal abuse. The Director of Nursing (DON) and Nursing Home Administrator (NHA) were notified of the IJ and provided with the IJ Template on 08/26/2021 at 12:00 PM. A Removal Plan was requested. The Removal Plan was accepted by the State Survey Agency on 08/27/2021 at 6:00 PM. The IJ was removed on 08/27/2021 at 6:00 PM after the survey team performed onsite verification that the Removal Plans had been implemented. Noncompliance remained at the lower scope and severity of pattern, no actual harm with potential for more than minimal harm that was not immediate jeopardy.

The findings included:

Review of the facility's policy, "The Abuse Prevention Program", reviewed September 2020 indicated under Paragraph #7 that allegations of abuse would be investigated and reported within the timeframes required by federal requirements.

A review of the facility;s policy, titled, "Abuse and Neglect - Clinical Protocol," revised July 2017, revealed abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain

serious bodily injury to the administrator of the facility and other officials. LNHA will immediately report and protect the identified residents prior to conducting the investigation. All the findings of the investigations will be reported to the Administrator and to the Survey Agency within 5 working days. Administrator, Director of Nursing, Unit Managers, Assistant Director of Nursing, MDS, Business office, Payroll, Activities, Maintenance, Therapy, Scheduling were educated per regional director of Clinical services on 8-26-2021 at 2:15 pm on What is abuse, how to prevent abuse and neglect, when to report abuse and neglect, and to report all abuse to the LNHA immediately. The licensed Nursing Home Administrator makes the initial report to the Office of the Inspector General, Department of Community Based Services, the State Ombudsman and Local Ombudsman, the responsible parties and the MD or Nurse practitioner within two hours. as appropriate. Director of Nursing, and Administrator, and designee educated all staff on 8/26/21 of the following:
"Identify types of Abuse and Neglect.
"When to report suspected abuse and neglect
"Reporting of abuse and neglect directly to the administrator immediately

4. The Abuse Quality Assurance and Performance Improvement tool and the reportable events logs will be completed monthly by the LNHA. Any concerns will be documented, corrected immediately,

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or maintain physical, mental, or psychosocial well-being. The management and staff, with the support of the physicians, will address situations of suspected or identified abuse and report them in a timely manner to appropriate agencies, consistent with applicable laws and regulations.

1. Record review revealed the facility admitted Resident #6 on 01/19/2017 with diagnoses of dementia with behavioral disturbances, anxiety/agitation, schizophrenia, adult failure to thrive, anorexia, intellectual disability, and depression. The Annual Minimum Data Set (MDS) dated 02/16/2021 indicated Resident #6's cognition was severely impaired with a Brief Interview for Mental Status (BIMS) of three (3) out of fifteen (15). The resident required supervision with ambulation using a walker. This MDS indicated the resident had no behaviors. The most recent Quarterly MDS, dated 05/19/2021 indicated diagnoses of impulse disorder and physical and verbal aggression directed toward others occurred one (1) - three (3) days during the seven (7) day assessment period.

Review of a Progress Note, dated 04/01/2021, indicated Resident #6 was cursing and yelling at another resident. There was no evidence provided that this was reported to the State Survey Agency.

Review of a Progress Note, dated 04/03/2021, indicated Resident #6 was cursing other residents and making multiple verbal threats. There was no evidence provided that this was reported to the State Survey Agency.

Review of Progress Note, dated 04/04/2021 at 5:20 PM, indicated Resident #6 was extremely

and staff educated accordingly. The reportable events log will be audited weekly x 3 months and then quarterly x 12 months and reported to the facility Quality Assurance and Performance Improvement committee for review and recommendation to ensure continued compliance.

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agitated and yelling at other residents. There was no evidence provided that this was reported to the State Survey Agency.

Review of a Progress Note, dated 04/09/2021 at 10:04 AM, indicated Resident #6 was verbally aggressive with other residents, threatening harm, and cursing. There was no evidence provided that this was reported to the State Survey Agency .

Review a Progress Note, dated 04/13/2021 at 7:50 AM, indicated Resident #6 was cursing and threatening to harm other residents. There was no evidence provided that this was reported to the State Survey Agency.

Review of a Progress Note, dated 04/16/2021, indicated Resident #6 was yelling and cursing at other residents, and the facility had the Director of Nursing come back to the unit. There was no evidence provided that this was reported to the State Survey Agency.

Review of a Progress Note, dated 04/18/2021, indicated Resident #6 was yelling, throwing stuff, and cussing at other residents. There was no evidence provided that this was reported to the State Survey Agency .

Review of a Progress Note, dated 05/08/2021, indicated Resident #6 was yelling and cussing at other residents. There was no evidence provided that this was reported to the State Survey Agency.

Review of a Progress Note, dated 05/29/2021, indicated Resident #6 had been cursing, yelling, and threatening other residents. There was no evidence provided that showed this was reported

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to the State Survey Agency.

Review of a Progress Note, dated 06/29/2021, indicated Resident #6 was threatening to hit, was cursing, and was being verbally aggressive with other residents. Review of a Progress note, dated 07/27/2021, indicated Resident #6 was cursing and threatening to hit other residents. There was no evidence provided that showed this was reported to the State Survey Agency.

Review of a Progress Note, dated 08/11/2021, indicated Resident #6 was being verbally aggressive with other residents and was threatening to harm other residents. There was no evidence provided that showed this was reported to the State Survey Agency.

During an interview on 08/24/2021 at 3:15 PM, Licensed Practical Nurse (LPN) #3 indicated Resident #6 threatened to kill other residents, and it was "just a matter of time" before the resident hurt another resident.

During an interview on 08/24/2021 at 2:16 PM, Resident #54 indicated Resident #6 had kicked Resident #54 in the leg with three (3) staff members present who witnessed the incident.

During an interview on 08/24/2021 at 3:30 PM, the Activity Assistant (AA) indicated she had witnessed Resident #6 kick Resident #54.

Record review and interview revealed there were no reports filed with the State Survey Agency for the verbal, physical, or sexual abuse allegations. During an interview on 08/25/2021, with the DON revealed allegations of abuse were to be reported to their immediate supervisor, and it would then

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be reported to the DON or NHA. She indicated she was not aware of the allegations of physical, verbal, and sexual abuse. The DON indicated she would report verbal allegations of abuse depending on how the other residents felt about it. She indicated the incident of Resident #6 exposing self during an activity should have been reported.

2. Record review revealed the facility admitted Resident #85 on 01/27/2020 with diagnoses that included schizoaffective disorder, vascular dementia with behaviors, anxiety disorder, early onset Alzheimer's, and depression.

Review of Resident 85's medical record revealed the resident had previously been discharged from another skilled nursing facility due to two (2) resident-to-resident altercations in two (2) days with behaviors that had become more aggressive leading up to the transfer.

Review of the Nursing Progress Notes dated 03/10/2021 at 2:51 PM revealed Resident #85 was transferred to the hospital for geriatric psychiatric services due to anxiousness, agitation, and endangering self and others. The documentation did not reveal how the resident endangered self or others. The facility readmitted Resident #85 on 03/22/2021. Upon readmission Resident #85 experienced agitation, restlessness, hyperactivity, and sought companionship.

Review of a SBAR dated 05/22/2021 indicated Resident #85 pushed another resident down. Review of the facility's list of State-Reported Incidents for the past three (3) months revealed there was no report for this incident. There was no documentation presented that supported an

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investigation of this incident had been completed.

Review of a facility reported incident (FRI) dated 07/06/2021 indicated a certified nursing assistant (CNA) came out of the shower room and saw Resident #85 in the hallway with two (2) other unidentified residents, with all residents hitting one another. Review of the facility's list of state-reported incidents revealed a report had not been submitted to the State.

Review of the Quarterly Minimum Data Set (MDS), dated 07/30/2021, revealed the facility assessed Resident #85 as moderately cognitively impaired with a Brief Interview for Mental Status score of nine (9). Physical behaviors occurred (1) - three (3) days during the assessment period, other behaviors not directed toward others were documented as occurring (1) - three (3) days, and rejection of care (1) - three (3) days. No verbal behaviors were identified as occurring during the assessment period. A review of the facility's list of state-reported incidents revealed no reports had been submitted to the State during the assessment period, although the MDS indicated there had been one (1) - three (3) incidents during the assessment period.

Record review revealed on 08/21/2021 at 2:40 PM, Licensed Practical Nurse (LPN) #6 documented she observed Resident #85 grab Resident #35 by the shirt. Resident #35 attempted to pull away, and Resident #85 pulled the resident closer. When Resident #85 let go of the resident's shirt, Resident #35 fell to the floor. Resident #35 sustained no injury.

Review of the facility's list of state-reported incidents revealed there had been no submission

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of a report for Resident #85's incident on 08/21/2021.

Licensed Practical Nurse (LPN) #6 was interviewed on 08/25/2021 at 11:43 AM. She stated on 08/21/2021, she was sitting at the nurse's station when she heard a CNA yell Resident #85's name. LPN #6 stated the 08/21/2021 incident with Resident #85 was reported to the weekend supervisor.

The Director of Nursing (DON) was interviewed on 08/25/2021 at 2:26 PM. She stated if one (1) resident placed their hands on another, to include pushing, kicking, and hitting, it would be considered resident-to-resident abuse and would be reported to the State agencies. The DON stated she had not read the 08/21/2021 Nurse's Note or talked with any of the staff that were there. She added that based on what had been reported to her by the Weekend Supervisor, she had not thought aggression was a part of the incident and therefore, it was not considered abuse. The DON stated that was the reason the 08/21/2021 incident involving Resident #85 had not been reported or investigated. The DON reviewed the state-reported folder for the 05/07/2021 incident, including the CNA's statement dated 05/05/2021, and stated the CNA might have dated the statement wrong.

Observation revealed that on 08/25/2021 at 12:16 PM, the Nursing Home Administrator (NHA) brought in the facility's state-reported incidents for the past three (3) months. When asked, the NHA confirmed the folders she brought in represented all she had reported to the State Agency or investigated for the past three (3) months. A review of the information provided by the facility

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indicated Resident #85 had two (2) incidents reported to the State agencies, one (1) incident for 05/05/2021 and another for 08/22/2021.

The DON was interviewed on 08/26/2021 at 8:21 AM. She stated she had not reported the incident or investigated the incident involving Resident #85 that occurred on 08/21/2021 due to the way the incident had been presented to her. She reviewed the remaining physically aggressive incident reports and Nurse's Notes and had no reason why those incidents had not been reported or investigated.

3. Record review revealed the facility admitted Resident #83 on 10/16/2019 with diagnoses that included cerebral palsy, chronic obstructive pulmonary disease, contractures, dysphagia, paranoid schizophrenia, need for assistance with personal care, mild cognitive impairment, major depressive disorder, anxiety disorder, and intermittent explosive disorder.

Review of the Significant Change Minimum Data Set (MDS) for Resident #83, dated 07/27/2021, revealed the facility assessed that Resident #83 had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated significant cognitive impairment. Resident #83 required extensive assistance of two (2) people with bed mobility, dressing, and toileting. Resident #83 required limited assistance of one person with eating. The resident was totally dependent on staff for bathing.

Review of a Progress Note dated 07/20/2021 at 1:05 PM revealed, "CNAs asked this nurse to come to room to look at resident. When this

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nurse went in the room the CNA's (sic) showed me that the resident had some yellow bruising to [the resident's] right inner thigh that wrapped around to the front and back of [the] thigh, 3 small open areas to [the] scrotum, and some discoloration spots to [the] right outer foot."

An interview on 08/26/2021 at 12:48 PM with the DON revealed that if an injury was found that has no immediate known cause, it would be unknown and should be reported. The DON stated that when staff reported on 07/20/2021, significant bruising was observed on the resident's thigh it was not reported to the State Survey Agency at that time. The DON stated she concluded it was most likely a result of improper incontinent care.

3b. Review of a Progress Note dated 07/23/2021 at 5:46 PM, for Resident #83 revealed, "ER nurse called to inform of acute right hip fracture, unknown cause at this time, DON [Director of Nursing] aware." [The resident had been sent out for a possible bowel obstruction. During the CT scan for this, the fracture was found.]

An interview on 08/26/2021 at 12:48 PM with the Director of Nursing (DON) revealed she did not report the right hip fracture to the State Survey Agency that was discovered in the hospital and reported to the facility on 07/23/2021. The DON stated it was not reported since she felt it was also a result of improper incontinent care and that she did not feel either incident met the criteria for reporting.

The facility's Removal Plan included:

"1. Resident #85 was reported to push Resident #8 resulting in a fractured femur. The incident

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was reported on 08/26/21 and the follow up investigation was finalized and reported 08/27/21. Resident #6 was reported to have exposed (himself/herself) in a group activity on 08/14/21. This event reported to OIG (Office of the Inspector General/Sttae Survey Agency) 08/27/21.
2. All incidents identified during the survey reported on 08/27/2021
3. All alleged violations involving abuse, neglect, exploitation, mistreatment, including injuries of unknown source and misappropriation were reported immediately but not later than two hours after the allegation if they result in serious bodily injury, but not later than 24 hours if they do not involve abuse and do not result in serious bodily injury.
4. All the findings of the investigation reported to the Administrator and to the Survey Agency within 5 working days.
5. Alleged violations identified are reported to the Administrator. LNHA will immediately report and protect the identified residents prior to conducting the investigation.
6. LNHA, DON, Unit Managers [UM], ADON, MOS [sic] [Minimum Data Set, MDS], Business office, Payroll, Activities, Maintenance, Therapy, Scheduling were educated per Regional Director of Clinical services on 08-26-2021 at 2:15 pm on What is abuse, how to prevent abuse and neglect, when to report abuse and neglect, and to report all abuse to the LNHA immediately. The licensed Nursing Home Administrator makes the initial report to the Office of the Inspector General, Department of Community Based Services, the State Ombudsman and Local Ombudsman, the responsible parties and the MD or Nurse practitioner within two hours.
7. IDT [interdisciplinary team] meeting held

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8-27-2021 reviewed behaviors for all residents that have behaviors affecting others. Interventions and care plans were put in place by DON, UM and MOS [sic, MDS]. All interventions and care plans communicated to floor staff per Kardex, and referrals made to psychiatric services as appropriate.

DON, and LNHA, and or designee educated all staff on the following:
- Identify types of Abuse and Neglect.
- When to report suspected abuse and neglect
- Reporting of abuse and neglect directly to the administrator immediately
- This education completed 08/27/2021
- In addition, a list of all staff has been developed and no persons will be allowed to work without having completed this education prior to assuming the floor.

1. DON, LNHA, and or designee reported all findings to QAPI
i. The Abuse QAPI [quality assurance performance improvement] tool and the reportable events logs completed monthly by the LNHA. Events audited weekly x 3 months and then quarterly x 12 months. Any concerns will be documented, corrected immediately, and staff educated accordingly.
ii. Findings/trends reported at the monthly quality assurance and performance improvement committee by the Director of Nursing or designee for a minimum of six months.
iii. QAPI meetings weekly for four weeks to monitor progress and then monthly thereafter."

The IJ was removed on 08/27/2021 at 6:00 PM after the survey team performed onsite verification that the Removal Plans had been

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implemented.

Onsite verification of the implementation of the Removal Plan was conducted during the survey. On 08/27/2021 between the hours of 11:00 AM and 6:00 PM. Review of the educational materials indicated 100% of staff to include all departments had been completed on 08/26/2021.

Twelve interviews were conducted to verify in-service training had been completed on the facility's Abuse Policy and Procedure training to include the types of abuse, what to report, to whom to report the allegations of abuse and when to report. Of those interviewed included certified nursing assistants (CNAs), licensed practical nurses (LPNs), registered nurses (RNs), housekeeping and scheduling staff. The staff interviewed revealed knowledge of what constituted abuse, what to do if abuse was observed, both staff to resident abuse and in the event of resident-to-resident abuse, when to report abuse and to whom the abuse should be reported.

The interviews revealed a consistent message that staff understood not only the different types of abuse, but that resident-to-resident altercations also constituted abuse. Staff indicated that through training they understood the need to intercede immediately and to always protect the resident before reporting any incident of abuse to the Administrator. Staff also acknowledged that have assuring resident safety, the abuse should be reported immediately.

Observations during the survey revealed Resident #85 was receiving 1:1 supervision. Record review for Resident #85 indicated the

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F 609	Continued From page 42 care plan had been revised to include exhibited physical behaviors and stealing food from other resident's trays. Interventions for Resident #85 included 1:1 supervision, psychiatric referral, laboratory testing and a care conference with family members to determine the resident's past interest. Resident #6 had been placed on every 15 minute checks, and the care plan had been updated on measures to address behaviors, and an IDT meeting was held on 08/27/2021. Resident #6 was seen by psych services on 08/25/2021. Surveyors verified 54 Residents with BIMS 8 or above were interviewed and indicated they felt safe. The LNHA, DON, unit managers, ADON, MDS, business office, payroll department, activities, maintenance, therapy, scheduling received education on what constitutes abuse and when to report.	F 609		
F 610 SS=K	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 610		11/5/21

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F 610	Continued From page 43 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and facility policy review, it was determined that the facility failed to investigate abuse allegations for six (6) (Residents #35, #8, #58, #54, #87 and #83) out of six (6) residents reviewed for abuse by Resident #85 and Resident #6. Resident #6 had multiple occurrences of cursing, yelling, throwing things, threatening other residents, and publicly masturbating in front of other residents. These incidents were not investigated. Resident #85 had physical or verbal altercations with other residents and the incidents were not investigated. One of the physical altercations with Resident #85 caused Resident #8 to fall, and Resident #8 sustained a hip fracture. Resident #83 had injuries of unknown origin, including bruising and a hip fracture, that were not thoroughly investigated. It was determined the facility's non-compliance with one or more requirements of participation caused, or was likely to cause, serious injury,	F 610	1.Resident #85 was reported to push Resident #8 resulting in a fractured femur. The incident was reported on 08/26/21 and the follow up investigation finalized and reported 08/27/21. Resident #6 was reported to have exposed himself in a group activity on 08/14/21. This event reported to OIG 08/27/21 and investigation and follow up were submitted 8/28/21. 2. All residents with BIMs of 8 or above were interviewed by social services on 8-25-2021 and 8-26-2021 to ensure there were no concerns of safety, or feelings of abuse while in this facility. None were noted. MDS nurse and SS assistant reviewed residents with BIMS of 7 and below for any signs of change in baseline mood or behavior and normal daily routine. No changes or concerns were identified.	

