DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long-Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Gilpin Hall Nursing Home

DATE SURVEY COMPLETED: October 18, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. A Recertification and Complaint Survey was conducted by Healthcare Management Solutions LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 10/14/24 to 10/18/24 Survey Census: 94 Sample Size: 34 Supplemental Residents: 8		
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed October 18, 2024: F580, F582, F585, F600, F610, F684, F689, F697 and F880.		

Provider's Signature _____ Title Administrator Date 11-01-2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING _____ B. WING _____	C 10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

(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
E 000	Initial Comments A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality on 10/14/24 to 10/18/24. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
F 000	INITIAL COMMENTS A Recertification and Complaint Survey was conducted by Healthcare Management Solutions LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 10/14/24 to 10/18/24 Survey Census: 94 Sample Size: 34 Supplemental Residents: 8	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or	F 580		12/2/24

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

Electronically Signed | 11/10/2024

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.

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F 580	Continued From page 1 clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to notify the	F 580	A. R94 did not return to the facility	

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F 580	Continued From page 2 Resident Representative (RR) following a fall with injuries for one of three residents (Resident (R) 94) out of a total sample of 34 residents. The failure created a delay for R94 to have their RR to get to the hospital to see before R94's condition worsened. Findings include: Review of the facility's "Fall Prevention/Post Fall Policy and procedure," last reviewed 08/25/24, revealed the following: "A. On admission 1. The nurse completes Morse Fall Scale. 2. If it is determined that the resident is at risk for falls a care plan will be put in the record. B. Post-fall l. An Incident Report will be completed. 2. Nurse will document in the resident's progress note. 3. Morse Fall Scale will be completed. 4. Contact responsible party, physician, and Director of Nursing. This should be documented in progress notes as well as Action section of incident report." Closed record review of R94's "Admission Record," located under the "Profile" tab in the electronic medical record (EMR), revealed the resident was admitted to the facility with diagnoses that included dementia, abnormalities of gait and mobility, unspecified convulsions, and seizures. Review of R94's quarterly "Minimum Data Set (MDS)," located under the "MDS" tab in the EMR, with an Assessment Reference Date (ARD) of 12/24/23, revealed a "Brief Interview for Mental	F 580	B. A record review of other residents being discharged to the hospital under emergent conditions was completed for the last three (3) months. No other incidents of delayed notification were identified. C. The root cause was identified that the resident's records were not updated with the correct contact information after the passing of resident's spouse. The preferred contact phone number to reach resident□s representative was also not clearly indicated. To ensure no further delays in notification, the admissions office, or designee, will perform an annual review with each resident representative to ensure contact information on file reflects the current representative name, phone number, mailing address and email address. The resident's records within PCC will indicate the preferred primary contact number for all emergencies as identified by the resident's representative. A policy/procedure was created to reflect this process (Attachment F580-1). Nursing staff will undergo in-servicing on how to read and identify the proper phone chain within resident□s records to ensure notification is timely. D. DON/designee will perform audits of three charts daily to confirm documentation of notification to representative was performed timely until there are three consecutive days with 100% compliance. Then, DON/designee will then review three charts weekly until 100% compliance is achieved for three	

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F 580	Continued From page 3 Status (BIMS)" score of 00 out of 15 which indicated R94 had severe cognitive impairment. R94 was identified to be dependent on staff for all cares and was not walking at the time of the assessment. Review of R94's "Care Plan," updated 1023/23 located under the "Care Plan" tab in the EMR noted R94 had a history of wandering and a history of falls. The resident attended the "Safety Program," identified as the "Cottage," from 9:00 AM to 8:00 PM. Safety interventions were identified as "every 30 minute safety checks, safety helmet when out of bed, hipsters on at all times, followed by neurologist for seizures, non-slip footwear, wheelchair with anti tippers, and Physical Therapy evaluation and treatment dated 12/07/23." Review of a 12/24/23 "Incident Report," provided by the Director of Nursing (DON), noted "Resident witnessed by dietary staff getting up from wheelchair and falling to the floor. Dietary staff notified nursing staff. Resident assessed for injuries, noted W [with] facial laceration and bleeding from the mouth, upper/lower extrimities [extremities] assessed no limitations noted, VS [vital signs] assessed WNL [within normal limits], area noted with adequate lighting, wheelchair noted in lock position. PCP [primary care physician] notifled [notified], resident sent to hospital for further evaluation." Review of the "Nurses Note," located under the "Progress Notes" tab in the EMR, dated 12/24/23 at 11:53 PM, read "Resident witnessed by dietary staff getting up from wheelchair and falling to the floor. Dietary staff notified nursing staff. Resident assessed for injuries, noted w/ [with] facial	F 580	consecutive weeks. Then, three charts will be reviewed by DON/designee monthly until 100% compliance is achieved for three consecutive months. After 3 months with 100% compliance, the monitoring will be concluded. Results will be reviewed with QAPI.	

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F 580	Continued From page 4	F 580		

laceration and bleeding from the mouth, upper/lower extrimities [extremities] assessed no limitations noted, VS [vital signs] assessed WNL [within normal limits], area noted with adequate lighting, free of clutter, wheelchair noted in lock position. PCP notified, resident sent to hospital for further evaluation. Attempted to notify POA, unsuccessful." The incident was identified to have occurred at 6:30 PM. Both the incident report and the nurses note were written by Licensed Practical Nurse (LPN)1.

During an interview on 10/16/24 at 9:41 AM, R94's RR stated "On Christmas eve, 12/24/23, her sister's friend who works at the hospital, notified her sister that [R94] was at the hospital. The sister called [R94's RR] who called the facility to ask what was going on. Neither the [R94's RR] or the sister had been notified by the facility. [R94] should not have been left alone. She was in a wheelchair next to the desk outside the nurse's station. She stood up and fell over the foot pedals. The facility never called me." R94's RR stated "When I questioned nurse, the nurse [LPN1] said she called the resident's husband, she could not have, that number is disconnected, he passed on 11/01/23. Then the nurse said she had tried the next number, [RR's] cell, but couldn't get through. That's not true either. I did not receive any calls. By the time I got to the second hospital where she was transferred, [R94] was intubated, and I didn't get to speak to her." R94 was placed on Hospice (end of life) care and subsequently passed away.