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F 610	Continued From page 44 harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.12 (Freedom from Abuse, Neglect, and Exploitation) at a scope and severity of "K." The Immediate Jeopardy (IJ) began on 04/01/2021 when Resident #6 was yelling and cursing at another resident and the facility failed to investigate the allegation of verbal abuse. The Director of Nursing (DON) and Nursing Home Administrator (NHA) were notified of the IJ and provided with the IJ Template on 08/26/2021 at 12:00 PM. A Removal Plan was requested. The Removal Plan was accepted by the State Survey Agency on 08/27/2021 at 6:00 PM. The IJ was removed on 08/27/2021 at 6:00 PM after the survey team performed onsite verification that the Removal Plans had been implemented. Noncompliance remained at the lower scope and severity of pattern, no actual harm with potential for more than minimal harm that was not immediate jeopardy. The findings included: Review of the facility's The Abuse Prevention Program reviewed September 2020 indicated under Paragraph #7 that allegations of abuse would be investigated and reported within the timeframes required by federal requirements. A review of the facility's policy, titled, "Abuse and Neglect - Clinical Protocol," revised July 2017, revealed abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also included the deprivation by an individual, including a caretaker,	F 610	3. Administrator, Director of Nursing, Unit Managers, Assistant Director of Nursing, MDS, Business office, Payroll, Activities, Maintenance, Therapy, Scheduling were educated per regional director of Clinical services on 8-26-2021 at 2:15 pm on What is abuse, how to prevent abuse and neglect, when to report abuse and neglect, and to report all abuse to the LNHA immediately. The licensed Nursing Home Administrator will make the initial report to the Office of the Inspector General, Department of Community Based Services, the State Ombudsman and Local Ombudsman, the responsible parties and the MD or Nurse practitioner within two hours. Director of Nursing, and administrator, and or regional director of clinical services have educated all staff on the following on 8/26/21: " Identify types of Abuse and Neglect. " When to report suspected abuse and neglect " Reporting of abuse and neglect directly to the administrator immediately Facility Nursing administration reviews all nursing notes and trigger word alerts daily in morning clinical meeting to ensure all documented incidents and behaviors are addressed by Director of nursing, assistant director of nursing or unit managers. Weekend Manager and Director of nursing reviews nursing notes every weekend. Interdisciplinary team reviews weekly Clinically at-risk meeting to ensure new interventions are effective and care plans are updated. Review nursing notes for trigger words daily to	

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F 610	Continued From page 45 of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well-being. The management and staff, with the support of the physicians, will address situations of suspected or identified abuse and report them in a timely manner to appropriate agencies, consistent with applicable laws and regulations. 1. Record review revealed the facility admitted Resident #6 with diagnoses of dementia with behavioral disturbances and schizophrenia. The Quarterly Minimum Data Set dated 05/19/2021 indicated Resident #6's cognition was severely impaired with Brief Interview for Mental Score (BIMS) of three (3) out of fifteen (15). Review of a Progress Note, dated 04/01/2021, indicated Resident #6 was cursing and yelling at another resident. There was no evidence provided that showed this was investigated. Review of a Progress Note, dated 04/03/2021, revealed Resident #6 was cursing other residents and making multiple verbal threats. There was no evidence provided that showed this was investigated. Review of a Progress Note, dated 04/04/2021 at 5:20 PM, indicated Resident #6 was extremely agitated and yelling at other residents. There was no evidence provided that showed this was investigated. Review of a Progress Note, dated 04/09/2021 at 10:04 AM, indicated Resident #6 was verbally aggressive with other residents, threatening harm, and cursing. There was no evidence provided that showed this was investigated.	F 610	identify events that occurred throughout the day. Any triggers reported to the Administrator immediately and licensed Nursing Home Administrator will make the initial report to the Office of the Inspector General, Department of Community Based Services, the State Ombudsman and Local Ombudsman, the responsible parties and the physician or Nurse practitioner within two hours. Behaviors affecting others addressed immediately as appropriate, residents with noted behaviors will be referred to psych services. Interviews will be conducted with the alleged victim representative, perpetrator, witness, practitioner, outside agencies as needed. The facility will conduct a record review for pertinent information such as progress notes, social services notes, physician, therapist and consultant notes, financial records, incident reports, reports from hospital, lab or x ray, medication records and any other agencies as deemed necessary to complete a thorough investigation. 4. All alleged abuse, neglect or exploitation allegations will be monitored and recorded on a reportable event log for tracking purposes. The Abuse Quality Assurance and Performance Improvement tool and the reportable events logs will be completed monthly by the administrator. Events audited weekly x 3 months and then quarterly x 12 months. Any concerns documented, corrected immediately, and staff will be educated accordingly. Findings/trends will be reported at the monthly quality	

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F 610	Continued From page 46 Review of a Progress Note, dated 04/13/2021 at 7:50 AM, indicated Resident #6 was cursing and threatening to harm other residents. There was no evidence provided that showed this was investigated. Review of a Progress Note, dated 04/16/2021, indicated Resident #6 was yelling and cursing at other residents, and the facility had the Director of Nursing come back to the unit. There was no evidence provided that showed this was investigated. Review of a Progress Note, dated 04/18/2021, indicated Resident #6 was yelling, throwing stuff, and cussing at other residents. There was no evidence provided that showed this was investigated. Review of a Progress Note, dated 04/30/2021, indicated Resident #6 was publicly masturbating during an activity. There was no evidence provided that showed this was investigated. Review of a Progress Note, dated 05/08/2021, indicated Resident #6 was yelling and cussing at other residents. There was no evidence provided that showed this was investigated. Review of a Progress Note, dated 05/29/2021, indicated Resident #6 had been cursing, yelling, and threatening other residents. There was no evidence provided that showed this was investigated. Review of a Progress Note, dated 06/05/2021, indicated Resident #6 was verbally aggressive with another resident. There was no evidence provided that showed this was investigated.	F 610	assurance and performance improvement committee by the Director of Nursing or designee for a minimum of six months for review and recommendations. Quality Assurance and Performance Improvement meetings were held weekly for four weeks and then monthly thereafter to ensure continued compliance.	

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Review of a Progress Note, dated 06/14/2021, indicated Resident #6 had been cursing and yelling at other residents and throwing items in the resident's room. There was no evidence provided that showed this was investigated.

Review of a Physician's Progress Note, dated 06/16/2021, indicated Resident #6 was noted to have the potential to harm staff, other residents, or self.

Review of a Physician's Progress Note, dated 06/17/2021, indicated Resident #6 had a long history with physical aggression related to schizoaffective bipolar disorder.

Review of a Progress Note, dated 06/29/2021, indicated Resident #6 was threatening to hit, was cursing, and was being verbally aggressive with other residents. There was no evidence provided that showed this was investigated.

Review of a Progress Note, dated 07/27/2021, indicated Resident #6 was cursing and threatening to hit other residents. There was no evidence provided that showed this was investigated.

Review of a Progress Note, dated 08/11/2021, indicated Resident #6 was being verbally aggressive with other residents and was threatening to harm other residents. There was no evidence provided that showed this was investigated.

Review of a Progress Note, dated 08/14/2021, indicated Resident #6 had exposed himself/herself and touched self inappropriately in

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front of other residents during an activity. The DON had come to the unit to talk to the resident regarding behaviors. There was no evidence provided that showed this was investigated.

Review of a Physician's Progress Note, dated 08/18/2021 at 12:00 PM, indicated Resident #6 was verbally and physically aggressive, was throwing things, trying to break things, slamming the walker, and yelling and cursing. Haldol 2.5 mg (milligrams) was given.

During an interview on 08/24/2021 at 3:15 PM, Licensed Practical Nurse (LPN) #3 indicated Resident #6 threatened to kill other residents, and it was "just a matter of time" before the resident hurt another resident. She indicated the facility's administration was aware of Resident #6's aggressive physical and verbal behaviors.

During an interview on 08/24/2021 at 2:16 PM, Resident #54 indicated Resident #6 had kicked Resident #54 in the leg with three (3) staff members present who witnessed the incident.

During an interview on 08/24/2021 at 3:30 PM, the Activity Assistant (AA) indicated she had witnessed Resident #6 kick Resident #54.

During an interview on 08/26/2021 at 12:15 PM, the AA indicated Resident #6 exposed self to two (2) female residents during an airshow while outside in the courtyard.

During an interview on 08/26/2021 at 12:20 PM, Resident #58 indicated Resident #6 had exposed self to Resident #58 during the airshow, and that it made the resident feel uncomfortable, "wondering what [Resident #58] did to provoke

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this."

During an interview on 08/26/2021 at 12:30 PM, Resident #87 indicated Resident #6 had their genitals in his/her hand and was exposing self to Resident #58. Resident #87 indicated (gender) felt "bad" for Resident #58.

There were no investigations completed for these verbal, physical, or sexual abuse allegations.

During an interview on 08/25/2021 at 2:23 PM, the DON indicated allegations of abuse were to be reported to their immediate supervisor, and it would then be reported to the DON or Nursing Home Administrator (NHA). The DON stated she was not aware of the allegations of physical, verbal, and sexual abuse. The DON indicated she would report verbal allegations of abuse depending on how the other residents felt. She indicated the incident of Resident #6 exposing self during an activity should have been reported.

2. Review of the facility's Abuse Prevention Program, under Paragraph #7, revealed that allegations of abuse would be investigated and reported within the timeframes required by federal requirements.

Record review revealed the facility admitted Resident #85 on 01/27/2020 with diagnoses that included schizoaffective disorder, vascular dementia with behaviors, anxiety disorder, early onset Alzheimer's, and depression.

Review of the Quarterly Minimum Data Set (MDS), dated 07/30/2021, indicated the facility assessed Resident #85 as moderately cognitively

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impaired with a Brief Interview for Mental Status (BIMS) score of nine (9) out of fifteen (15). Physical behaviors occurred one (1) to three (3) days during the assessment period, other behaviors not directed toward others were documented as occurring one (1) to three (3) days, and rejection of care one (1) to three (3) days. No verbal behaviors were identified as occurring during the assessment period.

Review of the Nurse's Progress Notes and/or incident reports indicated Resident #85 had physical or verbal altercations with other residents on the following days: 06/13/2021, 07/09/2021, 07/24/2021, 08/21/2021 and 08/22/202; however, there was no documented evidence the incidents were investigated by the facility.

Record review revealed that on 08/21/2021 at 2:40 PM, Licensed Practical Nurse (LPN) #6 documented she observed Resident #85 grab Resident #35 by the shirt. Resident #35 attempted to pull away, and Resident #85 pulled Resident #35 closer. When Resident #85 let go of Resident #35's shirt, Resident #35 fell to the floor. Resident #35 sustained no apparent injury.

Certified Nursing Assistant (CNA) #1 was interviewed on 08/25/2021 at 9:16 AM. CNA #1 stated at the present time, Resident #85 was on a special observation schedule of every 15 minutes due to an incident over the weekend. CNA #1 stated she had worked the weekend and stated on Saturday, 08/21/2021, Resident #85 had pushed Resident #35 down in the living area. The CNA stated Resident #85 had grabbed Resident #35 by the shirt, and. then as Resident #35 tried to get away, Resident #85 let go of the shirt causing Resident #35 to fall. The CNA stated

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Resident #85 had been taken to the room and remained in the room until dinner. No special monitoring had been placed for Resident #85. The CNA stated 15-minute checks had not started until 08/22/2021 when Resident #85 pushed Resident #8 down, resulting in a fracture for Resident #8.

CNA #2 was interviewed on 08/25/2021 at 10:19 AM. She stated she had worked in the secure unit on Saturday 08/21/2021. Further interview revealed around 1:00-1:30 PM, Resident #85 had a hold on Resident #35's shirt. When Resident #85 let go, Resident #35 fell, but there was no apparent injury. The CNA stated staff took Resident #85 to the bedroom for rest. CNA #2 stated she also worked on Sunday 08/22/2021. The CNA stated after breakfast (10:30 AM) she was at the nurse's station and heard Resident #85 making sounds. When she looked up, she saw Resident #85 push Resident #8 and saw Resident #8 fall. At that time, 15-minute checks were started for Resident #85.

Licensed Practical Nurse (LPN) #6 was interviewed on 08/25/2021 at 11:43 AM. She stated on 08/21/2021 she had been sitting at the nurse's station when she heard a CNA yell Resident #85's name. LPN #6 added Resident #85 was pulling Resident #35 close by grabbing Resident #35's clothing. When Resident #85 let go of Resident #35, Resident #35 fell to the floor. LPN #6 stated Resident #85 was put to bed and stayed in the room until dinner. Staff was not assigned to monitor Resident #85, adding that if another resident had wandered into the room, staff would have to have waited to see if anything happened. The nurse stated the incidents had been reported to the weekend supervisor.

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During the survey, the weekend supervisor was supposed to come in for an interview, but she did not. Follow up phone calls made to the weekend supervisor were not answered.

The DON was interviewed on 08/25/2021 at 2:26 PM. The DON stated she had not investigated the incident that occurred on 08/21/2021. She had not read the Nurse's Notes regarding the incident nor talked to any staff involved based on the report received from the weekend supervisor. The DON stated the incident was investigated by the weekend supervisor. Requests were made several times for investigative information related to the 08/21/2021 incident. No information was provided. The DON reviewed the Nurse's Progress Notes and incident reports from other physically aggressive incidents involving Resident #85 and other residents. She stated she would look for any investigations and if found would return them to the Surveyors for review. No investigations were provided. When the DON reviewed the SBARs or the incident reports for the other incidents, she was unable to provide documentation of investigation.

3a. Record review revealed Resident #83 was admitted on 10/16/2019 with diagnoses including cerebral palsy, chronic obstructive pulmonary disease, contractures, dysphagia, paranoid schizophrenia, abnormal posture, neuromuscular dysfunction of the bladder, muscle weakness, type 2 diabetes, need for assistance with personal care, mild cognitive impairment, major depressive disorder, anxiety disorder, and intermittent explosive disorder.

A review of the Significant Change Minimum Data

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Set for Resident #83 dated 07/27/2021 indicated that Resident #83 had a Brief Interview for Mental Status (BIMS) score of zero (00) out of fifteen (15), indicating significant cognitive impairment. Resident #83 required extensive assistance of two (2) persons with bed mobility, dressing, and toileting. Resident #83 required limited assistance of one person with eating. The resident was totally dependent on staff for bathing.

A review of a Progress Note dated 07/20/2021 at 1:05 PM revealed, "CNAs [Certified Nurse Aide] asked this nurse to come to room to look at resident. When this nurse went in the room the CNA's [sic] showed me that the resident had some yellow bruising to [the resident's] right inner thigh that wrapped around to the front and back of [the] thigh, 3 small open areas to [the] scrotum, and some discoloration spots to [the] right outer foot."

An interview on 08/26/2021 at 12:48 PM, with the Director of Nursing (DON) revealed that when staff reported observing significant bruising on Resident #83's thigh on 07/20/2021, the Assistant Director of Nursing (ADON) talked to the staff about their observations. The DON stated that after the ADON spoke to staff, it was determined that CNA staff probably accidentally caused the bruising while providing care. The DON stated that due to the resident's contractures, staff must hold the resident's thighs apart while providing incontinent care. The DON acknowledged there was no documentation of those conversations or determination of the cause. The DON stated she did not ask the ADON for any documentation related to her findings, but there was education provided to the staff. The DON further stated that the nurse practitioner (NP) was made aware, and

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that she followed up on it. During the interview, the DON reviewed the progress notes and verified the NP did not document anywhere that there was ever any follow up on the bruising when she saw the resident on 07/20/2021. When asked if she would expect staff to document that injuries of an unknown origin are followed up on, the DON stated she would expect nurses to act according to their license and document accordingly.

An interview on 08/26/2021 at 12:48 PM with the Nursing Home Administrator (NHA) revealed that when the bruise on Resident #83 was reported by the CNA staff, the ADON talked to staff about the bruise. The NHA stated she did not follow up with the ADON to see if she documented anything in relation to her investigation. The NHA stated there was no documentation that an investigation into how the bruising occurred was completed.