During an interview on 10/16/24 at 10:17 AM, LPN1 said "I was on second floor, called when incident happened. I assessed the resident; she was bleeding from her head and lip. I called the

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F 580	Continued From page 5 ambulance, called the Power of Attorney [RR] home number, couldn't get through, tried both numbers but they didn't work. I remember that I talked to the daughter who had got wind of the incident, so I told her what happened and that I tried both numbers, they were busy or not working. [R94] was in the safety program, the Cottage, and had just come down from there. She was seated next to the desk, tried to get up and fell. Dietary saw it happen." During an interview on 10/18/24 at 11:55 AM, LPN5 stated "I remember [R94], she walked all the time, we would have to encourage her to sit down or sit in the recliner to get her to rest, especially when she appeared tired. She did not always use a wheelchair, just sometimes. When you are sending someone to the hospital, you first take care of the resident, if bleeding put pressure, call doctor, get order to transmit, call ambulance, notify family. May not always check the box on the form, but always put it in the progress notes." The hospital transfer form for the 12/24/23 incident was not located in the EMR. The form had an area "to check" that the RR had been notified. The DON and Administrator were asked, on 10/18/24 at 12:19 PM, to locate the document. No documentation was provided as of exit on 10/18/24 at 4:00 PM. During an interview on 10/18/24 at 1:00 PM, the Administrator said she knew about the concern with notification because the RR "had come in after the resident passed away. I thought [RR] had been notified."	F 580		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)	F 582		11/1/24

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F 582	Continued From page 6 §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any	F 582		

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F 582	Continued From page 7 deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to provide Form CMS-10055 (Centers for Medicaid and Medicare Services) Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) to two of three residents (Resident (R) 10 and R77) reviewed for liability notices out of a total sample of 34 residents. This failure prevented the resident or responsible party the ability to make an informed decision related to the cost of continued therapy services. Findings include: Review of the CMS site, "Form Instructions Advance Beneficiary Notice of Non-coverage (ABN) OMB Approval Number: 0938-0566" accessed at https://www.cms.gov/medicare/medicare-general-information/bni/downloads/abn-form-instructions.pdf on 06/04/24 revealed, "The beneficiary or his or her representative must choose only one of the three options listed in Blank (G). Unless otherwise instructed to do so according to the	F 582	A. Both R10 and R77 are long-term care residents of facility who received timely notice through facility-issued CMS form 10123, Notice of Medicare Non-coverage (NOMNC), of the discontinuation of Medicare A services and were provided information to the appeal process. Although both residents did not receive the CMS 10055 Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF-ABN) indicating the estimated per diem rate of continued services, neither resident incurred additional charges. R77 continued therapy services under Medicare B benefits. B. A review of all residents receiving Medicare A benefits in the last twelve (12) months was performed. No residents incurred additional charges for services at the completion of their Medicare A benefit period. C. Root cause was determined to be that	

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F 582	Continued From page 8 specific guidance provided in these instructions, the notifier must not decide for the beneficiary which of the 3 checkboxes to select . . . If the beneficiary cannot or will not make a choice, the notice should be annotated, for example: "beneficiary refused to choose an option." 1. Review of R10's electronic medical record (EMR) titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on 07/28/20. Review of a document provided by the facility titled provided by the facility titled "Notice of Medicare Non-Coverage" indicated R10's skilled services ended on 10/12/24. Review of R10's EMR indicated the resident remained in the facility after the end of her skilled services. 2. Review of R77's EMR titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on 07/22/24. Review of a document provided by the facility titled provided by the facility titled "Notice of Medicare Non-Coverage" indicated R77's skilled services ended on 08/28/24. Review of R15's EMR indicated the resident remained in the facility after the end of her skilled services. During an interview conducted on 10/16/24 at 9:50 AM, the Admission Coordinator confirmed she never provided the ABN letter along with the NOMNC notice.	F 582	CMS guidelines were not properly interpreted regarding notification as they relate to the facility's long-term care population with additional payor sources upon the completion of Medicare A benefit period. Facility personnel responsible for such notifications and billing were provided education surrounding the CMS requirement to issue both CMS-10055 SNF ABN and CMS 10112-NOMNC at the time Medicare A benefit period is scheduled to end. Facility procedure, Notification of Medicare Provider Non-Coverage (attachment F582-1), has been updated to reflect this CMS requirement. D. The Administrator or designee will perform audit of all Medicare notices for discontinuation of service weekly until there are 3 consecutive weeks with 100% compliance to ensure all required forms are provided and recorded. After that, the Administrator/designee will review all Medicare notices for discontinuation of service monthly until there are 3 consecutive months with 100% compliance. After 3 months with 100% compliance, the monitoring will be concluded. Results to be reported to QAPI.	

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F 582	Continued From page 9 During an interview conducted on 10/18/24 at 11:07 AM, the Administrator stated they have never provided the ABN notice since there were residents who remained in their facility and Medicaid was their payment source and this would add to the confusion for the resident and/or family members, if the facility broke down the costs to provide continued skilled services.	F 582		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy	F 585		11/12/24

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F 585	Continued From page 10 to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by	F 585		

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F 585	Continued From page 11 anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on facility policy review, record review, and interviews, the facility failed to ensure their grievance procedures were followed for one resident (Resident (R) 79) of one resident reviewed for grievances out of a total sample of 34 residents. This failure increased the potential for resident grievances to go unresolved. Findings include: Review of a policy provided by the facility titled "Grievance Procedure" dated 03/11/22 indicated	F 585	A. R79 chart reviewed and showed no issues of weight loss. The dietary slip for R79 was reviewed and confirmed resident preference for meal tray in room. No additional concerns were recorded for R79 regarding delay of/no meal tray delivery within grievance log. B. A review of last month's grievance log identified no outstanding grievances awaiting response to person(s) filing complaint.	

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F 585	Continued From page 12 ". . .The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; and other concerns regarding their LTC facility stay. . . The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. . .Notice on how to make a grievance is included in the Resident Handbook, and is also reviewed upon admission, is posted on each nursing floor. . .A copy of this procedure must be given to the resident upon request. Equipment and Supplies. . .Point Click Care Risk Management Incident report form (online). . .Grievance Form. . ." Review of R79's electronic medical record (EMR) titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on 09/13/22. Review of a document provided by the facility titled "Grievance Log" dated 01/16/24 indicated a family member of R79 filed a grievance alleging the resident did not receive a dinner tray the night before. Under a heading titled "Resolution" it revealed there was a delay in staff delivery. During an interview conducted on 10/16/24 at 12:01 PM, the Administrator stated she was the staff member who handled all of the facility grievances and stated she had no additional information to provide on the meal tray issue and R79.	F 585	C. Root cause was determined to be an ambiguous process for closing grievance. A review of the current Grievance policy and procedure was reviewed with QAPI team. Identified areas for improvements to procedure and documentation to capture all grievances, staff response and how to review with complainant before closing event. Grievance procedure (Attachment F585-1) updated to reflect the process to review grievance investigation findings and resolution with person filing complaint prior to closing event. This communication will be documented on Grievance Log with date and time of closing of grievance. An internal Grievance Tracking Form has been developed (Attachment F585-2) to track progress of waged concern. This form also acts as a checklist during QAPI review. Managers and QAPI committee members have received training regarding procedural updates and internal tracking form. D. Administrator/designee will review Grievance Log weekly until there are three consecutive weeks with 100% compliance to ensure a resolution was reviewed with the person lodging grievance prior to closing the event. Then, the Administrator/designee will review Grievance log monthly until there are three consecutive months with 100% compliance in providing response prior to closing event. After 3 months with 100% compliance, the monitoring will be concluded. Results to be reported to	