An interview on 08/26/2021 at 1:38 PM with the ADON revealed she was on E Hall on 07/20/2021 when staff observed bruising to Resident #83's thigh and staff informed the DON and NP. The ADON stated she looked at the resident's thigh and confirmed bruising and assumed it occurred when CNAs were providing perineal care. The ADON stated staff would use the bend of their arms to open the resident's legs in order to clean the resident's groin and thigh area, and that may have caused the bruising. The ADON stated there was no documentation that staff were interviewed about the bruising. The ADON stated at that time, the ADON provided information to staff on proper perineal care and did education, but there was no documentation in relation to the education and that no staff signed that they attended. The ADON stated it was very informal, and she did

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not document anything in the electronic medical record because the NP was aware. The ADON stated she assumed the NP was documenting about it. The ADON was unaware that the NP never mentioned or documented anything in relation to the bruising on the resident's thigh but confirmed she never checked to make sure there was documentation.

3b. Review of Resident #83's Progress Note dated 07/23/2021 at 5:46 PM, revealed, "ER nurse called to inform of acute right hip fracture, unknown cause at this time, DON aware." [The resident had been sent out for a possible bowel obstruction. During the computer tomography (CT) scan for this, the fracture was found.]

An interview on 08/25/2021 at 12:00 PM, with the Director of Nursing (DON) revealed she was aware that the hospital reported on 07/23/2021 that Resident #83 had an acute right hip fracture. The hospital did additional testing, and it was ruled as a chronic condition and not a new acute injury. The DON stated she would get the hospital records and provide those to the Surveyor. The DON also stated she was not sure why there was not any documentation in the Progress notes related to the follow-up or outcome of the final diagnosis.

Review of the "Imaging" dated 07/24/2021 of the CT Cystogram per contrast protocol revealed Resident #83 had a comminuted and impacted fracture in the proximal right femur in the sub-capital region. Further review revealed the assessment was right femoral neck fracture of undetermined age.

An interview on 08/26/2021 at 12:48 PM with the

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DON revealed she did not feel Resident #83's fracture was an injury of unknown origin and therefore it did not need to be investigated. The DON stated they received a report on 07/24/2021 from urology and from the CT scan, and that there were two different findings, but she did not follow up with either urology or with the hospital about the CT scan to verify both results. The DON stated she never contacted urology to ask how they made their determination that it "appears" to be a chronic since the CT scan contradicted the urology report stating there was a comminuted and impacted fracture in the right femur of undetermined age. The DON stated the facility never initiated an investigation into how the fracture occurred or interviewed any staff in relation to the fracture. The DON stated she felt the fracture was also a result of how the bruising was determined to have been caused due to staff separating the resident's legs during care.

The facility's Removal Plan included:

1. Resident #85 was reported to push Resident #8 resulting in a fractured femur. The incident was reported on 08/26/21 and the follow up investigation finalized and reported 08/27/21. Resident #6 was reported to have exposed [himself/herself] in a group activity on 08/14/21. This event reported to OIG [Office of Inspector General] 08/27/21.

Investigations going forward will include:

- Conducted observations of the alleged victim, identification of any injuries as appropriate, location where the situation occurred, interaction and relationships between staff and other residents.

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- Interviews conducted with the alleged victim representative, perpetrator, witness, practitioner, outside agencies as needed. The facility conducted a record review for pertinent information such as progress notes, social services notes, physician, therapist and consultant notes, financial records, incident reports, reports from hospital, lab or x ray, medication records and any other agencies as deemed necessary.

- Depending on the nature of the allegation, the facility has put effective measures in place to ensure that further abuse, neglect or exploitation or mistreatment does not occur while the investigation is in progress. The facility will monitor the alleged victim and monitor the other residents at risk, by conducting management visits at different times and shifts. The facility evaluated if the alleged victim felt safe. If they do not, immediate action will be taken to alleviate fear, i.e. room relocation, increased supervision, etc., immediate notification of the victim's practitioner and the family or the victims responsible party. The facility oversees the implementation of corrective action and evaluates effectiveness through the QAPI process. All alleged abuse, neglect or exploitation monitored and recorded on a reportable event log.

2. All residents with BIMs of 8 or above were interviewed by Social Services on 08-25-2021 and 08-26-2021 to ensure there were no concerns of safety, or feelings of abuse while in this facility. None were noted. MOS nurse and SS assistant reviewed residents with BIMS of 7 and below for any signs of change in baseline mood or behavior and normal daily routine. No changes

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F 610	Continued From page 58 or concerns were identified. 3. LNHA, DON, Unit Managers, ADON, MOS, Business office, Payroll, Activities, Maintenance, Therapy, Scheduling were educated per regional director of Clinical services on 8-26-2021 at 2:15 PM on What is abuse, how to prevent abuse and neglect, when to report abuse and neglect, and to report all abuse to the LNHA immediately. The licensed Nursing Home Administrator will make the initial report to the Office of the Inspector General, Department of Community Based Services, the State Ombudsman and Local Ombudsman, the responsible parties and the MD or Nurse practitioner within two hours. 4. IDT meeting held 8-27-2021; behaviors reviewed to ensure all residents that have behaviors affecting others have interventions and care plans in place. All interventions and care plans were communicated to floor staff by way of the Kardex. Education on this provided by DON on 8-27-2021. Referrals were made to psychiatric services as appropriate by Social services assistant. DON, and LNHA, and or designee educated all staff on the following: - Identify types of Abuse and Neglect. - When to report suspected abuse and neglect - Reporting of abuse and neglect directly to the administrator immediately - This education completed by 8/27/2021 - In addition, a list of all staff has been developed and no persons will be allowed to work without having completed this education prior to assuming the floor.	F 610		

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F 610	Continued From page 59 1. Facility system changes: i. Behavior monitoring to TAR to be completed every shift. By the RN ii. Facility has reviewed TAR daily in morning clinical meeting. Reviewed 8-27-2021 by DONs iii. Weekend Manager reviews TAR every weekend. iv. IDT team reviews weekly TAR meeting to ensure new interventions were effective and care plans were updated. Review nursing notes for trigger words daily to identify events that occurred throughout the day. Any triggers reported to the Administrator immediately and the licensed Nursing Home Administrator will make the initial report to the Office of the Inspector General (State Survey Agency), Department of Community Based Services, the State Ombudsman and Local Ombudsman, the responsible parties and the MD or Nurse practitioner within two hours. v. Behaviors affecting others addressed immediately as appropriate, residents with noted behaviors will be referred to psych services. DON, LNHA, and or designee audited: i. The Abuse QAPI tool and the reportable events logs completed monthly by the LNHA. Events audited weekly x 3 months and then quarterly x 12 months. Any concerns documented, corrected immediately, and staff will be educated accordingly. ii. Findings/trends reported at the monthly quality assurance and performance improvement committee by the Director of Nursing or designee for a minimum of six months. iii. QAPI meetings weekly for four weeks to monitor progress and then monthly thereafter." The IJ was removed on 08/27/2021 at 6:00 PM	F 610		

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after the survey team performed onsite verification that the Removal Plans had been implemented.

Onsite verification of the implementation of the Removal Plan was conducted during the survey. On 08/27/2021 between the hours of 11:00 AM and 6:00 PM. Review of the educational materials indicated 100% of staff to include all departments had been completed on 08/26/2021.

1. Resident #85 was reported to push Resident #8 resulting in a fractured femur. The incident was reported on 08/26/2021 and the follow up investigation finalized and reported 08/27/2021. Resident #6 was reported to have exposed [himself/herself] in a group activity on 08/14/2021. This event was reported to OIG on 08/27/2021.

2. Surveyors verified 54 Residents with BIMS 8 or above were interviewed and indicated they felt safe.

3. Review of the educational materials indicated 100% of staff to include all departments had been completed on 08/26/2021. Twelve interviews were conducted on 08/27/2021 between the hours of 11:00 AM - 6:00 PM to verify in-service training had been completed on the facility's Abuse Policy and Procedure training to include the types of abuse, what to report, to whom to report the allegations of abuse and when to report. Of those interviewed included certified nursing assistants (CNAs), licensed practical nurses (LPNs), registered nurses (RNs), housekeeping and scheduling staff. The staff interviewed revealed knowledge of what constituted abuse, what to do if abuse was observed, both staff to resident abuse and in the event of resident-to-resident

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F 610	Continued From page 61 abuse, when to report abuse and to whom the abuse should be reported. The interviews revealed a consistent message that staff understood not only the different types of abuse, but that resident-to-resident altercations also constituted abuse. Staff indicated that through training they understood the need to intercede immediately and to always protect the resident before reporting any incident of abuse to the Administrator. Staff also acknowledged that have assuring resident safety, abuse should be reported immediately. The LNHA, DON, unit managers, ADON, MDS, business office, payroll department, activities, maintenance, therapy, scheduling received education on what constitutes abuse and when to report. 4. Observations during the survey revealed Resident #85 was receiving 1:1 supervision. Record review for Resident #85 indicated the care plan had been revised to include exhibited physical behaviors and stealing food from other resident's trays. Interventions for Resident #85 included 1:1 supervision, psychiatric referral, laboratory testing and a care conference with family members to determine the resident's past interest. Resident #6 had been placed on every 15-minute checks, and the care plan had been updated on measures to address behaviors, and an IDT meeting was held on 08/27/2021. Resident #6 was seen by psych services on 08/25/2021.	F 610		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a	F 625		11/5/21

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	185236	A. BUILDING _____ B. WING _____	08/27/2021

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F 625	Continued From page 62 nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and facility policy review, it was determined the facility failed to ensure one (1) of five (5) sampled residents (Resident #42) reviewed for hospitalizations received a bed-hold notice. Staff failed to ensure a bed-hold notice was provided to Resident #42 or the resident's representative prior to the hospitalization on 08/18/2021. The findings included: Review of the facility's policy titled, "Bed Hold,"	F 625	1. A review of the bed hold policy was completed with Resident # 42's family on 10/14/21. 2. Residents sent out of facility since 8/27/21 were reviewed to ensure bed hold policy was presented to the resident or their responsible party timely. 3. The bed hold policy added to the transfer paperwork to be sent with all transfers in the PCC documentation system. Licensed nurse educated completed by 11/4/21 and the business	

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F 625	Continued From page 63 not dated, revealed that prior to transfer, written information would be given to the residents and the residents' representatives that explained in detail: a.) the rights and limitations of the resident regarding bed holds; b.) the reserve bed payment policy as indicated by the state plan (Medicaid residents); c.) the facility's per diem rate required to hold a bed (non-Medicaid residents) or to hold a bed beyond the state bed-hold period (Medicaid residents); and d.) the details of the transfer (per the Notice of Transfer). Record review revealed the facility admitted Resident #42, on 05/24/2021, with a recent hospitalization on 08/18/2021 with diagnoses that included Type 2 Diabetes Mellitus, Depression, Anemia, Anxiety, and Hypercholesterolemia. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 07/02/2021, revealed the facility assessed Resident #42's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of four (4) out of fifteen (15). The resident was not interviewable. Record review revealed a bed-hold notice was provided to Resident #42 for the hospitalizations on 06/10/2021 and 07/16/2021. These were signed by the resident. However, there was no bed-hold notice for the hospitalization on 08/18/2021. Interview with the Business Office Manager (BOM), on 08/24/2021 at 1:24 PM, revealed the facility had not completed a bed-hold notification for Resident #42. An interview with the Director of Nurses (DON), on 08/24/2021 at 1:47 PM, revealed the nurse on	F 625	office manager was re-educated on the necessity of reviewing the bed hold policy with family or responsible parties for all transfers by the administrator on 10/25/21 4. The facility administrator will review each transfer for 3 months to ensure that the bed hold information is presented per facility policy. The administrator will present the results of this review monthly to the facility Quality Assurance and Performance Improvement committee for review and recommendation to ensure continued compliance.	

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F 625	Continued From page 64 the floor was supposed to ensure all the necessary paperwork was completed prior to transfers. She stated there was a red folder at the nurses' station that had all the paperwork. The DON stated they used agency staff, and that could have been how it was missed. An interview with the DON, on 08/26/2021 at 9:23 AM, revealed she did not know why the bed-hold notice was not completed for this resident. An interview with the Nursing Home Administrator (NHA), on 08/26/2021 at 9:39 AM, revealed the bed-hold notice should have been completed at the time of the transfer, and the BOM was the staff who followed up on them the next day.	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		11/5/21

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F 656	Continued From page 65 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record	F 656	1. The care plan interventions for	

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F 656	Continued From page 66	F 656		

review, and facility policy review, it was determined the facility failed to implement fall care plan interventions for bed wedges for one (1) of three (3) sampled residents (Resident #3)reviewed for falls. The facility failed to develop a care plan for physical behaviors for one (1) of six (6) residents reviewed for behaviors (Resident #85).

The findings included:

Review of the facility's policy titled, "Care Plans, Comprehensive Person-Centered," revised December 2016, revealed: A comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident. The comprehensive care plan would describe the services that were furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. Per the policy, the care plan would incorporate identified problem areas and incorporate risk factors associated with identified problems.

Record review revealed the facility admitted Resident #3 on 02/09/2019 with diagnoses that included Parkinson's Disease, repeated Falls, Muscle Weakness, Anxiety Disorder, Hyperlipidemia, Major Depressive Disorder, Cognitive Communication Deficit, Weakness, Abnormalities of Gait and Mobility, and Unsteadiness on Feet.

Review of the Quarterly Minimum Data Set (MDS) Assessment for Resident #3, dated 05/18/2021, revealed the facility assessed Resident #3 to have a Brief Interview for Mental

wedges for fall prevention were implemented on 8/27/21 for resident #3. A care plan for physical behaviors was developed for resident #85 on 8/26/21.

2. Care plans for residents at risk for falls were reviewed and all interventions are in place. Records for residents with physical behaviors were reviewed and care plans are in place for those residents.

3. Licensed nurses retrained on the facility policy for care plan implementation by the Director of nursing and Director of Clinical services by 11/4/21. The social services staff retrained on the facility policy for behavior care planning by the Director of nursing and Director of Clinical services by 11/4/21.

4. A daily observation sheet has been developed the care planned falls interventions are being observed daily. Any changes to fall care plans will be reviewed in the morning leadership meeting so the team knows what intervention should be in place. The Director of Social Services will review the care plans for physical behaviors for each newly identified resident to ensure a care plan is in place. Findings will be reported to the facility Quality Assurance and Performance Improvement committee monthly for review and recommendation to ensure continued compliance.

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Status (BIMS) score of eleven (11) out of fifteen (15), indicating no cognitive impairment. Resident #3 required limited assistance of two (2) persons with bed mobility, transfer, dressing, and toileting. The resident was totally dependent on staff for bathing.

Review of a Progress Note, dated 08/03/2021 at 4:15 PM, revealed Resident #3 was sitting on the mat next to bed. The resident stated [they] slid onto the mat because the bed was small. Per the note, the resident tends to sleep sideways most of the time. Continued review of the note revealed updated care plan to place wedges on bilateral sides of the bed to help stabilize theresident while sleeping. Per the note, the intervention were effective and the resident stated [he/she] was sleeping more comfortably. Further review of the note, the resident refused to keep non-skid socks on with three (3) staff attempts, fall mats on bilateral sides of bed, fluids and bedside table within reach and the call light within reach. There were no signs or symptoms or complaints of pain or discomfort noted. Safety measures were maintained.

Review of Resident #3's care plan for falls, initiated on 02/22/2021, revealed an intervention added on 08/03/2021 for wedges on bilateral sides of the bed.

An observation of Resident #3, on 08/23/2021 at 10:59 AM, revealed the resident lying in bed with fall mats on both sides of the bed and grab bars in the up position; however, no wedges were observed in the bed with the resident.

An observation of Resident #3, on 08/24/2021 at 2:20 PM, revealed the resident in bed with grab

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F 656	Continued From page 68	F 656		

bars in the up position, fall mats to both sides of the bed, and no wedges in the bed.

An observation of Resident #3, on 08/25/2021 at 1:07 PM, revealed the resident in bed with grab bars in the up position and fall mats to both sides of the bed, but no wedges in the bed.

An interview on 08/26/2021 at 10:40 AM, with Certified Nurse Aide (CNA) #5, revealed she had checked on Resident #3 three (3) times that morning. The CNA stated staff could access the resident's care plan to see what type of interventions were in place. CNA #5 stated she checked the care plan daily. Continued interview revealed CNA #5 stated Resident #3 had a bed in the lower position and fall mats. The CNA stated she was aware Resident #3 should have wedges. However, she stated she puts pillows under the resident sometimes. CNA #5 stated it was not her place to decide to use pillows instead of the wedges that the resident was care planned to have. CNA #5 stated she did not request wedges that morning from therapy when she observed that Resident #3 did not have them. She stated she did not report it to any nurse or supervisor.

An interview on 08/26/2021 at 11:42 AM, with CNA #7, revealed Resident #3 did not have a wedge or anything, so staff put pillows under the resident at times. CNA #7 stated she looked at the care plans daily when she charted. CNA #7 stated the last time she looked at Resident #3's care plan was on Sunday 08/22/2021. CNA #7 stated there were currently no wedges available in the facility for Resident #3. Continued interview revealed the lack of wedges was reported to nursing staff about a week ago, but she was not sure of who specifically it was reported to.

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An interview on 08/26/2021 at 1:25 PM, with the Director of Nursing (DON), revealed she was unaware why the care plan was not being implemented related to wedges for Resident #3 as the care plan was updated for the resident to have bilateral wedges in bed on 08/03/2021. The DON stated she was unaware that staff stated there were not any wedges available in the building for residents. She stated she expected staff to implement and ensure interventions were in place and in use after they had been identified and the care plan was updated. The DON stated it was ultimately her responsibility, along with the clinical team, to ensure care plans were implemented. Continued interview revealed they currently had a partner program with department managers in place. The DON stated that department managers walked around at least once weekly to check on residents and ensure all things such as current interventions were in place. The DON stated it was supposed to be completed weekly, but the DON was unsure of when it was completed last, and there was no documentation related to this.

On 08/26/2021 at 1:40 PM, an observation of the linen closet with the DON revealed that wedges were stored in there, but there were none currently on the shelves. The DON stated there should be some around in the building.

2. Resident #85 was initially admitted by the facility on 01/27/2020 and re-admitted on 04/22/2021 with diagnoses that included Schizoaffective Disorder, Vascular Dementia with Behaviors, early onset Alzheimer's Disease, Anxiety, and Depression.

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F 656	Continued From page 70 A review of Resident #85's Quarterly Minimum Data Set (MDS) Assessment, dated 07/30/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of nine (9) out of fifteen (15), indicating moderately impaired cognition. The resident's behaviors included physical aggression toward others. Review of Resident #85's hospital discharge summary, dated 01/11/2020, revealed the resident had been admitted to a geriatric behavior unit, on 01/11/2020, from a nursing home due to increasingly aggressive behaviors and altercations with two (2) different residents in two (2) days. A review of the nurse's progress notes and/or incident reports indicated Resident #85 had physical or verbal altercations with residents on 05/05/2021, 06/13/2021, 07/07/2021, 07/09/2021, 07/24/2021, 08/21/2021 and 08/22/2021. Review of Resident #85's care plan, with a start date of 08/23/2021, addressed the resident's verbal aggression. There was not a care plan that addressed Resident #85's physically aggressive behaviors directed toward other residents. Interview with the Director of Nursing (DON), on 08/25/2021 at 2:26 PM, revealed Resident #85's physical behaviors should have been care planned. The DON reviewed the care plan for Resident #85 and confirmed physically aggressive behaviors had not been addressed.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		11/5/21

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F 677	Continued From page 71 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, and review of the facility's policies, it was determined the facility failed to provide nail care and failed to shave one (1) of four (4) dependent residents (Resident #46) from the sampled residents reviewed for activities of daily living (ADLs). The findings included: Review of the facility's policy on Care of Fingernails/Toenails, revised 2010, indicated the purpose of the policy was to clean the nail bed, to keep the nails trimmed, and to prevent infection. Under General Guidelines, the policy nail care included daily cleaning and regular trimming. Documentation including the date and time nail care was provided, the name of the person who administered nail care, and documentation of refusal with the intervention(s) attempted. Review of the facility's policy, titled Shaving the Resident, revised 2010, indicated the purpose was to promote cleanliness and to provide skin care. After shave documentation should include the time and date of the shave along with the name of the person that provided the shave. Directions included notifying the supervisor of any refusals. Record review revealed Resident #46 was initially	F 677	F677 1. Resident # 46 was shaved, and nails were trimmed on 8/27/2021 2. All residents were observed for shaving needs and nail care needs. Both performed as needed and as allowed per resident on 8/30/2021. 3. A Resident Observation round tool was created by the Administrator and initiated 10/20/2021 to include resident shaving and nail care needs per resident preference. All irregularities will be corrected immediately and reported to the administrative team in the next morning administrative meeting to allow further intervention by social services if resident refuses shaving and nail care. The administrative team which includes, the Administrator, Director of Nursing, Assistant Director of nursing, Unit Managers, Staff Development Coordinator, Social Services Director, Human resources Director, Business Office Manager, and MDS Coordinator, and weekend manager will use the tool daily to observe resident shaving and nail care needs per resident preference. All nursing staff will be educated on facility	

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F 677	Continued From page 72 admitted by the facility on 04/28/2019 and re-admitted on 03/29/2021 with diagnoses that included dementia without behaviors, and peripheral vascular disease. Review of Resident #46's Quarterly Minimum Data Set (MDS), dated 07/06/2021, indicated the resident had severe cognitive impairment with a Brief Interview of Mental Status (BIMS) score of four (4) out of fifteen (15). Resident #46 was not identified to have physical or verbal behaviors or rejection of care. The facility assessed Resident #46 to require extensive assistance with bathing and personal hygiene. Review of Resident #46's Comprehensive Care Plan for refusal of care, last revised 05/16/2020, indicated a goal of the resident refusing care less than ten (10) times through the next review. Interventions included providing the resident with opportunities for choice, allowing time for expression of feelings, encouragement, explaining care and the reason for the care and simplifying tasks into simple one step directions. A review of the resident's progress notes from 08/23/2021 through 08/25/2021, revealed no documented evidence Resident #46 refused nail care or shaving. Review of the Behavior Observation sheet from 08/23/2021 through 08/25/2021, revealed one (1) episode of rejection of care on 08/23/2021. Observations of Resident #46, on 08/23/2021 at 12:19 PM, 08/24/2021 at 10:40 AM, 11:10 AM and 3:55 PM, revealed Resident #46's nails were extended over the end of the fingertips and black matter was seen underneath the nails. Continued	F 677	policy and procedure for Activity of Daily Living care by the Regional Director of Clinical Services, Administrator Director of Nursing, Assistant Director of Nursing, or Staff Development Coordinator. Education completed by 11/4/21 4.The issues will be reviewed daily times 2 weeks, weekly times 2 weeks, monthly for 2 months and then quarterly times 9 months by the Administrator, Director of Nursing, Assistant Director of Nursing, or Unit Manager to ensure residents are clean shaven and nails kept clean and trimmed. Results will be reported by the Director of Nursing at the monthly Quality Assurance and Performance Improvement Committee meeting. Any irregularities will be corrected immediately.	

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observations revealed unshaven facial hair was present.

Observation of Resident #46, on 08/25/2021 at 8:55 AM, revealed the resident was sitting in the common area on the unit. The resident's facial hair was long and black matter was seen under long nails. The resident had no socks or shoes on.

Interview with Certified Nursing Assistant (CNA) #1, on 08/25/2021 at 8:58 AM, revealed she had worked on that unit for five (5) months and knew the residents. The CNA stated if residents refused care, she reported the refusal to the nurse for documentation. She added if the resident refused, she would leave the resident and return later and try again to provide the needed care. CNA #1 stated, Resident #46 was dependent on staff for all ADLs including nail care and shaving. She acknowledged the CNA assigned to a given resident was responsible for shaving the resident, cleaning and clipping nails. The CNA added Resident #46 did not refuse care. Per interview, CNA #1 saw Resident #46 and stated the resident needed a shave and the resident's nails needed to be cleaned and clipped.

Interview with CNA #2, on 08/25/2021 at 10:11 AM, revealed she typically worked the unit where Resident #46 lived and was familiar with the resident. Continued interview revealed the resident was dependent on staff for daily care and did not have a history of refusing care.

Interview with the Director of Nursing (DON), on 08/26/2021 at 8:38 AM, revealed she would need to review the facility's policy on nail care and

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F 677	Continued From page 74 shaving residents prior to and questions. Per interview, the DON stated, from a standard of care perspective, shaving should be done with showers. The DON stated she would hope there was no black matter under any residents' nails and added the danger of long nails would be a resident could sustain scratches or skin tears.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review it was determined the facility failed to complete weekly wound assessments for two (2) of two (2) sampled residents (Residents #7 and #25) reviewed for wound assessments and failed to follow physician's orders and utilize pressure	F 686	1. Wound assessments were completed for Residents #7 on 9/3/21 and # 25 on 9/3/21. Pressure reducing interventions were implemented for resident # 7 per physician orders on 8/27/21.	11/5/21

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F 686	Continued From page 75 reducing interventions for one (1) of two (2) sampled residents (Resident #7) reviewed for pressure ulcers. The findings included: Review of the facility's policy titled, Pressure Injuries Overview, revised October 2019, revealed that an avoidable ulcer developed due to one or more of the following not being completed. This list included implementation of interventions that were consistent with the resident's needs, goals, and professional standards of practice. The policy also indicated lack of monitoring, evaluation, or reassessment of the interventions could lead to the development of pressure ulcers. 1. Review of the medical record revealed the facility admitted Resident #7, on 11/21/2018, with diagnoses of Dementia without behaviors, Falls, Generalized Muscle Weakness, Anxiety, and Major Depression. Review of Resident #7's Significant Change in Status Minimum Data Set (MDS) Assessment, dated 05/20/2021, revealed Resident #7 had both short- and long-term memory impairment. Behaviors occurring during the assessment period included physical behaviors, verbal behaviors, and rejection of care. The resident was identified as requiring the extensive assistance with bed mobility, eating and personal hygiene. Per the MDS, Resident #7 had a pressure ulcer over a bony prominence, and was at risk of developing additional pressure ulcers. The assessment indicated the existing pressure ulcer was an unstageable wound described as a deep tissue injury (DTI). While nutritional and hydration interventions were not identified as	F 686	2. Other residents with pressure ulcers were reviewed and assessments and interventions are in place for each resident. Vora Wound care physician all residents with wounds on 8/20/21 and began routinely monitoring wounds and making recommendations as needed. 3. Licensed nurses retrained on the facility policy for wound assessments and following physician orders for pressure reduction devices by the Director of Nursing, Assistant Director of Nursing and Regional Clinical director completed. Leadership team was trained on identifying pressure relieving devices by the Director of Nursing, Assistant Director of Nursing and Regional Clinical director completed. Education completed by 11/4/21. 4. A daily observation round sheet has been implemented and the leadership team will review each person daily to ensure the physician ordered interventions are in place. The Director of nursing or the assistant director of nursing will review each resident with wounds daily times 2 weeks, weekly times 2 weeks, monthly times 2 months and quarterly times 9 months to ensure that wound assessments are Quality Assurance and Performance Improvement team monthly for review and recommendations to ensure continued compliance.	

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used, the MDS indicated Resident #7 received specialized turning and repositioning and had both a pressure reducing device for the bed and chair.

Review of Resident #7's current Comprehensive Care Plan, revealed interventions to prevent further skin breakdown and to assist in healing current breakdown included floating both heels while in bed, treatments as ordered and weekly assessments by a licensed nurse.

A review of the 07/2021 Treatment Administration Record (TAR) indicated nurses had signed daily that Resident #7's heels had been elevated. Also signed daily was that Resident #7 had been out of bed daily.

Review of the 08/2021 TAR indicated Resident #7's feet had been elevated while in bed and Resident #7 had been out of bed daily.

An observation made, on 08/23/2021 at 11:42 AM, revealed Resident #7's feet were flat on the bed. There was no pillow seen on the bed or near the bed on which to float the resident's heels.

Observations were made on 08/24/2021 at 8:10 AM. The resident was in bed with feet/heels lying flat on the bed. No wedges or pillows for elevating Resident #7's feet were seen in the room. A decorative pillow was observed in the wheelchair that was positioned at the head of the resident's bed.

During an observation on 08/24/2021 at 4:00 PM, revealed Resident #7 was seen lying in bed on his/her left side with his/her feet on the bed. Further observation revealed no boots or pillows

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elevated the resident's feet. A decorative pillow remained in a wheelchair next to the resident's bed.

An observation of Resident #7 was made on 08/25/2021 at 9:28 AM with Certified Nursing Assistant (CNA) #1. Resident #7 was lying in bed with his/her feet not elevated. The CNA removed the resident's left sock to reveal a quarter sized area on the left heel that was covered in black tissue.

Interview with Certified Nursing Assistant (CNA) #1, on 08/25/2021 at 9:28 AM, revealed Resident #7 had the pressure ulcer on the heel since 05/2021. The CNA added she had been told the pressure ulcer was the result of the resident lying in bed and that when Resident #7 was in bed, both feet should be elevated. The CNA added the resident had a special boot at one time, but she had not seen the boot for at least two (2) weeks. Per interview, the CNA could give no reason why the resident's feet were not elevated while in bed.

An interview was held, on 08/25/2021 at 10:28 PM, with CNA #2. She stated she was familiar with Resident #7. The CNA stated Resident #7 had special boots to elevate his/her feet for a while. She added the last time she had seen the boots was about three (3) weeks ago when the boots had been sent to the laundry and had not been returned.

An observation was made with Licensed Practical Nurse (LPN) #7, on 08/25/2021 at 3:30 PM, of Resident #7. Observation revealed Resident #7 was lying in bed with his/her feet not elevated.

Interview with LPN #7, on 08/25/2021 at 3:39 PM,

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revealed Resident #7 was in bed and did not have his/her feet elevated. Per interview he was unaware why the resident's feet were not elevated and did not know why the resident was still in bed.

Observations throughout the survey revealed Resident #7 was not out of bed during the survey.

The Director of Nursing (DON) was interviewed, on 08/26/2021 at 8:41 AM. She stated the administrative nursing team was responsible for making sure pressure ulcer reducing interventions were in place. The DON added the team should be checking daily to make sure all interventions were in place and all refusal of any intervention should be documented.

2. Review of Resident #7's Weekly Pressure Wound Observation Tool revealed no weekly assessment of Resident #7's left heel deep tissue injury (DTI) for the months of May 2021 and June 2021.

Review of the Weekly Pressure Wound Observation Tool, dated 07/17/2021, revealed the date Resident #7 acquired the DTI was 06/22/2021. The location was documented as the right heel. Measurements were one point two (1.2) centimeters (cm) by one (1) cm with 100% necrotic (dead) tissue. The overall condition of the wound was listed as improving. The treatment was to apply skin prep.

Review of the 07/2021 Treatment Administration Record (TAR) indicated skin prep had been applied to the left heel daily.

Record review revealed on 08/12/2021, a nurse

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indicated on the weekly skin review that Resident #7's DTI was on the left heel.

Review of the Weekly Wound Observation Tool dated 08/14/2021 identified a left heel DTI for Resident #7. The DTI had an onset date of 06/22/2021. Measurements were 3.0 cm x 2.2 cm with 100% necrotic tissue. Overall impression of the wound was documented as improving. The treatment remained for skin prep daily.

Review of the August 2021 TAR indicated skin prep daily to the heel per Physician's Orders.

Interview with the Director of Nursing (DON), on 08/26/2021 at 8:41 AM revealed a wound care physician had just started in the facility and would be responsible for weekly measurements and weekly wound assessments. Prior to the wound physician, the DON stated the nurses on the halls were responsible for weekly assessments of their assigned residents. She could offer no explanation why Resident #7 had missing weekly wound assessments.

3. Record review revealed the facility admitted Resident #25 on 03/07/2020 and readmitted the resident on 03/25/2021 with diagnoses that included, Cerebral Palsy, Aphasia, Seizure Disorder, and one (1) Stage Three (3) Pressure Ulcer.

Review of Resident #25's Significant Change in Condition Minimum Data Set (MDS) Assessment, dated 06/03/2021, indicated the resident had a Staff Assessment of Mental Status (SAMS) showing severe cognition deficit. The MDS indicated the resident required extensive assistance for transfers with two (2) plus persons,

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toileting, and personal hygiene. The resident required total dependence on staff for bed mobility, dressing, and eating. Further review revealed the resident had limited range of motion in all four (4) extremities.

Review of the care plan, indicated Resident #25 had skin breakdown to the heel and thigh.

Review of the Treatment Administration Record (TAR), dated 08/01/2021 - 08/31/2021, indicated Resident #25 had orders for low air loss mattress, apply skin prep to left heel once daily, and clean the right heel with soap and water, cover with foam, and wrap with Kerlix gauze.

Review of a Weekly Pressure Wound Observation Note, dated 07/10/2021, indicated Resident #25 had a pressure ulcer to the left gluteal fold measuring one and two tenths (1.2) centimeters (cm) by one and two tenths (1.2) cm that was initially identified.

Review of a Weekly Pressure Wound Observation Note, dated 07/11/2021, indicated Resident #25 had a pressure ulcer to the left heel measuring one and four tenths (1.4) cm by three and two tenths (3.2) cm by zero (0) cm and a pressure area to the left heel measuring one and one tenth (1.1) cm by one (1) cm by zero (0) cm, and another to the left heel measuring one and two tenths (1.2) cm by zero and four tenths (0.4) cm by zero (0) cm that was originally identified on 05/07/2021.

Review of a shower sheet, dated 08/14/2021, indicated Resident #25 had two (2) wounds to the left heel measuring three (3) cm by two and two tenths (2.2) cm and one (1) wound to the left

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F 686	Continued From page 81 buttock measuring one (1) cm by three and two tenths (3.2) cm, and one (1) wound to the right buttock measuring one (1) cm by three and two tenths (3.2) cm. Review of a Wound Evaluation & Management Summary, dated 08/20/2021, indicated Resident #25 had an unstageable pressure ulcer to the left heel measuring one (1) cm by (0.5) cm by zero (0). Further review revealed there was no other wound documentation available. During an interview on 08/26/2021, at 8:41 AM, the ADON (Assistant Director of Nursing) indicated pressure ulcers were to be assessed and documented weekly. She indicated there was no other wound documentation available for review for Resident #25.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		11/5/21

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This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and facility policy review, it was determined the facility failed to ensure fall investigations were completed after a fall occurred for two (2) residents (Resident #83 and Resident #3) out of five (5) residents reviewed for falls.

The findings include:

Review of the facility's policy titled "Fall Management Program," dated December 2018, revealed the facility strived to maintain a hazard free environment, mitigate fall risk factors and implement preventative measure. The facility recognized even the most vigilant efforts may not prevent all falls and injuries. In those cases, intensive efforts would be directed toward minimizing or preventing injury. Should the resident experience a fall the attending nurse shall complete a post fall assessment, this included an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce risk of repeat episode and a review by the IDT to evaluate thoroughness of the investigation and appropriateness of the interventions.