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F 585	Continued From page 13 A subsequent interview was conducted on 10/16/24 at 12:23 PM, and the Administrator confirmed she did not provide residents and/or family members with a written response of grievance(s) which included the resolution.	F 585	QAPI.	
F 600 SS=E	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 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 record review, interviews, and facility policy review, the facility failed to ensure: seven of 10 residents (Residents (R)69, R83, R89, R87, R20, and R67) reviewed for abuse were free from resident-to-resident abuse. These failures increased the risk of continued abuse towards the residents. Findings include: 1. Review of the Abuse Policy/Procedure, review date 06/27/23, under "Identification" indicated " ...	F 600	Incident 1: A. R69 and R44 were immediately separated. R69 was assessed at the hospital and returned to facility to complete treatment for injury. Both R69 and R44 were provided with emotional support at the time of the incident. Both residents are also noted with cognitive decline and do not recall the details of event at present.	12/10/24

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F 600	Continued From page 14 abuse, neglect or mistreatment may be suspected in, but not limited to the following situations: "ii. Physical Abuse: Intentionally and unnecessarily inflicting pain, injury, or degradation to a resident' This includes, but is not limited to hit, push, kick, slap, pinch, or sexually molest any resident'. iii. Verbal Abuse: ridiculing or demeaning a resident, cursing directed to a resident, threatening to inflict harm or verbal abuse to a resident . . . "Under "Protection" ... c. "Residents will be protected from other residents in various ways depending on the level and type of abuse. Alternatives may include changing resident rooms, altering resident care plans or discharging a resident from the facility to protect the safety of other residents. d. Incidents involving resident to resident abuse will be reviewed by the clinical team. A care plan review will also be conducted to implement interventions to avoid further instances . . . " a.Review of R69's EMR "Admission Record" located under the "Profile" tab, indicated the resident was admitted to the facility with a diagnosis of Anxiety disorder, Dementia, and Major Depressive disorder, Review of R69's EMR quarterly "MDS" with an ARD of 08/26/24 indicated the resident had a "BIMS" score of three out of 15 which revealed the resident was cognitively impaired. Review of R69's EMR "Care Plan" located under the "Care Plan" tab, revision date 09/14/22, indicated the resident was at risk for elopement/wanderer, entering into other resident's rooms looking for family, car, related to impaired safety awareness and dementia. The Intervention/Tasks, revision date 12/22/21,	F 600	B. A review of all active incident reports was conducted to identify other instance of R44 with episodes of abuse/aggression. No other residents were affected. C. The facility has established that the root cause of the deficient practice occurred due to the need for increased staff awareness to potential triggers or environmental settings for resident aggression and how to best intervene and redirect. The facility Abuse Policy/Procedure (F600-1) has been updated to expand upon Resident-to-Resident abuse, how to identify warning signs, training for interventions and reporting of Resident-to-Resident abuse. Staff will be educated on the updates made to the Policy/Procedure. D. The DON or designee will observe a sampling of 2 residents with history of Resident-to-Resident aggression for 15 minutes daily until there are three (3) days with no observed instances of abuse. DON/designee will then observe 2 Residents with history of aggression weekly until there are three weeks with no instances. Finally, DON/Designee will observe two (2) Residents with history towards aggression monthly until there are three months with no instances of aggression. After 3 months with no observed resident aggression, the monitoring will be concluded. Results of observations will be presented to QAPI team.	

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F 600	Continued From page 15 indicated to distract resident from wandering, provide structured activities, visual safety checks every hour. Review of R69's EMR "Nurse's Notes" located under the "Progress Notes" tab, indicated that on 02/27/24 an altercation coming from R44's room was heard, R69 was observed placing his hand over his left eye. R69 was noted to have bloodshot and specks of blood within the orbital area. It was also documented in the same nurse's note that R69 stated he was hit in the eye by the other resident (R44) in the room. R69 was sent to the Emergency Department for further treatment and evaluation on 02/27/24 via ambulance services. Further review of the resident EMR indicated that R69 is on Xarelto, an anticoagulant medication, which can result in excessive bleeding and bruising. Review of the Emergency Department note, dated 02/27/24, indicated R69's sustained a Subconjunctival hemorrhage, and Corneal abrasion. R69 was discharged and returned to the nursing facility on 02/27/24 with a prescription for Erythromycin ophthalmic ointment. Review of the ER Discharge Instructions, dated 02/27/24, revealed the following prescription: Erythromycin ophthalmic (erythromycin 0.5% ophthalmic ointment) 0.5 inch in the eye four times a day. Review of the "Medication Administration Record (MAR)" of the months of February and March 2024, revealed that the resident was started on the Erythromycin ointment at 9:00 AM and with the last dose given on 03/04/24 at 12 noon. Review of the MAR for February 2024 revealed that on 02/27/24 the resident was medicated with Tylenol 325 mg ii tablets for pain. The pain was	F 600	Incident 2: A. R83 and R64 were immediately separated. R83 provided emotional support and does not indicate any long-term effects from event. B. A review of all active incidents was completed and found no further incidents of abuse involving R64 since 7/20/2024. R64□s care plan was amended on 7/21/2024 to include 1:1 supervision during waking hours and 30-minute safety checks during evening/night. C. Root cause has been identified as the need for increased staff awareness and education around potential triggers and environmental settings that can promote resident aggression/inappropriate behavior is needed. The facility Abuse Policy/Procedure (F600-1) has been updated to elaborate on Resident to-Resident abuse, steps to prevent Resident-to-Resident aggression and appropriate response interventions to avoid escalation. Resident-to-Resident abuse training will include management of incidents involving residents who are not capable of consenting to sexual contact/inappropriate touching. All staff will be educated on Policy/Procedure updates. D. The DON or designee will observe a sampling of two (2) residents with history of Resident-to-Resident inappropriate	