1. Record review revealed Resident #83 was admitted by the facility on 10/16/2019 with diagnoses including Cerebral Palsy, Chronic Obstructive Pulmonary Disease, Hip and Knee Contractures, Dysphagia, Paranoid Schizophrenia, Abnormal Posture, need for

1. The fall investigation for resident # 83 fall was completed on 8/25/21 and the fall investigation for resident # 3 . Fall risk assessments for both residents were completed and circumstances surrounding prior falls were reviewed to ensure proper interventions are in place

2. Other residents with falls since 8/27/21 have been reviewed and all have fall investigations in place.

3. The new Director of Nursing, unit managers and assistant director of nursing were educated on facility policy for fall investigations by the regional director of clinical services. The new administrator was educated by the regional director of clinical services on reviewing fall investigations for completion and care planning interventions in the next morning clinical meeting and signing off on completion. Licensed nurses were educated on the facility policy for assessment, interventions, and investigations after falls. Education completed by 11/4/21

4. The Director of Nursing and the administrator will review each fall to ensure that investigations are completed daily Monday through Friday. Results will be reported to the facility Quality Assurance and Performance

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F 689	Continued From page 83 assistance with personal care, Mild Cognitive Impairment, Major Depressive Disorder, Anxiety Disorder, and Intermittent Explosive Disorder. Review of the Significant Change Minimum Data Set (MDS) for Resident #83, dated 07/27/2021, revealed Resident #83 had a Brief Interview for Mental Status (BIMS) score of zero (00) out of fifteen (15), indicating significant cognitive impairment. Continued review revealed Resident #83 required extensive assistance of two persons with bed mobility, dressing, and toileting. Further review revealed Resident #83 required limited assistance of one (1) person with eating. The resident was totally dependent on staff for bathing. Review of Resident #83's Comprehensive Care Plan, initiated on 10/09/2020, revealed the resident was at risk for falls related to impaired mobility and cognitive impairment. Further review revealed the first and only intervention added to the care plan in 2021, was on 07/15/2021 for adaptive positioning cover to mattress. Review of a Change-of-Condition evaluation for Resident #83, completed on 06/08/2021 at 1:30 PM, revealed a fall occurred on 06/07/2021. Further review revealed the resident rolled out of bed, and the bed was locked and in lowest position. The resident was verbal and alert, able to make needs known, and voiced no complaint, pain, or discomfort. No new skin areas were noted. Review of the progress notes for Resident #83 revealed there was no documented evidence related to the fall that occurred on 06/07/2021.	F 689	Improvement committee monthly on an ongoing basis to ensure continued compliance.	

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A review of Falls Investigation revealed no documented evidence an investigation was completed at the time of the fall. Continued review revealed the falls investigation for 06/07/2021 was completed on 08/25/2021, during the time of the survey.

Interview with the Director of Nursing (DON), on 08/26/2021 at 1:25 PM, revealed the facility had no documentation that an investigations was completed for the fall that occurred on 06/07/2021 for Resident #83, per the facility's policy.

2. Record Review revealed Resident #3 was admitted by the facility on 02/09/2019 with diagnoses including Parkinson's Disease, Repeated Falls, Muscle Weakness, Anxiety Disorder, Hyperlipidemia, Major Depressive Disorder, Cognitive Communication Deficit, Weakness, Abnormalities of Gait and Mobility, and Unsteadiness on Feet.

Review of Resident #3's Quarterly Minimum Data (MDS) Set, dated 05/18/2021, revealed that facility assessed Resident #3 to have a Brief Interview for Mental Status (BIMS) score of eleven (11) out of fifteen (15), indicating some cognitive impairment. Continued review revealed Resident #3 required limited assistance of two (2) persons with bed mobility, transfer, dressing, and toileting. Resident #3 required supervision with set-up only with eating. The resident was totally dependent on staff for bathing.

Review of Resident #3's Comprehensive Care Plan for falls, initiated on 02/11/2021, revealed interventions added on 02/11/2021 were to provide verbal cues, place call light within reach,

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maintain a clutter free environment, place personal items within reach, and observe for unsafe actions and intervene. Interventions added on 03/19/2021 were for staff to assist the resident with desired items. Interventions added on 04/03/2021 were for staff to ensure the resident had on non-skid socks when out of bed. Lastly, an intervention was added on 08/03/2021 revealed wedges on bilateral sides of bed.

Review of a Situation Background Assessment Recommendation (SBAR) communication form for Resident #3, completed on 02/10/2021, revealed a fall occurred on 02/10/2021. Continued review revealed no specific information related to the fall was indicated.

Review of Resident #3's progress notes, dated on 02/10/2021 at 10:50 AM, revealed SBAR Summary for Providers: Staff were called to the resident's room per CNA. Staff observed the resident sitting on buttocks on the floor beside the bed. The resident denied hitting head and denied pain or discomfort. No apparent injury was noted. The resident stated, "I was trying to get in the bed and my chair slipped away from me." Staff encouraged the resident to call for assistance and lock the wheelchair when not in use. The resident verbalized understanding.

A review was conducted of a SBAR communication form for Resident #3, completed on 03/19/2021, related to a fall. Continued review revealed no specific information related to the fall was indicated.

Review of Resident #3's progress notes, dated on 03/19/2021 at 5:59 PM, revealed "Resident [Resident #3] was attempting to get chips off floor

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when [the resident] slid to floor without injury noted. Staff will assist resident with desired items to prevent future falls."

Review of a SBAR communication form, completed on 04/03/2021, revealed Resident #3 was sent to emergency room for evaluation after a fall occurred. No specific information related to the fall was included.

Review of Resident #3's progress note, dated on 04/03/2021 at 5:29 PM, revealed "Called to resident's room by CNAs stating that resident has fall[en]. Resident states that [the resident] was trying to get up and fell. States that [the resident] hit head on the floor. Upon examination resident noted to have a laceration 2 cm [centimeters] * [by] 0.4cm to the back of [the] head with moderate amount of blood on floor. Resident vitals assessed. Reports pain to back of head. Pressure applied to wound to control bleeding. Bleeding controlled with pressure applied. Ambulance services contacted for transport. Physician notified and gave order to send to ER. Note: Staff to ensure resident is wearing nonskid socks to prevent future incidents."

Review of Resident #3's progress notes, dated on 04/05/2021 at 1:00 AM, revealed "Patient seen today for follow up for recent fall and medication review. On 04/03/2021 the patient had a fall and was complaining of neck pain and right shoulder pain. [The resident] was sent to the ER for further evaluation. In the ER the patient had a computed tomography (CT) [scan] of the head without contrast and a CT [scan] of the cervical spine without contrast that was negative for any acute abnormality. Patient also had an x-ray of [the] right shoulder that showed an Anterior and

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Inferior Dislocation of the Humeral component of the Right Shoulder Arthroplasty. Patient's right shoulder was reduced in emergency room (ER) and was placed in a sling. Patient also obtained a small laceration to the back of [the] head that was too small to be repaired. Patient has a history of Dementia and Parkinson's with multiple falls in the past primarily related to impulsive behavior and unsteady gait. Today the patient states [the patient's] head feels a little sore but not bad. The patient was sitting in [the] wheelchair without the sling to [the] right arm, the patient states [the patient] does not need the sling and is fine without it."

Review of Resident #3's progress note, dated on 08/03/2021 at 4:15 PM, revealed "Resident sitting on mat next to bed. Resident stated [the resident] slid onto the mat because the bed is small. Resident tends to sleep sideways on most of the time. Updated care plan to place wedges on bilateral sides of the bed to help stabilize resident while sleeping. Intervention effective and resident states [the resident] is sleeping more comfortably. Resident refuses to keep non-skid socks on x3 attempts, fall mats on bilateral sides of bed. Fluids and bedside table within reach. Call light within reach. no s/s [signs/symptoms] or c/o [complaints of] pain or discomfort noted. Safety measures maintained."

A review of documentation for Resident #3 revealed no documented evidence an SBAR was completed for the fall that occurred on 08/03/2021.

Review of the facility's Falls Investigations revealed there was no documented evidence the attending nurse completed a post fall assessment

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to include an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce risk of repeat episode and a review by the IDT to evaluate thoroughness of the investigation and appropriateness of the interventions for Resident #3's falls on 02/10/2021, 03/19/2021, 04/03/2021 or 08/03/2021 per the facility's policy. A further review revealed falls investigations for the fall that occurred on 08/03/2021 was completed on 08/25/2021, at the time of the survey.

Interview with the Director of Nursing (DON), on 08/25/2021 at 12:00 PM, revealed she would expect that an investigation be completed at the time a fall occurs, and the clinical team would be responsible for ensuring that it was completed. Continued interview with the DON on 08/25/2021 at 2:23 PM, revealed when a fall occurred, the floor nurse completed a RMF (Risk Management Form) and based on the information entered, that may trigger additional areas that request more information. The Interdisciplinary Team (IDT) would meet the next morning and review all the incident reports/falls reports, and they would look at possible patterns, injury if any, and interventions for appropriateness and adjust as needed. Minimum Data Set (MDS) staff would updates the care plan, but the DON was responsible for ensuring the care had been updated to reflect any new interventions.

Interview with the DON, on 08/26/2021 at 1:25 PM, revealed the facility had no documentation that investigations were completed for the falls that occurred on 02/10/2021, 03/19/2021, 04/03/2021, and 08/03/2021 for Resident #3, at the time of the fall.

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F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 690		11/5/21

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F 690	Continued From page 90 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review and review of the facility's policy, it was determined the facility failed to secure an indwelling urinary catheter to prevent trauma or accidental dislodgement for one (1) of four (4) sampled residents (Resident #67) with an indwelling urinary catheter. The findings include: Review of the facility's policy titled, Catheter Care Urinary, revised 09/2014, indicated the purpose of the procedure was to prevent catheter associated urinary tract infections. Review of the section Maintaining Unobstructed Urine Flow, revealed staff should ensure the resident was not lying on the catheter tubing and to keep the catheter tubing free of kinks. Review of the section titled Changing Catheter, revealed the catheter should remain secured with a leg strap to the resident's inner thigh to reduce friction and movement at the insertion site. Record review revealed Resident #67 was initially admitted by the facility on 01/18/2021 and re-admitted on 02/14/2021 with diagnoses that included Disruption of a Surgical Wound, Obstructive Uropathy, Diabetes, and Morbidly Obese. Review of Resident #67's Quarterly Minimum Data Set (MDS), dated 07/19/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fourteen (14) out of fifteen (15), indicating the resident was cognitively intact. Continued review revealed the resident had an indwelling urinary	F 690	1. Resident #67's catheter was secured on 8/27/21. 2. All other residents with catheters were checked and found to be secured to prevent dislodgement. 3. Licensed nurses have been educated on the facility policy for indwelling catheters by the regional director of clinical services or Director of Nursing, Education completed by 11/4/21 4. Residents with indwelling catheters will checked each shift by a licensed nurse to ensure they are properly secured and documented on the Treatment Administration Record. Director of Nursing will review the Treatment Administration record daily times 2 weeks, weekly times 2 weeks, monthly times 2 months and then quarterly times 9 months. The director of nursing will report findings to the facility Quality Assurance and Performance Improvement committee monthly for review and recommendations to ensure continued compliance.	

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catheter, surgical wounds required extensive to total care for bed mobility, transfers and bathing, and limited to extensive care for toileting and personal hygiene. The resident was independent with eating and mobility in wheelchair.

Review of Resident #67's Annual Examination, dated 01/25/2021, revealed an indwelling urinary catheter had been placed due to multiple abdominal wounds that involved the resident's groin to inner thighs.

Review of the 08/2021 Physician's orders, revealed a Physician's order, dated 08/09/2021, to secure the indwelling urinary catheter to prevent pulling or dislodgement of the catheter and to check every shift.

Review of Resident #67 Comprehensive Care Plan, last reviewed on 08/12/2021, indicated a requirement of an indwelling urinary catheter; however, there was no documented evidence it included securing the catheter tubing.

Observation of catheter care being provided by Certified Nursing Assistant (CNA) #2 and CNA #3, on 08/25/2021 at 10:50 AM, revealed Resident #67 had an indwelling catheter in place. Continued observation of the care revealed Resident #67 had no strap to secured the catheter tubing to the thigh.

Interview with CNA #2, on 08/25/2021 at 11:10 AM, revealed there was no strap securing Resident #67's indwelling catheter. Continued interview revealed the catheter should have a strap securing the catheter tubing to the resident's leg and she would notify the resident's nurse.

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F 690	Continued From page 92 Interview with Resident #67, on 08/23/2021 at 2:47 PM, revealed the catheter was placed during a hospitalization after surgery. The resident stated the catheter was not secured to prevent pulling. Continued interview with Resident #67, on 08/24/2021 at 2:00 PM, revealed the catheter was not secured to the resident's leg. Per interview the catheter tubing was not secured and had been under his/her abdominal folds. Interview with Registered Nurse (RN), #1 on 08/25/2021 at 10:34 AM, revealed she was assigned to care for Resident #67. Continued interview revealed she was not certain about the facility's policy for securing catheters and was unable to state if Resident #67's catheter was secured. Interview with the Director of Nursing (DON), on 08/26/2021 at 8:15 AM, revealed she was unsure about the facility's policy for securing an indwelling urinary catheter. Continued interview revealed the dangers of not having the catheter tubing secured could cause trauma from the tubing being pulled on.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.	F 695		11/5/21

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This REQUIREMENT is not met as evidenced by:
Based on observations, interviews, record reviews, and facility policy review, it was determined the facility failed to ensure oxygen therapy was administered per the physician's orders for two (2) of three (3) residents with oxygen (Resident #27 and Resident #16).

Findings included:

A review of the facility's policy titled, "Oxygen Administration" revised October 2019, revealed the purpose was to provide guidelines for safe oxygen administration. Continued review revealed staff should verify there was Physician's order for the procedure. Further review revealed, after completing the oxygen setup of adjustment, the following information should be recorded in the resident's medical record: the rate of oxygen flow, the route, and the rationale.

1. Record review revealed Resident #27 was admitted by the facility, on 03/25/2019, with diagnoses including Quadriplegia, Type 2 Diabetes, Muscle Weakness, Contractures, Cognitive Communication Deficit, Anxiety Disorder, and Major Depressive Disorder.

Review of Resident #27's Quarterly Minimum Data (MDS) Set, dated 06/06/2021, reveal the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), indicating no cognitive impairment. Continued review revealed Resident

1. Residents # 27 and # 16 oxygen flow was set to the rate ordered by their physicians on 8/27/21.

2. All other residents with orders for continuous oxygen were reviewed and oxygen settings are per physician orders for each one.

3. Licensed nurses have been educated on facility policy for oxygen administration by the regional director of clinical operations or Director of Nursing. Leadership staff were trained on viewing settings by the director of nursing. Licensed nurses will document every shift on the treatment administration record that the physician's orders for oxygen settings are being followed. Education Completed by 11/4/21.

4. A daily observation round sheet is being utilized for leadership to check the settings for oxygen administration daily. If the setting is found to be incorrect, the licensed nurse will be notified immediately to correct it. Any changes to physician orders concerning oxygen administration will be reviewed in the morning leadership meeting. Licensed nurses will document on the treatment administration record that the settings are correct as well. The director of nursing will report findings to

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F 695	Continued From page 94 #27 required extensive assistance of two (2) persons with bed mobility, transfer, dressing, toileting, and eating. The resident was totally dependent on staff for bathing. Further review revealed Resident #27 required oxygen therapy. Review of Resident #27's Comprehensive Care Plan, initiated 04/24/2019, revealed the resident was at risk for respiratory complications related to a history of pneumonia and required Oxygen use. Continued review revealed interventions in place were oxygen to be administered as ordered. Review of Resident #27's physician's orders, dated August 2021, revealed an order for Oxygen to be administered continuously at two (2) liters per minute via a nasal cannula. Observation of Resident #27, on 08/23/2021 at 3:31 PM, 08/24/2021 at 9:13 AM and 08/25/2021 at 9:30 AM, revealed the resident was wearing a nasal cannula device for Oxygen administration. Continued observations revealed the Oxygen concentration setting was set at three (3) liter per minute. Interview with Licensed Practical Nurse (LPN) #5, on 08/25/2021 at 9:30 AM, revealed Resident #27's Oxygen concentration setting was set at three (3) liters per minute; however, it should be set at two (2) liters per minute. LPN #5 stated staff should be checking to ensure the Oxygen setting was set on the correct concentration for administration of the Oxygen every shift. 2. Record review revealed Resident #16 was re-admitted by the facility, on 04/05/2020 with diagnoses including Cardiomyopathy, Heart Failure, Acute and Chronic Respiratory Failure,	F 695	the facility Quality Assurance and Performance Improvement committee monthly for review and recommendation to ensure continued compliance.	

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Quadriplegia, Type 2 Diabetes, Contracture Right Hand, Contracture Left Hand, Contracture Left Elbow, Contracture Right Elbow, Cognitive Communication Deficit, Dementia, Anemia, Major Depressive Disorder, Chronic Kidney Disease, and Anxiety.

Review of Resident #16's Annual Minimum Data Set, dated 05/28/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of one (1) out of fifteen (15), indicating serious cognitive impairment. Resident #16 required extensive assistance of 2 persons with bed mobility, transfer, dressing, toileting, and eating. The resident was totally dependent on staff for bathing. Further review revealed Resident #16 required oxygen therapy.

Review of Resident #16's Comprehensive Care Plan, initiated 09/18/2019, revealed the resident exhibited or was at risk for respiratory complications related to a history of Upper Respiratory Infections, Pneumonia, and a diagnosis of Acute or Chronic Respiratory Failure and required Oxygen use. Continued review revealed interventions in place were Oxygen was to be administered as ordered.

Review of Resident #16's Physician's orders, dated August 2021, revealed an order for Oxygen to be administered continuously at two (2) liters per minute via nasal cannula.

Observation of Resident #16, on 08/23/2021 at 12:36 PM, 08/24/2021 at 9:11 AM, 08/24/2021 at 1:20 PM and 08/25/2021 at 9:15 AM, revealed the resident was wearing a nasal cannula device for Oxygen administration. Continued observations

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F 695	Continued From page 96 revealed the Oxygen concentration setting was set at four (4) liter per minute. Interview with the Director of Nursing (DON), on 08/25/2021 at 9:15 AM, revealed Resident #16's Oxygen Concentration setting was set at four (4) liters per minute. Per interview, she was not aware of what concentration the Physician ordered for Resident #16. Continued interview revealed Resident #16 was a Hospice resident and that maybe the Hospice nurse wanted the concentration set at a higher setting. However, the DON stated, she expected licensed nurses to act within their licensure and ensure residents received the correct Oxygen setting per the Physician's orders.	F 695		
F 740 SS=J	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews and reviews of the facility's policies, it was determined the facility failed to ensure each resident received the necessary behavioral health care and services to attain or maintain the highest practicable physical,	F 740	1. Resident # 85 was immediately placed on 1-1 and remained 1-1 until 9/1/21 when was sent to an inpatient behavioral health facility for evaluation and treatment. There have been no further incidents between	11/5/21

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mental, and psychological well-being, in accordance with the comprehensive assessment and plan of care. This deficient practice affected one (1) (Resident #6) of six (6) sampled residents reviewed for behaviors. Specifically, Resident #6 displayed behaviors directed toward other residents, and no new interventions were implemented to address behaviors. Resident #6 had multiple episodes of verbal and physical aggression towards other residents. Resident #6 exposed self sexually during an activity. Staff reported that when Resident #6 came into the common area, other residents left due to the resident's behaviors. Staff indicated they were fearful Resident #6 would hurt another resident. The Director of Nursing (DON) indicated Resident's #6's behaviors created a stressful environment for the other residents.

It was determined the facility's non-compliance with one or more requirements of participation caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.40 (Behavioral Health) at a scope and severity of "J."

The Immediate Jeopardy (IJ) began on 04/01/2021 when Resident #6 was yelling and cursing at another resident and the facility failed to investigate the allegation of verbal abuse. The Director of Nursing (DON) and Nursing Home Administrator (NHA) were notified of the IJ and provided with the IJ Template on 08/26/2021 at 12:00 PM. A Removal Plan was requested. The Removal Plan was accepted by the State Survey Agency on 08/27/2021 at 6:00 PM. The IJ was removed on 08/27/2021 at 6:00 PM after the survey team performed onsite verification that the

resident #85 and other residents.
Resident # 6 was placed on 15 min checks when he is out of his room as of 8-26-2021. Resident was seen on 08-25-21 by psychiatric services and seen again on 8-27-2021. Resident was moved to a smaller unit to help reduce his agitation on 8/30/21 and has shown marked improvement since then.
2. An interdisciplinary team meeting was held to ensure all residents that have behaviors per the comprehensive assessment have interventions and care plans in place and are receiving appropriate behavioral health services.
3. The social services director is reviewing documented behaviors daily Monday -Friday and Monday for the weekend to ensure that all residents are referred for behavioral health services as needed. At the weekly Clinical At-Risk meeting residents with behaviors are reviewed for appropriate behavioral interventions and need for psych services. The interdisciplinary team was re-educated on 10/19/21 on identifying residents with behaviors and referring for appropriate behavioral health services by the Licensed nursing home administrator.
4. Director of Nursing, administrator, and or designee will audit behavior documentation weekly x 3 months and then quarterly x 12 months. Any concerns will be documented, corrected immediately, and staff will be educated accordingly. Results will be reported monthly to the facility Quality Assurance and Performance Improvement committee for review and

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Removal Plans had been implemented. Noncompliance remained at the lower scope and severity of pattern, no actual harm with potential for more than minimal harm that was not immediate jeopardy.

The finding included:

On 08/26/2021 at 1:45 PM, the Director of Nursing (DON) provided the policy on, "Unmanageable Residents," dated 09/2010, and indicated this was the policy currently being used by the facility. Review of the facility's policy revealed that should a resident's behavior become abusive, hostile, assaultive, or unmanageable in any way that would jeopardize his or her safety or the safety of others, the Nurse Supervisor/Charge Nurse must immediately: a) provide for the safety of all concerned, b) notify the resident's attending physician for instructions, notify the Director of Nursing. Complete documentation of the incident must be recorded in the resident's medical record and an incident report must be filed with the Administrator.

On 08/26/2021 at 1:45 PM, the DON provided the policy on, "Behavioral Assessment, Intervention and Monitoring," dated 12/2016, and indicated this was the policy currently being used by the facility. The policy indicated the interdisciplinary team would evaluate behavior symptoms in a resident to determine the degree of severity, distress, and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm. The care plan will incorporate findings from the comprehensive assessment and be consistent with current standards of practice.

recommendations to ensure continued compliance.

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Interventions will be individualized and part of an overall care environment that supports physical, functional, and psychosocial needs, and strives to understand, prevent, or relieve the resident's distress or loss of abilities. Interventions and approaches will be based on a detailed assessment of physical, psychological, and behavioral symptoms and their underlying causes.

Record review revealed Resident #6 was admitted to the facility on 01/19/2017 with diagnoses of dementia with behavioral disturbances, anxiety/agitation, schizophrenia, adult failure to thrive, anorexia, intellectual disability, and depression. The Annual Minimum Data Set (MDS) dated 02/16/2021 indicated Resident #6's cognition was severely impaired with a Brief Interview for Mental Status (BIMS) of three (3) out of fifteen (15). The resident required supervision with ambulation using a walker. Further review revealed the MDS indicated the resident had no behaviors. The most recent Quarterly MDS, dated 05/19/2021 indicated a diagnosis of impulse disorder and physical and verbal aggression directed toward others occurred one (1) - three (3) days during the seven (7) day assessment period.

Review of a care plan, dated 02/02/2017, indicated Resident #6 exhibited or had the potential to exhibit or demonstrate verbal behaviors such as the use of abusive language and sexually inappropriate language. Interventions included to place resident on one on one, place in lobby to provide decreased stimulation, provide consistent, trusted caregivers and structured daily activities, and postpone activities if resident becomes combative or

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resistive.

Review of the care plan, dated 10/26/2020, indicated Resident #6 exhibited or had the potential to exhibit physical behaviors related to poor anger management, poor impulse control, and public masturbation. Interventions included: resident will have quite time in room to include rest time, listening to music, and to divert by giving alternative choices.

Review of a Progress Note, dated 03/26/2021, indicated Resident #6 had a resident-to-resident altercation. Resident #6 continued to curse other residents and threatened to harm self and other residents.

Record review revealed a Progress Note, dated 04/01/2021, that indicated Resident #6 was cursing and yelling at another resident. Further review revealed a Progress note, dated 04/03/2021, that indicated Resident #6 was cursing other residents and making multiple verbal threats.

Review of a Progress Note, dated 04/04/2021 at 3:57 PM, revealed Resident #6 was inappropriately touching another resident. Further review revealed a Progress Note, dated 04/04/2021 at 5:20 PM, indicated Resident #6 was extremely agitated and yelling at other residents.

Review of a Progress Note, dated 04/09/2021 at 10:04 AM, indicated Resident #6 was verbally aggressive with other residents, threatening harm, and cursing. Review of a Progress Note, dated 04/13/2021 at 7:50 AM, indicated Resident #6 was cursing and threatening to harm other

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residents.

Review of a Progress Note, dated 04/16/2021, indicated Resident #6 was yelling and cursing at other residents, and the facility had Director of Nursing (DON) come back to the unit.

Record review revealed a Progress Note, dated 04/18/2021, indicated Resident #6 was yelling, throwing stuff, and cussing at other residents. On 04/30/2021, Resident #6 was publicly masturbating during an activity. Continued review revealed on 05/08/2021, Resident #6 was yelling and cussing at other residents. On 05/29/2021, Resident #6 had been cursing, yelling, and threatening other residents.

Record review revealed a psychiatrist initial visit, dated 06/04/2021, indicated Resident #6 was being seen for depression. However, there was no mention of verbal and physical aggression documented. Continued review revealed a Progress Note, dated 06/05/2021, that indicated Resident #6 was verbally aggressive with another resident.

Review of a Psychotherapy Comprehensive Clinical Assessment, dated 06/09/2021, revealed Resident #6 was referred due to concern of increased anxiety, impulsive behavior, and feeling angry. However, there was no mention of verbal and physical aggression documented.

Record review revealed a Progress Note, dated 06/14/2021, that indicated Resident #6 had been cursing and yelling at other residents and throwing items in the resident's room.

Review of a Physician's Progress Note, dated

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06/16/2021, revealed Resident #6 was noted to have the potential to harm staff, other residents, or self.

Record of a Physician's Progress Note, dated 06/17/2021, revealed Resident #6 had a long history with physical aggression related to schizoaffective bipolar disorder.

Review of Psychotherapy Progress Notes, dated 06/18/2021, 06/23/2021, 07/04/2021, 07/05/2021, 07/17/2021, 07/21/2021, 07/31/2021, 08/06/2021, 08/14/2021 indicated Resident #6 was being seen for individual psychotherapy. However, there was no mention of verbal and physical aggression documented.

Record review revealed a Progress Note, dated 06/29/2021, that indicated Resident #6 was threatening to hit other residents, was cursing, and being verbally aggressive with other residents.

Record review revealed a psychiatry follow-up note, dated 07/16/2021, indicated Resident #6 was being seen for depression. There was no mention of verbal and physical aggression documented.

Record review revealed a Progress Note, dated 07/27/2021, that indicated Resident #6 was cursing and threatening to hit other residents. Continued review revealed a Progress Note, dated 08/11/2021, that indicated Resident #6 was being verbally aggressive with other residents and was threatening to harm other residents.

Review of a psychiatry follow-up note, dated 08/15/2021, indicated Resident #6 was being

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seen for depression. There was no mention of verbal and physical aggression documented.

Review of a Progress Note, dated 08/14/2021, indicated Resident #6 had exposed self and touched self inappropriately in front of other residents during an activity. The DON had come to the unit to talk to the resident regarding behaviors.

Record review revealed a Progress Note, dated 08/18/2021 at 12:00 AM, indicated Resident #6 was verbally and physically aggressive, was throwing things, trying to break things, slamming the resident's walker, and yelling and cursing. Haldol 2.5 mg (milligrams) was given.

Record review revealed a Social Service Note, dated 08/19/2021, that indicated Resident #6 had diagnoses of anxiety and major depressive disorder, schizoaffective disorder, and intellectual disabilities. There were no social service notes available to indicate the facility was providing a plan of care for Resident #6's behaviors.

Review of a Psychotherapy Progress Note, dated 08/23/2021, indicated Resident #6 had generalized anxiety and other specified depressive disorders and was seen for individual psychotherapy to explore and utilize coping techniques to manage isolation and depressed mood.

During an interview on 08/24/2021, Licensed Practical Nurse (LPN) #3 indicated Resident #6 threatened to kill other residents, and it was "just a matter of time" before the resident hurt another resident. She indicated administration was aware of Resident #6's aggressive physical and verbal

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behaviors.

During an interview on 08/24/2021 at 2:16 PM, Resident #54 indicated Resident #6 had kicked (Resident #54) in the leg with 3 staff members present who witnessed the incident.

During an interview on 08/24/2021 at 3:30 PM, the Activity Assistant (AA) indicated she had witnessed Resident #6 kick Resident #54.

During an interview on 08/25/2021 at 12:59 PM, the SSD (Social Service Director) indicated she was aware of the Resident #6 kicking someone and exposing himself/herself. She indicated the resident was sent back to their room for quite time. She stated she was new to her position, and she was unsure of the previous incidents in the progress notes.

During an interview on 08/25/2021 at 2:23 PM, the Director of Nursing (DON) indicated she was familiar with Resident #6. She stated they have had behavioral issues with the resident before. The resident had a room to themself so they could go cool off if the resident got upset. The DON stated Resident #6 yelled and sometimes used explicit words. She stated, the resident may say "I'm going to hit you.", but he/she had not. She was not aware if the resident had ever hit any staff. The DON stated Resident #6 had emptied the catheter bag on the floor. She was not aware that the resident punched the TV or had thrown the walker. She stated he/she had moved the walker towards people. The DON stated she did not doubt that the resident had cursed or yelled at other residents. She stated she did not know any specifics, "I don't doubt that there are incidents documented, but I don't know

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any specifics." Since her time at the facility, they had intervened between the resident and who ever was involved. Continued interview revealed they had called for EMS (emergeny medical services) or an officer for back up if needed. She stated to protect residents, the resident's room was near the nurse's station. When the resident was near people, it made the resident's behaviors worse. They had tried to reward Resident #6's good behavior.

Review of a statement for the psychotherapy provider, dated 08/25/2021, indicated Resident #6 started receiving therapy in June of 2021 to decrease mood and reduce anger outbursts. The interventions included using a stress ball for 5-10 minutes when the resident felt his/her stress level was at a five (5) or higher and to practice deep breathing exercises 2-3 times a week.

Record review revealed there were no other updates noted to Resident #6's plan of care for behaviors.

During an interview on 08/26/2021 at 12:15 PM, the AA indicated Resident #6 exposed self to two female residents during an airshow while outside in the courtyard.

During an interview on 08/26/2021 at 12:20 PM, Resident #58 indicated Resident #6 had exposed self to (Resident #58) during the airshow, and that it made the resident feel uncomfortable, "Wondering what [Resident #58] did to provoke this."

During an interview on 08/26/2021 at 12:30 PM, Resident #87 indicated Resident #6 was exposing self to Resident #58. The resident

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indicated he/she "felt bad" for Resident #58.

During an interview on 08/26/2021 at 12:20 PM, the Assistant Director of Nursing (ADON) indicated there were no other notes available for psychotherapy services or social services in relation to multiple behaviors displayed over the last several months.

The facility provided a Removal Plan that included:

1. Resident #6 was placed on 15 min checks when [the resident] was out of [his/her] room as of 08-26-2021. Resident was seen on 08-25-2021 by psychiatric services and seen again on 08-27-2021. Care plan updated to observe for signs of over stimulation such as grumbling while walking, complaints of other residents, etc. Staff to take resident to room, close the door and practice the interventions recommended by the psychologist such as using a stress ball and deep breathing. IDT met on 08-26-2021 and developed new interventions and updated care plan.

2. All residents with 8 or above were interviewed by social services on 08-25-2021 and 08-26-2021 to ensure there were no concerns of safety, or feelings of abuse while in this facility. None were noted. Unit Manager Nurse, MDS, and SS [social services] assistant evaluated all residents with BIMS 7 and below for any signs of change in baseline mood or behavior and normal daily routine. Documentation placed in medical record 08-26-2021 and 08-27-2021. No concerns or changes noted.

4. LNHA [licensed nursing home administrator], DON [DON], Unit Managers [UM], ADON, MOS

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[sic, MDS, Minimum Data Set], Business office, Payroll, Activities, Maintenance, Therapy, Scheduling were educated per Regional Director of Clinical Services on 08-26-2021 at 2:15 PM on "What is abuse and neglect, when to report abuse and neglect, and to report all abuse to the LNHA".

5. IDT [interdisciplinary team] meeting held 8-27-2021; behaviors reviewed to ensure all residents that have behaviors per the comprehensive assessment have intervention and care plan in place. All interventions and care plans communicated to floor staff per DON 8-27-2021.

6. DON, and LNHA, and or designee will educate all staff on the following:
- Abuse and Neglect
- When to report suspected abuse and neglect
- Reporting of abuse and neglect directly to the administrator immediately
- This education completed 8/27/2021
- If any behaviors occur on your shift please protect the resident, stay with them until the Administrator has been notified and intervention is in place.
- In addition, a list of all staff has been developed and no persons will be allowed to work without having completed this education prior to assuming the floor.

7. Facility system changes:
i. Facility added behavior monitoring to TAR [treatment administration record] to be completed Q [every] shift.
ii. All residents with noted behaviors were referred to psych services by assistant social services.
iii. Residents with identified behavioral health

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needs have person centered care plans that were updated on 08-27-2021 by MDS. Care plans include behavioral health needs which are identified in the comprehensive assessment.
iv. Individualized interventions related to diagnoses and conditions were added to each resident with behavioral health needs by DON, UM and MOS nurses on 08-27-2021.

DON, LNHA, and/or designee audited:
i. Behavior documentation audited weekly x 3 months and then quarterly x 12 months. Any concerns will be documented, corrected immediately, and staff will be educated accordingly.
ii. A trigger report was run by RN, BSN, RDO on 08-27-2021 and all issues were immediately addressed.

The results of the assessments/audits reported reviewed and trended for compliance through the campus quality assurance performance improvement committee for a minimum of 6 months. QAPI [quality assurance performance improvement] meetings weekly times 4 weeks and then monthly thereafter.

The IJ was removed on 08/27/2021 at 6:00 PM after the survey team performed onsite verification that the Removal Plans had been implemented.