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F 600	Continued From page 16 documented at a "5" out of 10 at 9:11 AM and 5:14 PM. During a telephone interview on 10/18/24 at 10:17AM, Registered Nurse (RN)1 stated R69 had wandered into resident R44's room and RN1 heard R44 say "get out of my room, get out of my room." RN1 stated he went into the room and observed R69 covering his eye. RN1 stated he separated both residents and examined R69's eye and noted that R69's eye was bloodshot with blood specks. RN1 stated he notified the physician and transferred R69 to the Emergency Department for further treatment and evaluation. RN1 also stated that he talked to R44 and asked him to use the call light or call a staff member when someone enters his room. RN1 further stated R44 was in agreement with calling staff when someone entered his room. Review of R44's EMR "Admission Record" located under the "Profile" tab, indicated the resident was admitted to the facility with diagnoses including Dementia and Alzheimer's disease. Review of R44's EMR annual "MDS" with an ARD of 08/16/24 indicated the resident had a "BIMS" score of five out of 15 which revealed the resident was cognitively impaired. Review of R44's EMR "Care Plan" located under the "Care Plan" tab, revision date 02/28/24, indicated the resident had the "potential to become verbally and physically aggressive towards other residents that cause him to feel threatened or invade his personal space secondary to being impulsive, short tempered and territorial." The Intervention/Tasks revision dated 02/28/24 indicated the resident's behaviors	F 600	actions for 15 minutes daily until there are three (3) days with no observed instances of abuse. DON/designee will then observe 2 Residents with history of inappropriate touching weekly until there are three consecutive weeks with no instances. Finally, DON/Designee will observe two (2) residents with history towards inappropriate touching monthly until there are three consecutive months without instance. After three months without instances of inappropriate touching between residents, the monitoring will be concluded. Results of observations will be reviewed with QAPI team. Incident 3: A. Both R89 and R87 were immediately separated and provided emotional support. B. A review of incident reports completed from 10/07/24, date of incident was conducted to identify other instances of R44 with episodes of abuse. No other residents were affected. C. Root cause identified to be the need for staff□s increased awareness and education around potential triggers or environmental settings that may promote resident aggression/inappropriate behavior is needed. Seating in the common areas can become congested, promoting opportunities for altercations. Staff have been educated and measures	

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F 600	Continued From page 17 was de-escalated by removing other persons from his space, . . . encourage seeking out of staff member when agitated before becoming physical . . . when the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress . . . " Interview on 10/15/24 at 10:23AM, and 4:05 PM and on 10/18/24 at 8:15AM, R44 stated that R69 wanders into his room, and he tells him "get out of my room" but denied hitting R69. Interview on 10/18/24 at 5:20 PM, the Assistant Director of Nursing (ADON) stated R44 denied hitting resident R69. The ADON further stated that there have been no further altercations and or resident to resident abuse involving R44 and R69. b. Review of R83's EMR "Admission Record" located under the "Profile" tab, indicated the resident was admitted to the facility diagnoses of Dementia, Personality Disorders, and Major Depressive disorder. Review of R83's EMR annual "MDS" with ARD of 11/20/23 indicated the resident had no "BIMS" score to determine the resident's was cognitive status. The assessment revealed the resident was dependent on staff for activities of daily living (ADL). Review of R83's EMR "Care Plan" located under the "Care Plan" tab, revision date 11/25/22, indicated the resident had an ADL self-care performance deficit related to Dementia, and had limited physical mobility related to being non-ambulatory. The Intervention/Tasks revision date 11/25/22 under "locomotion" indicated R83	F 600	taken to provide increased space between chairs to allow residents to maintain personal boundaries. The facility Abuse Policy/Procedure (F600-1) has been updated to elaborate on Resident to-Resident abuse, steps to prevent Resident-to-Resident aggression and appropriate response interventions to avoid escalation. All staff will be educated to policy/procedure updates. D. The DON or designee will observe a sampling of two (2) residents with history of Resident-to-Resident aggression for 15 minutes daily until there are three (3) consecutive days with no observed instances of abuse. DON/designee will then observe 2 Residents with history of aggression weekly until there are three consecutive weeks with no instances. Finally, DON/Designee will observe two (2) residents with history towards aggression monthly until there are three (3) consecutive months with no instances. After three months without instance, monitoring will be concluded and 100% compliance achieved. Results of observations will be reviewed with QAPI team. Incident 4: A. R20 was provided emotional support and encouraged to communicate concerns to Supervisor/Administration. CNA7 was immediately suspended pending outcome of investigation and ultimately terminated.	

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F 600	Continued From page 18 was dependent on staff for locomotion using a Geri-chair. Further review of the Care Plan revealed R83 was at risk for emotional distress related to male resident rubbing her "stomach and while she was seated in the lounge waiting for dinner." The Intervention/Tasks initiated date 07/18/24 indicated "resident remains in common area for increased observation." Review of R83's EMR "Nurse's Notes" located under the "Progress Notes" tab, indicated a late entry note dated 07/21/24 indicated that on 07/20/24 a male resident was observed rubbing R83's groin area. R83 was "sitting in a Geri-chair at the TV lounge." Interview with R83 was attempted during the survey without success. During an interview on 10/16/24 at 1:09 PM, Dietary Aide (DA) 1 stated that R83 was sitting in her Geri-chair near the nurses' station when R64 was observed rubbing R83's legs near the groin area, she stated "I was breaking down the trays after lunch and I saw what he was doing and I told the nurse immediately. I separated them first, and then told the nurse, there were no nurses or staff around they were busy taking people to their rooms. He just rolled himself over to her, she doesn't talk so she did not tell him to get away or push him away. I rolled him to the opposite side of the room, locked his wheelchair and went to get and tell the nurse." Review of R64's EMR "Admission Record" located under the "Profile" tab, indicated the resident was re-admitted into the facility with a diagnosis of Dementia.	F 600	B. A review of past incident reports/grievances for 2024 was reviewed and showed no other incidents involving CNA7. A review of current/active incident reports/grievances found no instances of verbal/emotional abuse. C. Root cause of incident identified as need for increased awareness to types of abuse, the definition of abuse, and how one□s interpretation of a comment can be considered abuse. Facility Abuse policy/procedure(attachment F600-1) has been updated to reflect types of abuse and what constitutes abuse. Abuse education has been developed to include interpretive scenarios to aid in staff comprehension of abuse. Facility will continue to require staff attendance at the annual visit from the Department of Justice who speak on resident Abuse, Neglect and Exploitation. D. Administrator/designee will review all incident reports/grievances for reports of abuse/inappropriate behaviors weekly until there are 3 consecutive weeks without instance. The Administrator/designee will then conduct a review of all incident reports/grievances monthly to ensure no instances of abuse/inappropriate behaviors until there are 3 months without instance. After 3 months with 100% compliance, the monitoring will be concluded. Outcomes will be reviewed with QAPI.	