Onsite verification of the implementation of the Removal Plan was conducted during the survey. On 08/27/2021 between the hours of 11:00 AM and 6:00 PM. Review of the educational materials indicated 100% of staff to include all departments had been completed on 08/26/2021.

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Twelve interviews were conducted to verify in-service training had been completed on the facility's Abuse Policy and Procedure training to include the types of abuse, what to report, to whom to report the allegations of abuse and when to report. Of those interviewed included certified nursing assistants (CNAs), licensed practical nurses (LPNs), registered nurses (RNs), housekeeping and scheduling staff. The staff interviewed revealed knowledge of what constituted abuse, what to do if abuse was observed, both staff to resident abuse and in the event of resident-to-resident abuse, when to report abuse and to whom the abuse should be reported.

The interviews revealed a consistent message that staff understood not only the different types of abuse, but that resident-to-resident altercations also constituted abuse. Staff indicated that through training they understood the need to intercede immediately and to always protect the resident before reporting any incident of abuse to the Administrator. Staff also acknowledged that have assuring resident safety, the abuse should be reported immediately.

Resident #6 had been placed on every 15-minute checks, and the care plan had been updated on measures to address behaviors, and an IDT meeting was held on 08/27/2021. Resident #6 was seen by psych services on 08/25/2021. Surveyors verified 54 Residents with BIMS 8 or above were interviewed and indicated they felt safe. The LNHA, DON, unit managers, ADON, MDS, business office, payroll department, activities, maintenance, therapy, scheduling received education on what constitutes abuse and when to report.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.	F 801		11/5/21

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	185236	A. BUILDING _____ B. WING _____	08/27/2021

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F 801	Continued From page 111 (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, it was determined the facility failed to ensure there was a qualified food and nutrition director with appropriate competencies and skill	F 801	1. All residents had the potential to be impacted by the alleged deficiency. 2. The dietary manager at the time of the	

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F 801	Continued From page 112 sets to carry out food and nutrition services for all one hundred eleven (111) residents in the facility. The facility failed to ensure the Director for Food and Nutrition Services was a Certified Dietary Manager (CDM), a Certified Food Service Manager, had a national certification for food service management or had an Associates or higher degree in food service management. The findings included: Review of the facility's policy titled, "Professional Staffing" revised 10/2019, revealed a qualified Food Services Director was one who: was a Certified Dietary Manager; or was a Certified Food Service Manager; or had similar national certification for food service management and safety from a national certifying body; or had an Associate's or higher degree in food service management or in hospitality, if the course of study included food service or restaurant management from an accredited institution of higher learning, and in states that have established standards for Food Service Manager or Dietary Managers, meet state requirements for food service managers or dietary managers ...The qualified Dietitian or other clinically qualified nutrition professional would provide guidance and oversight to the Dining Services Director for the consistent preparation and service of all regular and therapeutic diets and the training and supervision of all department staff. Cross reference: F803 (Menus) and F812 (Kitchen sanitation) Review of the Dietary Manager's (DM) personnel records revealed it contained no specific training	F 801	survey is no longer employed at the facility effective 8/24/21. 3. A qualified Dietary Manager began working at the facility on 8/27/21 and has been continually supervising the dietary department and staff fi since that date. Additional qualified Registered Dietitian consultant licensed by the State of Kentucky to be onsite 35 hours a week or more effective 10/20/2021 and will provide direct oversight of kitchen staff, including sanitation audits, menu oversight, and staff in-servicing as needed. No one will be hired to serve as the director of food and nutrition services that is not a qualified director unless they are enrolled in a certified dietary manager course. All Dietary Management staff will be required to maintain valid credentials/licenses. 4. The facility administrator will review and validate credentials for any person hired to oversee the dietary department prior to their start date with the facility. Credentials will be reviewed by the facility Quality Assurance and Performance Improvement committee monthly to ensure continued compliance.	

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F 801	Continued From page 113 related to food service management. Continued review revealed the DM had a chef position from 03/05/2019 to 07/01/2021 and was placed in the current position of DM July 1,2021. Interview with the Registered Dietitian (RD) and the Regional Director of Culinary Services (RDCS), on 08/25/2021 at 12:15 PM, revealed a new company for the kitchen staff had been contracted about seven (7) weeks ago. The RD said the DM would not be in the facility the rest of the week. Continued interview revealed the RDCS was the Dietary Manager's supervisor. Per interview, the Dietary Managere was not a Certified Dietary Manager and had not been enrolled in the Certified Dietary Manager (CDM) course. Interview with the Nursing Home Administrator (NHA), on 08/26/2021 at 9:39 AM, revealed she was aware they needed to have a qualified dietary manager or CDM in place. Continued interview revealed the Dietary Manager had previously worked at the facility as a cook and then went to an assisted living facility. Per inteview, the Dietary Manager came back to the facility with the new contract company, on 07/01/2021, as the Dietary Manager. The Administrator stated, she was under the impression the Dietary Manager was a qualified DM. She said the Registered Dietician was only contracted for two (2) days a week. Further interview revealed the current Dietary Manager was not a CDM or qualified DM and not certified in ServSafe (Safe food handling).	F 801		
F 803 SS=F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7)	F 803		11/5/21

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F 803	Continued From page 114 §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, and facility policy review, it was determined the facility failed to ensure the menus and recipes were followed in one (1) of one (1) facility kitchen with the potential to affect one hundred and eleven (111) residents.	F 803	1. No specific resident was impacted by the alleged deficiency. 2. All residents had the potential to be impacted by the alleged deficiency. Menus, recipes, and diet guides were printed 8/23/21 for staff and residents.	

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F 803	Continued From page 115 The findings include: Review of the facility's polic,y titled "Menus" revised 10/2019, revealed menu cycles would include standardized recipes. Continued review revealed the Menus were served as written, unless changed in response to preference, unavailability of an item, or a special meal. Review of the menus provided by the Registered Dietitian (RD), on 08/25/2021 at 12:15 PM, revealed the following menu: 08/24/2021 Tuesday lunch: Southern fried chicken, orange twist, macaroni and cheese, buttered chopped spinach, dinner roll, and cookie, 08/25/2021 Wednesday lunch: Salisbury steak, beef gravy, chopped parsley rice pilaf, buttered kernel corn, dinner roll, and orange sherbet. Observations of the lunch preparation in the kitchen, on 08/25/2021 at 9:51 AM, revealed the Dietary Aide (DA) was preparing a pureed dessert. Continued observation revealed the DA put a spoonful of the fruit/marshmallow mixture into the food processer and added thickener at various times, without measuring or referring to a recipe for puree texture. The DA said the mixture was called raspberry ambrosia. Per interview, the Dietary Manager (DM) was out of the facility for the next couple of days. The DA stated, a "fill-in" Dietary Manager was in the facility the day before. Interview with Resident #98, on 08/24/2021 at 12:16 PM, revealed the resident received chicken tenders, macaroni salad, green beans, and a cookie. Interview with an unsampled resident, on 08/25/2021 at 2:18 PM, revealed the resident	F 803	Residents receiving alternate entree items will be interviewed by the Dietary Manager or Registered Dietitian to obtain preferences and alternates will be provided that adhere to resident□s preferences and provide sufficient variation. 3. Menus and recipes have been provided by the contract company and the dietary staff was trained on 10/15/21 on tray card accuracy, including following menus as written, including all applicable therapeutic diets and texture-modified diets; proper measurement techniques for all ingredients; proper portion control; adherence to menu cycle and planned menus and the requirement to have Registered Dietitian approve any and all menu substitutions and need to have all substitutions properly documented. 4. The facility administrator or the certified dietary manager and/or the regional culinary director or dietitian will verify that menus and recipes are being followed three times per day for a week, then daily times 2 weeks then weekly times 2 weeks then monthly for 2 months and quarterly for nine months. The certified dietary manager will report findings to the facility Quality Assurance and Performance Improvement committee monthly for review and recommendations to ensure continued compliance.	

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F 803	Continued From page 116	F 803		

received a lot of the same alternates, and the grilled cheese was more like a buttered sandwich. The resident said they received too many fruit cups.

Interview with Cook #1, on 08/25/2021 at 10:09 AM, revealed the dietary staff did not have any supervision at this time, and they were "just winging it." Continued interview revealed the lunch meal consisted of a chicken sandwich with chicken patties, potato wedges, and peas.

Interview with Cook #1 and Registered Dietician (RD), on 08/25/2021 at 11:24 AM, revealed the RD was noted to have the menus from the menu book. Per intrview, Cook #1 had not seen the menus before. Cook #1 stated she changed the menu because she could not prepare seafood and the residents had green beans the day before so she changed the vegtable to peas. The RD advised Cook #1 that after she made the changes, the whole meal consisted of starches. Continued interview revealed Cook #1 was not aware that peas were a starch.

Interview with the Cook #1, on 08/25/2021 at 11:35 AM, revealed she did not have any recipes for the food items she prepared. She stated the only thing she knew for sure were the serving sizes. Continued interview revealed she had been making up her own recipes as she went along. She said the Dietary Manager would type up a menu every day and would give that to them to prepare, but no standard menu was available.

Interview with the Registered Dietitian (RD) and the Regional Director of Culinary Services (RDCS), on 08/25/2021 at 12:15 PM, revealed they provided the Dietary Manager with a copy of

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F 803	Continued From page 117 the necessary in-services for the staff, the menu, and the recipes that accompanied the menu. They said they did not know what happened to them after that point. Per interview, the kitchen was managed by a different contract company. The RD stated the menu book in the kitchen had missing sections and was not the same as the "official" menus provided by the RDCS. The RDCS stated the menus and recipes had been printed for the Dietary Manager, but they were unable to find them in the kitchen. Interview with the Nursing Home Administrator (NHA), on 08/26/2021 at 9:39 AM, revealed she was unaware the menus and recipes were not being followed until this week. She stated the menu and recipe binders were presented to the Dietary Manager by the new company weeks ago.	F 803		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		11/5/21

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F 812	Continued From page 118 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, and review of the facility's policies, it was determined the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for one (1) of one (1) kitchen and one (1) of two (2) nourishment refrigerators with the potential to affect all one hundred and eleven (111) residents. Staff failed to ensure cold foods were covered, expired foods were disposed of, the kitchen and equipment were cleaned, food was stored at the proper temperature, and food was prepared and held at the proper temperatures prior to meal service. The findings include: Review of the facility's policy titled, "Food Preparation" revised 10/2019, revealed time/temperature control for safety (TCS) hot food items would be heated according to the following guidelines: mechanically altered foods: reheated to one hundred and sixty-five (165) degrees Fahrenheit (F) for fifteen (15) seconds; reheated foods: one hundred and sixty-five (165) degrees Fahrenheit for 15 seconds and then discarded after two (2) hours. The cook ensures that all foods were held at appropriate temperatures, greater than one hundred and thirty-five (135) degrees Fahrenheit for hot holding and less than forty-one (41) degrees Fahrenheit for cold food holding. Temperature for	F 812	1. All residents have the potential to be impacted by the alleged deficiency. 2. The container of cottage cheese dated 8/23/21 was discarded along with the tuna salad and the bologna on 8/24/21 immediately on notice from inspector. The walk in refrigerator floor and the walk in freezer floors have been cleaned. The dry storage room floor and the dish area floors have been cleaned. The ice machine has been cleaned. The racks in the walk in refrigerator have been cleaned. The soiled food processor has been cleaned and the shelf it is stored on has also been cleaned. The wall behind the hand washing sink has been cleaned. The steam table and the table behind it have been cleaned. The ceiling above the trash container has been cleaned. All food in the nourishment refrigerator was discarded and the refrigerator was removed and disposed of. The ice bin was cleaned. 3. The dietary staff have all been trained on proper food preparation and refrigeration temperatures and safe storage practices, including but not limited to proper labeling technique, time/temperature control for safety (TCS), First In/First Out (FIFO), and sanitation.on 10/15/21. Logs have been provided for all refrigerators and for meal temperatures. All dietary staff have been trained on	

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F 812	Continued From page 119 TCS foods should be recorded at time of serving and monitored periodically during meal service periods as indicated. Review of the facility's policy titled, "Food Storage: Cold" revised 10/2019, revealed the Dining Services Director/ Cook(s) ensure that all perishable foods would be maintained at a temperature of forty-one (41) degrees Fahrenheit or below except during necessary periods of preparation and service. The Dining Service Director/ Cook(s) ensured that all food items were stored properly in covered containers, labeled, and dated and arranged in a manner to prevent cross contamination. Review of the facility's policy titled, "Ice" revised 10/2019, revealed the Dining Services Director would ensure that the ice bins were cleaned monthly and as needed. The Dining Services Director would ensure that proper utensils or clean gloved hands were used for handling. Review of the facility's policy titled, "Environment" revised 10/2019, revealed the Dining Services Director would ensure that the physical plant was maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation. 1. Observations of the kitchen walk-in refrigerator, on 08/23/2021 at 8:47 AM, revealed a five (5) pound container of cottage cheese with a use-by-date of 08/14/2021. Continued observation revealed a hard plastic container of tuna salad that was open to air and not fully covered. There was a package of bologna, opened to air and not fully covered.	F 812	kitchen sanitation on 10/15/21 and a cleaning schedule and log have been established. All dietary staff have been inserviced on proper cleaning techniques for equipment, coolers, surfaces, including proper use of applicable cleaning chemicals and sanitizer solutions on 10/15/21. The dish machine was replaced on 10/19/21. Ice bin will be cleaned monthly and as needed. Cleaning log posted near ice bin. Staff inserviced on proper handling of ice using approved sanitary handling per policy. An Ice scoop was provided and staff inserviced on proper use, storage, and cleaning of ice scoop on 10/15/21. 4. The Administrator or the Certified Dietary manager will complete a sanitation audit including temperature log reviews daily times two weeks, weekly times two weeks then monthly times nine months. The dietary manager will audit the coolers daily for expired foods. Items found out of compliance will be corrected immediately. Results will be provided monthly to the facility Quality Assurance and Performance Improvement committee for review and recommendations to ensure continued compliance.	

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F 812	Continued From page 120	F 812		

2. Observations of the kitchen, on 08/23/2021 at 8:47 AM, revealed the walk-in refrigerator flooring had dirty brown grout throughout. The flooring was dirty with food debris. The walk-in freezer flooring had areas of melted ice cream, frozen and unclean. The dry storage area flooring had food debris and old spills throughout. The inside of the ice machine was dirty with liquid spatter throughout. The dish machine area flooring was dirty with food debris.

Observations of the kitchen, on 08/25/2021 at 7:30 AM, revealed thick lint and food debris along the racks in the walk-in refrigerator. The inside of the ice machine remained dirty with liquid spatter throughout.

Observations of the lunch preparation in the kitchen, on 08/25/2021 at 9:51 AM, revealed the Dietary Aide (DA) was preparing a pureed dessert. Observation revealed she took out a food processer from the lower shelf. Continued observation revealed the food processer had various dried-on liquid spatter throughout the outside of the container. Further observation revealed the DA continued to puree a fruit/marshmallow dish with the soiled equipment. After using the food processor, the DA cleaned the outside of the food processor and placed it on the lower shelf. Observation of the food processor on the lower shelf revealed it remained soiled with liquid spatter along the crevices and the lower shelf had food debris on the shelf.

Interview with DA, on 08/25/2021 at 10:12 AM, revealed the Dietary Manager (DM) was out of the facility for the next couple of days. She stated a "fill-in" Dietary Manager was in the facility the day before.

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F 812	Continued From page 121	F 812		

Observations of the kitchen, on 08/25/2021 at 10:04 AM, revealed the wall behind the hand washing sink was soiled with brown smears, the trash container was soiled all along the outside of the container, the steam table remained soiled from the breakfast meal, the table behind the steam table was soiled with food debris, the ceiling above the trash container and above the steam table was soiled with an unknown liquid spatter. A dietary staff member used a beverage pitcher to scoop ice out of the ice machine with bare hands. The ice scoop was not used. The dietary staff member touched the bottom of the pitcher with a bare hand and the bottom of the pitcher touched the ice inside of the ice machine. At 11:12 AM, food was placed onto the dirty steam table and the steam table was not cleaned prior.

An interview with the Registered Dietitian (RD) on 08/25/2021 at 1:41 PM said they had no logs and did not know the last time the ice machine was cleaned. She said, "It's disgusting." She confirmed the kitchen had been dirty since she started in the building, and she had been trying to get things cleaned and fixed.

3. Observations of the nourishment refrigerator nearest the main dining room on 08/23/2021 at 11:36 AM revealed a temperature of sixty (60) degrees F. The door to the refrigerator lacked the ability to seal closed. The refrigerator contained resident food items, including yogurt containers. A dietary staff member in the area said she was the Dietary Manager. At 11:42 AM, she said she was not aware she needed to monitor the refrigerator temperatures. She acknowledged the temperature was high and the food needed to be

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disposed of as soon as possible.