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F 600	Continued From page 19 Review of 64's EMR quarterly "MDS" with an ARD of 08/21/24 indicated the resident had a "BIMS" of five out of 15 which revealed the resident was cognitively impaired. The assessment revealed the resident was dependent on staff for activities of daily living (ADL). Review of R64's EMR "Care Plan" located under the "Care Plan" tab, revision date 01/25/24, indicated the resident needed adequate supervision and observation as he had a behavior of becoming sexually inappropriate with female residents with dementia/cognitive impairment. The Intervention/Tasks revision date 07/22/24 indicated R64 was placed on "1:1 monitoring due to safety concerns when out of bed, 30-minute safety checks when in bed, re-direct resident if he displays any inappropriate behavior or verbalizations, visual safety checks put into place to monitor residents' location." Review of R64's EMR "Nurse's Notes" located under the "Progress Notes" tab, indicated a late entry note dated 07/24/24, revealed "Currently, resident is being monitored by 1:1 supervision. Alternate placement on another floor is also being explored. However, it is the opinion of the clinical team that resident's behavior will continue as he identifies another target. Also discussed option to locate another facility that could better address needs." An interview with R64 was attempted during the survey process without success. Interview on 10/18/24 at 5:20 PM, the ADON stated that the dietary aide had stopped R64 "if she had not stopped him, it could have gone a lot further." The ADON stated that no other	F 600	Incident 5: A. R67 and R95 were already separated when report was provided to staff. R95 has been discharged from the facility. R67 sustained no physical injuries from altercation. Emotional support was provided at the time and R67 currently does not recall details of the incident due to cognitive impairment. B. A review of six (6) months of incident reports prior to 12/25/23, date of incident, revealed no other incidents involving R95 toward another resident. C. Root cause of event is determined to be the need for staff□s increased awareness and education around potential triggers or environmental settings where resident aggression may occur. The facility Abuse Policy/Procedure (attachment F600-1) has been updated to include staff training regarding resident-to-resident aggression, steps to prevent resident-to-resident aggression, and appropriate responses and interventions. Staff will continue to receive on-going education and awareness training as it pertains to Resident abuse. D. The DON or designee will observe a sampling of two (2) residents with history of Resident-to-Resident aggression for 15 minutes daily until there are three (3) days with no observed instances of abuse. DON/designee will then observe 2 Residents with history of aggression weekly until there are three weeks with no	

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F 600	Continued From page 20 incidences of touching other female residents have occurred to include resident R83. The ADON stated the dietary aide observed R64 touching the thighs of the resident near the groin area. R64 had wheel himself out of the Dining Room (DR) and approached the female resident who was sitting in her Geri chair outside the DR and near the nurses' station. R64 was immediately removed from the area and placed on 1:1 monitoring. The ADON further stated that the facility is trying to find more appropriate living arrangements for him. R64 remains on 1:1 monitoring until alternate placement is found for R64. c. Review of R89's "Admission Record," located under the "Profile" tab in the EMR noted the resident was admitted with diagnoses that included dementia with agitation. Review of the quarterly "MDS," located under the "MDS" tab in the EMR with an ARD of 07/18/24 revealed a "BIMS" score of six out of 15 which indicated R89 had severe cognitive impairment. Review of the "Care Plan," dated 07/24, located under the "Care Plan" tab in the EMR revealed a problem of "Potential to be verbally aggressive, short tempered, displaying outbursts related to dementia and poor impulse control." Included in the interventions were "Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document. ... When the resident becomes agitated: intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later."	F 600	instances. Finally, DON/Designee will observe two (2) residents with history towards aggression monthly until there are three months with no instances. Results of observations will be reviewed with QAPI team.	

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F 600	Continued From page 21 Review of R87's "Admission Record," located under the "Profile" tab in the EMR noted the resident was initially admitted with diagnoses that included unspecified dementia, with mood disturbance, and cognitive communication deficit. Review of the admission "MDS," located under the "MDS" tab in the EMR with an ARD of 09/12/24 revealed a "BIMS" score of seven out of 15, which indicated R87 had severe cognitive impairment. Review of the "Care Plan," dated 07/24, located under the "Care Plan" tab in the EMR revealed no concerns related to behaviors, agitation, or aggression. Review of an incident report, dated 10/07/24, provided by the Assistant Director of Nurses (ADON), revealed "Residents were sitting next to one another in common area. I was in hall talking with charge nurse and heard a commotion. I turned to look and saw [R87] standing up in front of [R89] holding her walker by the legs and trying to hit [R89]. Myself and the charge nurse immediately separated both residents. [R89] was ask what happened and she did not give me an answer. Just stated she did not do anything. She denied any pain and was assessed for injury. No inlury [injury] found. She was put on 15 min checks- [R87] was also assessed and visibly upset. He denied injury and stated he would be OK. Resident was noted with 2 small red scratches on his clavicle area. Both residents have a Hx [history] of dementia with anxiety." During an interview on 10/16/24 at 2:44 PM, the ADON, responsible for completing the investigation, stated "[R89] was the aggressor.	F 600		

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F 600	Continued From page 22 [R87] had his arm up talking with another resident, [R89] hit him on his arm. [R87] did not pay attention to her. [R89] then shook her hands at him. [R87] then stood up and pushed [R89]'s walker at her. The second time [R87] tried to hit [R89] with the walker, she held on and nothing occurred." d. Review of R20's"Face Sheet," located in the EMR under the "Profile" tab revealed R20 was admitted to the facility with diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Depression, Anxiety and Acute Respiratory Failure. Review of the quarterly "MDS" located in the EMR under the "MDS" tab and dated 06/05/24, revealed the resident was assessed on the "BIMS" with a score of 14, indicating the resident was cognitively intact and exhibited no mood or behaviors during the same assessment period. Review of the resident's "Care Plan" located in the EMR under the "Care Plan" tab revealed the resident had the potential for sad mood, tearfulness, withdrawn state secondary to history of depression, anxiety and declining health. Review of a facility reported incident to the State Survey Agency (SSA) dated 04/01/24, indicated that the resident told the Director of Nursing (DON) that she wanted to talk to her privately about a particular aide. R20 said "The evening aide screams at me." She verbalized that the aide makes her cry sometimes. Review of the facility's investigation revealed that in an interview with the DON and the Assistant Director of Nursing (ADON) it was revealed that	F 600		

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F 600	Continued From page 23 Certified Nurse Aide (CNA) 7 was giving aide to R20 with an orientee. They turned the resident on her side and the resident started to scream in pain. CNA7 described and re-enacted backing away from the resident with her hands up in the air and saying, "I'm not even touching you." CNA7 told the resident that her backside (used a derogatory term). She also told the resident that "I guess that I will be in the DON's office on Tuesday." CNA7 described her relationship with the resident as friendly and they often joked around. The investigation determined that under the care of CNA7, the resident felt humiliated, tearful and manipulated. The resident was interviewed and indicated that she never felt comfortable with the aide, she disagreed with the description of their relationship. The CNA was initially suspended after the allegation was made and after the investigation, she was terminated from the facility. During an interview on 10/16/24 at 3:04 PM, R20 did not remember an incident with CNA7 and denied having any problems with staff. During an interview with the ADON on 10/16/24 at 3:36 PM, she stated that the resident about the incident. During the investigation, she asked the Quality Control Nurse to speak to the resident to see if she thinks the CNA should return to work. The resident stated she did not think the CNA should work at the facility. "We decided to terminate her because of the resident's statement and what the CNA wrote up in her statement." The ADON also stated that she had not had any concerns about CNA7 before, she just would have a big mouth sometimes but she was a good worker.	F 600		

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F 600	Continued From page 24 Review of the statement submitted by CNA7, dated 03/19/24 she stated, "while changing R20, she was resistant to care, throwing her leg out of the bed at one point. I was not even touching her and she was screaming like I had my hands on her. I said to her, "You sitting here yelling making it seem like I'm touching you and I'm leaning against the wall. The resident made the comment she would just leave or die. I stated you don't have to leave or die but please do not resist when someone is giving you care, you can do more harm to the aid than yourself." During an interview with the Quality Control Nurse on 10/17/24 at 9:52 AM, she stated she spoke to the resident about allowing CNA7 to return to work and the resident said no, she should not. She stated that she had not received any complaints regarding CNA7 in the past. In an interview with the DON, on 10/17/24 at 10:30 AM, she stated that she was involved with interviewing staff only when discipline was involved. The DON stated the way CNA7 described how she spoke to R20, just what she said to the resident, it was clear and concerning. "After the interview with CNA7, I did not feel that she thought she had done anything wrong. We had to let her go. The ADON and I both thought she should not be here and was terminated. We did not feel like she was fixable." The DON stated she could not remember any complaints from other residents concerning CNA7's behavior. The DON stated that as soon as she found out about the incident, CNA7 was suspended and terminated. e. Review of R67's EMR titled "Admission Record" located under the "Profile" tab indicated	F 600		

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F 600	Continued From page 25 the resident was admitted to the facility on 05/31/22. Review of R67's EMR titled annual " MDS" with an ARD of 08/29/23 indicated the resident had a "BIMS" score of six out of 15 which revealed the resident was severely cognitively impaired. The assessment indicated the resident had no behaviors. During an interview on 10/17/24 at 2:09 PM, R67 stated he did not remember the resident-to-resident which involved R95. The resident stated he was not fearful and stated he was fine. Review of R95's EMR titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on 05/20/21. Review of R95's EMR titled quarterly "MDS" with an ARD of 10/23/23 indicated the clinical staff could not determine the resident's "BIMS" and revealed the resident had short-term and long-term memory problems. The assessment indicated the resident had physical/verbal behavior directed towards others. Review of R95's EMR titled administration "Progress Notes" located under the "Prog (Progress) Note" dated 12/25/23 indicated the resident was observed to punch R67 in the eye and the resident was then redirected from the area. Review of a document provided by the facility titled "Physical" indicated R67 reported to the facility that R95 punched him in the left eye. R67 said that R95 attempted to open the dining room	F 600		

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F 600	Continued From page 26 door. R67 stated he tried to stop R95 from doing so and that was when R95 punched him in the eye. The clinical staff assessed the resident and there were no injuries. The resident's physician and responsible party were notified of the incident.	F 600		
F 610 SS=D	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 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, record review, and interview, the facility failed to ensure three of three residents (Residents (R) 20, R67, and R95) allegations of physical/verbal abuse were fully investigated out of sample of six residents reviewed for abuse out of a total sample of 34 residents. This lack of investigation had the potential to lead to continued episodes physical and verbal abuse.	F 610	A. Emotional Support was provided to R20, R67 and R95 at the time of the incidents and none sustained physical injury. B. A review of all current/active incident reports was completed, no issues identified with investigations in progress.	12/10/24

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F 610	Continued From page 27 Findings include: Review of a policy provided by the facility titled "Resident Abuse Policy/Procedure" dated 06/27/23, indicated ". . .Investigation. . .Facility will thoroughly investigate any incidents reported regarding the identification if incident as listed above. . .The facility will investigate all incident reports based on information obtained from witness statements, caregiver statements, and interviews as available. . ." 1. Review of R20's"Face Sheet," located in the EMR under the "Profile" tab revealed R 20 was admitted to the facility with diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Depression, Anxiety, and Acute Respiratory Failure. Review of the quarterly "MDS" located in the EMR under the "MDS" tab, dated 06/05/24 revealed the resident indicating the resident was cognitively intact and exhibited no mood or behaviors during the same assessment period. Review of the resident's "Care Plan" located in the EMR under the "Care Plan" tab revealed R20 had the potential for sad mood, tearfulness, withdrawn state secondary to history of depression, anxiety, and declining health. Review of the facility's investigation of a facility reported incident to the State Survey Agency (SSA) dated 04/01/24, revealed that in an interview with the DON and the Assistant Director of Nursing (ADON), Certified Nurse Aide (CNA) 7 stated she was giving aide to R20 with an orientee. They turned the resident on her side	F 610	C. Root cause identified as established policies of steps to complete a comprehensive investigation were not followed. To ensure a proper and thorough investigation is completed, an Investigation Checklist (attachment F610-1) was created. The facility Abuse Policy/Procedure (attachment F600-1) was updated to include reference to Investigation Checklist under paragraph 5 Investigation. Staff responsible for performing the steps of investigation will be educated to Abuse Policy/Procedure updates and Intervention Checklist. D. DON/designee will conduct a review of all active investigations daily to ensure all steps of the investigation process are in compliance for three days until 100% compliance is achieved; The DON/designee will then review all active investigations weekly for 3 weeks until 100% compliance is met. Finally, DON/designee will conduct a review of all active investigations monthly until 100% compliance is achieved for three consecutive months. Monitoring will be considered complete after 3 months of 100% compliance. Outcomes will be reviewed with QAPI.	

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F 610	Continued From page 28	F 610		

and the resident started to scream in pain. CNA7 described and re-enacted backing away from the resident with her hands up in the air and said, "I'm not even touching you." CNA7 told the resident that her backside (used a derogatory term) was showing. She also told the resident that "I guess that I will be in the DON's office on Tuesday." CNA7 described her relationship with the resident as friendly, and they often joked around. The investigation determined that under the care of CNA7, the resident felt humiliated, tearful, and manipulated. The resident was interviewed and indicated that she never felt comfortable with the aide, and she disagreed with the description of their relationship. CNA7 was initially suspended after the allegation was made and after the investigation, she was terminated from the facility.

During an interview with the ADON on 10/16/24 at 3:36 PM, she stated that the DON spoke to the resident about the incident since the DON was responsible for investigating and reporting the incidents. During the investigation, the Quality Control Nurse was asked to speak to the resident to see if she thought CNA7 should return to work after suspension. R20 stated she did not think CNA7 should work at the facility. So, based on the statement from R20 and CNA7, the decision was made to terminate CNA7.