4. Observations of food preparation on 08/25/2021 at 10:18 AM revealed the Cook blended some chicken for the mechanical texture. She placed the food into the oven. She took out some breaded chicken from the oven and temped the food item. The temperature was one hundred twenty (120) degrees F, and the food was placed back into the oven. At 10:53 AM, she took the breaded chicken out of the oven and took the temperature again with a temperature of one hundred twenty (120) degrees F. At 11:12 AM, hamburger patties were placed onto the steam table. The Cook took the breaded chicken out of the oven and the food item had a temperature of one hundred thirty-one (131) degrees F. At 11:18 AM, the peas were placed onto the steam table. At 11:30 AM, the Cook placed the breaded chicken into the Robo Coupe for processing. She said the temperature of the chicken was one hundred forty (140) degrees F. At 11:35 AM, she said the ground chicken had a temperature of one hundred forty-five (145) degrees F. She said she only needed to "reheat" the food. The pureed chicken had a temperature of one hundred thirty-five (135) degrees after processing and was placed onto the steam table, without reheating. The Cook said that the pureed chicken stayed hot because of the added hot water. The tall cart next to the steam table contained pimento cheese sandwiches, out at room temperature. The tray line started at 11:45 AM with no temperatures taken of the food items prior to service. The Cook finished pureeing the peas with a temperature of one hundred twenty-seven (127) degrees F, and they were placed back into the oven. The mashed potatoes remained on the stove with a temperature of one

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F 812	Continued From page 123 hundred twenty-nine (129) degrees F. An interview with the Cook on 08/25/2021 at 12:00 PM revealed the food items were not reheated to the proper temperatures. She said since the food was precooked, then it needed to be reheated to one hundred forty (140) degrees F. The Cook was unaware food items needed to be reheated to a temperature of one hundred sixty-five (165) degrees F. An interview with the RD and the Regional Director of Culinary Services (RDCS) on 08/25/2021 at 12:15 PM revealed the RD said the kitchen was responsible for checking the temperature of the nourishment refrigerators. She confirmed that had not been done, and there were no temperature logs available. An interview with the Nursing Home Administrator (NHA) on 08/26/2021 at 9:39 AM revealed orientation should have been completed with the Dietary Manager at the start. She said all the refrigerators should have been checked with temperatures maintained at less than 40 degrees F. She said she was not aware of the kitchen concerns until this week.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted	F 842		11/5/21

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F 842	Continued From page 124	F 842		

to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or

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F 842	Continued From page 125 (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and facility policy review, it was determined the facility failed ensure the medical record was complete, accurately documented, readily accessible and systemically organized for one (1) resident (Resident #101) out of five -seven (57) sampled residents. Review of Resident #101's medical record revealed the facility failed to accurately and completely document insulin administration and blood glucose monitoring. The findings include:	F 842	1. Resident #101's blood glucose level was checked on 8/27/21 and insulin administered as ordered and properly documented. 2. Records of other residents on insulin injections were reviewed on 8/30/21 by the Regional Director of Clinical Services to ensure proper documentation occurred of the injections and the blood glucose monitoring with no relevant findings. 3. Licensed nurses educated on the facility policy for documentation of blood glucose results, and dose and	

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F 842	Continued From page 126 Review of the facility's policy, titled, "Insulin Administration," revised September 2014, revealed staff should check blood glucose levels per the physician order or facility protocol. The policy revealed documentation needed to include the resident's blood glucose result, as ordered; the dose and concentration of the insulin injection. Medical record review revealed Resident #101 was admitted by the facility on 11/14/2019 with diagnoses that included Alzheimer's Disease, Depression, Dementia, and Type 2 Diabetes. Review of Resident #101's Quarterly Minimum Data Set (MDS) Assessment, dated 07/29/2021, revealed the facility assessed Resident #101's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of four (4) out of fifteen (15), indicating the resident was not interviewable. Continued review revealed Insulin injections were marked as given to the resident two (2) out of the seven (7) day look-back period. Review of the 07/2021 Medication Administration Record (MAR) for Resident #101 revealed the resident was ordered by the physician to be administered Humalog Solution one hundred (100) unit/ml (milliliters) Insulin Lispro (Human) Inject as per sliding scale: If zero to one hundred fifty (0-150) = administer zero (0) units and call MD if blood glucose is less than seventy (70); one hudred fity-one to two hundred (151-200) = administer two (2) units; two hundred and one to two hundred and fifty (201- 250) = administer four (4) units; two hundred fifty-one to three hundred (251-300) = administer six (6) units; three hundred and one to three hundred and fifty	F 842	concentration of the insulin injection and resident refusals by the Director of Nursing or the Regional Director of Clinical Services completed by 11/4/21 4. The resident Medication Administration Records will be reviewed daily times 2 weeks, weekly times 2 weeks, monthly times 2 months then quarterly times 9 months to ensure proper documentation has occurred. Results of the reviews will be reported to the facility Quality Assurance and Performance Improvement committee monthly by the director of nursing for review and recommendations to ensure continued compliance.	

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(301-350) = administer eight (8) units; three hundred fifty-one and over (351+) = administer ten (10) units and call MD immediately for further instruction if blood glucose greater than four hundred 400), subcutaneously before meals for thirty (30) days. Start date 07/27/2021, discontinue date 08/05/2021.

Continued review of Resident #101's 07/2021 MAR revealed the MAR was blank on 07/29/2021, 07/30/2021, and 07/31/2021 at 6:30 AM. There was no documentation that the insulin had been administered per the physician's orders and no documented evidence a blood glucose level was obtained. Further review of the MAR revealed the MAR was blank on 08/02/2021, 08/03/2021, and 08/04/2021 at 6:30 AM. There was no documentation that the insulin had been administered per the physician's orders and no documented evidence a blood glucose level was obtained.

A record review of the 08/2021 MAR for Resident #101 revealed the resident was ordered by the physician to be administered Humalog Solution one hundred (100) unit/ml Insulin Lispro (Human) Inject as per sliding scale: If zero to one hundred and fifty (0-150) = administer zero (0) units and call MD if blood glucose was less than seventy (70); one hundred fifty-one to two hundred (151-200) = administer two (2) units; two hundred and one to two hundred and fifty (201- 250) = administer four (4) units; two hundred fifty-one to three hundred (251-300A) = administer six (6) units; three hundred and one to three hundred and fifty (301-350) = administer eight (8) units; three hundred fifty-one and greater (351+) = administer ten (10) units and call MD immediately for further instruction if blood glucose greater

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than four hundred (400), subcutaneously before meals for thirty (30) days. Start date 08/05/2021, discontinue date 08/19/2021.

Continued review of Resident 101's 08/2021 MAR revealed the MAR was blank on 08/18/2021 at 6:00 AM. There was no documentation that the insulin had been administered per the physician's orders and no documented evidence a blood glucose level was obtained.

Further record review of the 08/2021 MAR revealed the resident was ordered by the physician to be administered Humalog OG Solution one hundred (100) unit/ml (Insulin Lispro) Inject three (3) units subcutaneously before meals for diabetes. Start date: 08/19/2021.

Review of the 08/2021 MAR revealed the MAR was blank on 08/20/2021 at 1630 (4:30 PM). There was no documentation that the Humalog OG Solution one hundred (100) unit/ml insulin had been administered per the physician's orders and no documented evidence a blood glucose level was obtained. Continued review revealed the MAR was blank on 08/21/2021, 08/22/2021, and 08/23/2021 at 6:30 AM. There was no documentation that the Humalog OG Solution one hundred (100) unit/ml insulin had been administered per the physician's orders and no documented evidence a blood glucose level was obtained.

Interview with the Director of Nurses (DON), on 08/24/2021 at 1:47 PM, revealed it looked as if they had started giving insulin at meals but had not been very successful. Continued interview revealed if the MAR was blank, then that meant there was no proof the medication had been

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F 842	Continued From page 129 given to the resident. She said if the resident refused, it should have been documented. An interview with the DON, on 08/26/2021 at 9:23 AM, revealed it was her expectation for the nursing staff to read the MAR and follow the physician's orders. She said there were concerns if insulin was not given with the blood sugars remaining high. She said this resident did not always allow the staff to give insulin in the morning, but it should have been accuratey and completed documented in the resident's medical record.	F 842		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on interview, record reviews, and facility policy review, it was determined the facility failed to ensure an effective Quality Assurance (QA) program was in place. The facility's census was 111 residents. Staff failed to ensure the QA program put plans in place to correct past deficiencies, identify its' own deficiencies, and resolve those deficiencies. The findings included:	F 867	1. No residents were directly impacted by the alleged deficient practice. 2. All residents had the potential to be impacted by the alleged deficient practice. 3. The facility Quality Assurance and Performance Improvement team was re-educated on the facility policy for Quality Assurance and Performance Improvement and on the repeat tags and	11/5/21

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F 867	Continued From page 130 A review of the facility's policy titled, "Quality Assurance and Performance Improvement (QAPI) Committee," dated 07/2016, revealed the primary goals of the QAPI Committee are to ...help identify actual and potential negative outcomes relative to resident care and resolve them appropriately; support the use of root cause analysis to help identify where patterns of negative outcomes point to underlying systemic problems; help departments, consultants and ancillary services implement systems to correct potential and actual issues in quality of care. 1. Review of the facility's repeat deficiencies from the 07/25/2019 survey included: -F686- failure to provide care and services related to pressure ulcers. -F690- failure to provide catheter care. -F695- failure to ensure proper oxygen care and services. -F880- failure to ensure proper infection control practices were in place 2. Cross reference tags: -F550- failed to ensure residents were dressed and catheter cover was provided. -F600- failed to ensure residents were safe from abuse. -F609- failed to ensure allegations of abuse were reported timely. -F610- failed to ensure allegations of abuse were thoroughly investigated. -F656- failed to ensure care plans were implemented. -F686- failed to provide care and services related to pressure ulcers.	F 867	how the process is supposed to work to correct potential and actual issues in quality of care. The facility Quality Assurance and Performance Improvement template was reviewed and team was educated on how each tool is used to identify issues that require performance improvement by the regional director of clinical services completed by 11/4/21 4. The facility administrator will ensure that Quality Assurance and Performance Improvement process is in place and that meetings are held routinely each month. The regional director of operations or the regional director of clinical operations will review the minutes of the Quality Assurance and Performance Improvement meetings monthly times 6 months to ensure that the facility is identifying and correcting systemic problems and that compliance is maintained for the survey tags received.	

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F 867	Continued From page 131 -F689- failed to provide care and services for the prevention of falls. -F690- failed to ensure proper catheter care. -F740- failed to ensure proper behavioral plans were in place. -F801- failed to ensure qualified dietary manager was in place. -F803- failed to ensure menus and recipes were followed. -F812- failed to ensure adequate kitchen sanitation. -F880- failed to ensure proper infection control practices were in place An interview with the Nursing Home Administration (NHA) on 08/27/2021 at 6:25 PM revealed they had not completed a live QA meeting in months. She stated they completed "Zoom" QA meetings with the Interdisciplinary Team (IDT) and then would report that information to the medical director. Three (3) staff members were recorded in attendance according to the sign-in sheets. She stated the current QA focus was the new company transition and the accuracy of weights. The Administrator stated they also reviewed COVID-19 and visitation. She said those were the primary areas of concern. Continued interview revealed they discussed reportable incidents with the medical director "this" day. She said they had some Performance Improvement Plans (PIP) areas of focus which included employee retention and the dining program. She said they did not have any documentation for the PIPs. She said she did not think there was any improvement in the PIPs. She said they reviewed falls every week in the critical at risk (CAR) meetings. She said she attended the CAR meetings when she was available. The Administrator stated she was not	F 867		

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F 867	Continued From page 132 aware of any kitchen sanitation or menu issues until "this week". She said everything had been a struggle with COVID-19 and they had been overwhelmed.	F 867		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		11/5/21

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F 880	Continued From page 133 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, and the review of a facility policy, it was determined that the facility failed to keep the	F 880	1. Resident #67 had his catheter bag removed from the floor on 8/27/21. All residents had the potential to be impacted	

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F 880	Continued From page 134 indwelling catheter drainage bag off the floor for one (1) of four (4) sampled residents (Resident #67); and, failed to maintain social distancing in the main hallway and wear the face mask properly in three (3) locations within the building. The deficient practice occurred during the COVID-19 pandemic and had the potential to affect all residents. The findings included: Review of the facility's policy, titled Catheter Care, Urinary, revised 09/2014, indicated under the section Infection Control that the catheter tubing and bag were to be kept off the floor. 1. Record review revealed the facility admitted Resident #67 on 01/18/2021 and re-admitted him/her on 02/14/2021 with diagnoses that included disruption of a surgical wound and obstructive uropathy. Review of Resident #67's Quarterly Minimum Data Set (MDS), dated 07/19/2021, indicated the resident was cognitively intact with a Brief Interview for Mental Status score of fourteen (14) out of fifteen (15). The assessment indicated the resident had an indwelling urinary catheter. Observations of the urinary drainage bag with at least half of the bag lying on the floor were made on 08/23/2021 at 2:47 PM; 08/24/2021 at 2:00 PM; and, on 08/25/2021 at 10:30 AM An interview was conducted with Certified Nursing Assistant (CNA) #2 on 08/25/2021 at 10:33 AM. The CNA, who was assigned to the resident, stated she had not noticed the drainage bag on the floor.	F 880	by the alleged deficient practice of failing to maintain social distancing and wearing masks properly but none were directly impacted. 2. Other residents with catheters were reviewed on 8/30/21 by the Regional Director of Clinical Services to endure their catheters were properly off the floor with no deficient findings identified. 3. All nursing staff have been retrained on proper catheter tubing and bag placement to prevent infection. All staff will be retrained on proper infection control during pandemic per the attached directed plan of correction to include proper wearing of masks and social distancing requirements by the Director of Nursing and Regional Director of Clinical Services. Education completed by 11/4/21 4. The Director of Nursing, licensed administrator and/or other members of facility leadership will make rounds daily to ensure proper infection control measures are enforced. Any issues will result in immediate retraining and repeat violators will be subject to disciplinary action up and including discharge from employment. Results of these daily rounds will be reported monthly to the facility Quality Assurance and Performance Improvement Committee monthly for at least 6 months for review and recommendation to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. BUILDING _____ B. WING _____	08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 135	F 880		

Interview with Registered Nurse (RN) #1 on 08/25/2021 at 10:34 AM, who was assigned to the resident, stated urinary drainage bags should be kept off the floor. She was unable to say how Resident #67's urinary drainage bag was positioned since she had not been in the resident's room that shift.

An interview with CNA #3 was conducted on 08/25/2021 at 11:12 AM. The CNA stated she had emptied the urinary drainage bag and had not noticed when the bed was lowered that the bag landed on the floor.

The Director of Nursing (DON) was interviewed on 08/26/2021 at 8:15 AM. The DON stated a basic standard of care included that the catheter drainage bag should not be placed on the floor related to infection control issues.

2. On 08/24/2021 at 10:50 AM, Licensed Practical Nurse (LPN) #9 was observed sitting at the A Unit nurse's station. His mask was below his nose. Interview with the LPN, at that time, revealed he had been taught to wear his mask above his nose, but the mask kept sliding down. LPN #9 stated he had tried many different types of masks with the same results.

On 08/24/2021 at 10:51 AM, six (6) members of housekeeping staff were seen in the hall outside of the laboratory door. The staff members, in some cases, were almost shoulder to shoulder. Housekeeper #1 stated someone in housekeeping had tested positive and the six (6) standing in front of the lab were waiting to be tested since they had close contact with the positive member of their team.

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F 880	Continued From page 136	F 880		

Unit Manager (UM) #1 was interviewed on 08/24/2021 at 10:56 AM. She stated staff had been taught to social distance. She denied any active cases of COVID-19 in the building at "this time".

Observation on 08/24/2021 starting at 12:30 PM, revealed three (3) employees came through the front door and stopped at the front desk to be screened. Two (2) of the three (3) employees were wearing their masks below their noses. The receptionist, who was screening employees, did not direct the employees to reposition their masks above their noses. Both employees went down the front hall to be COVID-19 tested. When interviewed, the receptionist stated she had been taught the proper way to wear a mask was above the nose. She stated there were so many things going on, she had not noticed the two (2) employees wearing the mask below their noses.

An interview was conducted on 08/24/2021 at 3:00 PM with the Nursing Home Administrator (NHA) and DON to discuss concerns with the breaks in infection control protocols considering the COVID-19 positive employee reported on 08/24/2021. The interview included staff coming through the front door and walking up to the screening desk with no mask, nurses throughout the building not wearing their mask properly and the lack of social distancing. The NHA stated initially a basket of masks had been placed by the door for employees to wear before screening, but someone had told her to remove the basket and place the basket of masks on the screening table. The NHA and the DON stated they understood the seriousness of the situation since they now had a positive employee. The NHA stated

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F 880	Continued From page 137 residents and staff had a choice of wearing a mask or not.	F 880		

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	185236	A. BUILDING _____ B. WING _____	08/27/2021

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E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was initiated on 08/23/2021 and concluded on 08/27/2021. There was no deficient practice identified at 42 CFR 483.73 related to E-0024 (b)(6).	E 000		

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

Electronically Signed | 10/20/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. BUILDING **01 - BUILDING 0101** B. WING _____	**08/25/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAUTAUQUA HEALTH AND REHABILITATION	**1205 LEITCHFIELD ROAD** **OWENSBORO, KY 42303**

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70 BUILDING: 01 PLAN APPROVAL: 1966, 1999 SURVEY UNDER: 2012 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: Type III (211) SMOKE COMPARTMENTS: Six (6) Smoke Compartments FIRE ALARM: Complete fire alarm system installed in 1966. Panel upgraded in 2001. . SPRINKLER SYSTEM: Complete automatic, dry sprinkler system installed in 1966, upgraded in 2012. GENERATOR: Type II, Natural Gas installed in 1983. A standard Life Safety Code Survey was initiated and concluded on 08/25/2021. The facility was found to be in compliance with the requirements for Medicare and Medicaid. The facility is certified for one-hundred forty-five (145) with a census of one-hundred eighteen (118). No deficiencies were cited.	K 000		

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

Electronically Signed | 10/18/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.