When asked for documentation of other interviews conducted during the investigation, the ADON stated that she did not interview other residents during the investigation that may have had any interactions or care provided by CNA7. The ADON stated she had asked other staff about CNA7, and they did not have any problems with her. When asked if she documented the

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F 610	Continued From page 29 interviews with other staff members regarding CNA 7, she stated no, she did not have any written documentation. 2. Review of R67's electronic medical record (EMR) titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on 05/31/22. 3. Review of R95's EMR titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on 05/20/21. Review of a document provided by the facility titled "Physical" dated 12/25/23 indicated R67 reported to staff he was punched in the eye by R95. R67 stated he attempted to intervene when R95 tried to open the dining room door. Continued review of the file failed to contain evidence of other potential staff and residents who may have witnessed the incident. During an interview on 10/17/24 at 12:29 PM, the Assistant Director of Nursing (ADON), with the Director of Nursing present, confirmed the investigative file did not contain evidence of interviews gathered from potential witnesses which would include staff and residents. During an interview on 10/18/24 at 11:10 AM, the Administrator stated the staff collect interviews from potential witnesses depending on the situation.	F 610		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		12/10/24

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F 684	Continued From page 30 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and facility policy review, the facility failed to ensure one of four residents (Resident (R) 30) reviewed for accident hazards did not suffer a delay in treatment when the facility did not notify the physician of the delay in obtaining an x-ray as ordered. R30 experienced swelling to the right knee area and was administered non-narcotic pain medication for three days. The x-ray was obtained three days after being originally ordered and showed the resident had suffered an acute fracture to the distal femur. Findings include: Review of R30's electronic medical record (EMR) "Admission Record" located under the "Profile" tab, indicated the resident was admitted to the facility on 10/26/16 with a diagnosis of Arthropathy (arthritis), Dementia, and Alzheimer's disease. Review of R30's EMR annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 06/28/24 indicated the resident had a "Brief Interview for Mental Status (BIMS)" score of three out of 15 which revealed the resident was cognitively impaired. The assessment indicated R30 was dependent on staff for transfer	F 684	A. R30 received treatment at the hospital and returned to facility with stabilized fracture. B. All current radiology orders were reviewed. None were identified to be outstanding. C. Root cause has been identified as the need for additional staff education to ensure all imaging orders are completed in a timely manner. The Policy/Procedure for Ordering X-Rays and Imaging (attachment F684-1) has been updated to include the entering of every imaging order into PCC under Alert Charting with required documentation every shift until order has been completed. If the order has not been completed within a 24-hour window, nurse must notify the ordering physician and POA. Nurses will receive education to monitoring/reporting process. D. A sampling of imaging orders will be reviewed by DON/designee daily for timely completion. Once there are 3 consecutive days with 100% compliance, another sampling will be reviewed by DON/designee weekly until 100%	

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F 684	Continued From page 31 (movement from one surface to another) mobility and activities of daily living (ADL). Review of R30's EMR "Nurse's Notes" located under the "Progress Notes" tab, indicated that on 07/19/24 at 3:17 PM, R30 was noted to have swelling to her right knee. The physician was notified and ordered a 2-view x-ray of the right knee. On 07/19/24 at 10:02 PM "Nurse's Notes" indicated R30's right knee remained with swelling and "awaiting x-ray to be completed." Further review of the "Nurse's Notes" for 07/19/24 indicated R30 was medicated for pain with Tylenol. On 07/20/24 at 2:23 PM "Nurse's Notes" indicated an ice pack was applied to the right knee. Tylenol 325mg two tablets administered for pain. "waiting for x-ray to the R[right] knee." On 07/20/24 at 9:55 PM "Nurse's Notes" indicated affected leg supported with pillow, "awaiting x-ray of right leg." On 07/21/24 at 3:19 PM "Nurse's Notes" indicated Tylenol administered for right knee pain. Attempted to reach Mobilex [x-ray] to know when staff was coming for x-ray "no response." On 07/21/24 at 9:19 PM "Nurse's Notes" indicated resident continues with swelling to R knee, pain medication administered. "Awaiting x-ray of the right knee." Review of R30's EMR "Nurse's Notes" and "Orders" revealed no documentation the physician was notified that the ordered x-ray had	F 684	compliance for three consecutive weeks. At that time, DON/designee will review a sampling of imaging orders monthly until 100% compliance is achieved for three consecutive months. At that time, monitoring will be considered complete. Results will be reviewed with QAPI.	

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F 684	Continued From page 32	F 684		

not been obtained. There was no documentation the facility attempted to contact another mobile x-ray company. There was no documentation the facility attempted to obtain physician guidance related to the resident's need for pain medication.

Review of the "Nurse's Notes" revealed that the attending physician was called three days later on 07/22/24 at 9:51 AM and notified of the delay in completing the x-ray.

On 07/22/24 at 9:51 AM nurse's notes indicated "resident continued with right knee pain with movement, Tylenol administered as needed. [name of x-ray facility] contacted requesting estimated time of arrival for x-ray. The physician was notified [that the x-ray had yet to be completed], resident to remain on bedrest until x-ray is completed."

Further review of the "Nurse's Notes" indicated that the x-ray to the right knee was completed on 07/22/24 at 10:41 PM, three days after the x-ray was ordered.

On 07/23/24 at 7:28 AM nurse's notes indicated x-ray results received with following conclusion "acute fracture of right distal femur [thigh bone are close to the knee] with modest displacement and angulation [fractured bone segments at an angle], old fracture of right mid patella [kneecap] with modest displacement without callus formation. Intact right knee Arthroplasty. MD [physician] made aware.

On 07/23/24 at 10:14 AM nurse's notes indicated "Oxycodone 1 tablet po Q 6H PRN for Pain . . . " Oxycodone is a narcotic pain medication.

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F 684	Continued From page 33 In addition, the nurse's notes dated 07/23/24 indicated R30 was diagnosed with a fractured femur and sent to the Emergency Department for evaluation of the right knee and swelling, and her pain management was adjusted to better regulate her pain. While R30 had initially been receiving Tylenol for pain relief, a stronger medication, Morphine was prescribed upon her return to the facility to more effectively address the pain associated with the fractured femur. On 07/23/24 at 12:14 PM nurse's notes indicated R30 was sent to the Emergency Department for an "Ortho consult" and further evaluation and treatment. Interview on 10/19/24 at 12:30 PM, the Director of Nursing (DON) confirmed that obtaining the x-ray was delayed.	F 684		
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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure one of four residents (Resident (R) 30) reviewed for accident hazards out of a total sample of 34 was transferred using the appropriate mechanical lift and number of staff as	F 689	Incident 1: A. R30 received treatment for sustained injury and returned to facility with stabilized fracture. Upon discovery of fracture, CNA9 was immediately removed	12/10/24

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F 689	Continued From page 34 per the resident's plan of care. Findings include: Review of the EZ Lift Policy and Procedures revised date 08/01/24 indicated under "Purpose . . . To prevent injury to the resident and staff when lifting and transferring . . . Key Procedural Points item 1. There will be (2) staff at all times when using the EZ way Lift or EZ Way stand up lift." Review of R30's electronic medical record (EMR) "Admission Record" located under the "Profile" tab, indicated the resident was admitted to the facility on 10/26/16 with a diagnosis of Arthropathy (arthritis), Dementia, and Alzheimer's disease. Review of R30's EMR annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 06/28/24 indicated the resident had a "Brief Interview for Mental Status (BIMS)" score of three out of 15 which revealed the resident was cognitively impaired. The assessment indicated R30 was dependent on staff for transfers (movement from one surface to another) and activities of daily living (ADL-bathing, toileting, dressing). Review of R30's EMR "Care Plan" located under the "Care Plan" tab, revision date 02/06/20, indicated the resident had an ADL self-care performance deficit related to dementia and decreased mobility. The Intervention/Tasks revision, dated 01/09/24, under "transfers" indicated R30 was a Hoyer lift with two staff. Review of the facility's follow up report to the State Survey Agency (SSA), dated 07/26/24,	F 689	from schedule until investigation was completed. CNA9 was then disciplined and terminated. B. A review of proper use of mechanical lift equipment and competencies were conducted with all nursing staff immediately following incident. All residents requiring EZ lift assistance were reviewed and none were found to be impacted. C. Root cause has determined that there is a need for increased competencies to ensure staff remain compliant with policy and procedures. The facility EZ Lift Procedure (attachment F689-1) was updated to clarify where staff can identify the proper lift to use within PCC. The procedure also addresses the process to follow if a resident exhibits a change in condition that prevents safe/proper use of EZ Lift device. Nursing staff will be educated to the updates made to current policy/procedure. In addition, on-going EZ Lift competencies will be conducted monthly on a random sample of staff to ensure compliance with policy/procedure. D. The DON/designee will complete three (3) lift competencies with staff daily until 100% compliance is achieved for three (3) consecutive days. The DON/designee will then complete lift competency with three (3) staff weekly until 100% compliance is achieved for three (3) consecutive weeks. Finally, DON/designee will complete lift competency with three (3) staff monthly	

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F 689	Continued From page 35 indicated "our investigation checked hours of video to check on who took care of resident on that particular day ... we believe that CNA caring for the resident might have used incorrect mechanical lift ..." Review of documentation provided by the Director of Nursing (DON), dated 07/24/24, revealed "video reviewed" which indicated Certified Nursing Assistant (CNA) 9 took the stand-up lift into R30's room "that morning" and was later seen removing the stand-up lift from the room and placing it in the hallway. After lunch, the video showed CNA 9 taking the resident into the spa room alone and leaving the spa room two minutes later. CNA9 was then seen getting another CNA and the Hoyer lift and taking it into the resident's room. Review of a written statement by CNA9 dated 07/18/24 and 07/19/24 provided by the DON revealed: Question: Did you help transfer resident to wheelchair? - Response by CNA: Yes, transfer to wheelchair. Question: How did you transfer Resident? Who assisted you with transfer? Response by CNA: Mechanical Lift 2 person. Review of "Employee Warning Record" dated 7/19/24 indicated that the CNA was witnessed using the wrong lift on a resident and not having a second person assist. "She failed to follow the resident's care plan and failed to follow the company policy of having a 2nd person with her while using the lift. She was previously made aware of this policy and signed a lift agreement that she knew if she would be terminated if she violated this policy . . ." During an interview on 10/19/24 at 12:30 PM, the DON confirmed that she reviewed the videos for	F 689	until 100% compliance is achieve for three (3) consecutive months. Upon completion of 100% compliance for 3 months, monitoring will be completed. Results of competencies will be reviewed with QAPI team. Incident 2: A. R38 has not sustained injury or harm from use of personal single cup Keurig machine. B. Nursing performed an assessment of R38□s capability to utilize personal Keurig single cup coffee machine and identified that resident exhibited proper safety awareness when using device. Resident□s care plan was updated to reflect ability to safely use Keurig machine. Incident reports reviewed (12/14/2023 □ 10/14/2024), no other residents received injury from use of single cup Keurig coffee machine. C. Root cause of incident identified to be lack of proper assessment/care planning for personal use items that were granted exception. Residents and representatives are educated on the list of restricted personal items upon admission. A separate acknowledgement form Restricted Resident Items (attachment F689-2) has been created to bring attention to potential risk with use of listed items. Residents and representatives are provided with the process to obtain	

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F 689	Continued From page 36 several days prior to the incident and observed CNA9 take the stand-up lift into R30's room and later removing the stand-up lift and placing it in the hallway. And then after lunch CNA 9 was seen in the video taking the resident into the spa room alone. The DON stated that two people are to be used when the stand-up and Hoyer lift are used. The DON further stated that patient care information provided to CNAs in Point Click Care (PCC) under the "Tasks" tab included patient care information under the "Task Care Record, Kardex and Task List." The DON confirmed CNA9 was aware of how the R30 was to be transferred by two staff using the Hoyer lift Review of the PCC patient care information under the "Task Care Record, Kardex and Task List" revealed that the facility staff, including CNA9, had easy access to the resident's care activities information to include ADL's, safety, bed mobility, bathing, and transfers. Review of the PCC Kardex documentation for R30 for the month of July 2024 indicated that R30 was assessed as a "4/3"for the task of "ADL-Transferring Hoyer Lift (2) staff members." The legend indicated 4 was "Total assistance and 3 was "Two plus person physical assist. CNA9 was aware that R30 was "Total Dependence "for transfer and required transfer support of "2 plus people" when transferring with the use of the Hoyer Lift and not with the standup lift. Review of the Lift agreement signed and dated by CNA 7 on 07/12/23 revealed "I verify that I have received training for the proper use of the EZ lift. I understand that there must always be two employees present while using the lifts ..."	F 689	authorized exception for any items listed. Staff are educated on the list of restricted items and directed to notify Administration if found in resident possession. Residents requesting use of such items will be assessed for safety awareness and care planned for such use as indicated in policy/procedure Restricted Resident Items Exception Procedure (attachment F689-3). Staff will be educated to identify items that pose safety concerns and how to report/respond. D. Admissions director/designee will conduct three room audits daily to determine no restricted items are in use without authorization/care planning for three consecutive days with no identified items. The Admissions director/designee will then conduct three room audits weekly until 100% compliance is achieved for three consecutive weeks. Finally, the admissions director/designee will audit three rooms per month until 100% compliance is achieved for three consecutive months. At that time, monitoring will be considered complete. Results of audits will be reviewed with QAPI.	

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F 689	Continued From page 37 2. Review of the "Face Sheet" located in the Electronic Medical Record (EMR) under the "Profile" tab revealed R38 was admitted to the facility with diagnoses including Multiple Sclerosis. Review of the quarterly "Minimum Data Set (MDS)" assessment located in the EMR under the "MDS" tab with an Assessment Reference Date (ARD) of 09/25/24 revealed the resident was assessed with a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, indicating R38 was cognitively intact. Further review of this "MDS" revealed R38 had no impairment of the upper extremities and was independent with eating. Review of the "Care plan" located in the "EMR" under the "Care Plan" tab revealed R38 was identified as being independent of dressing his upper extremity and with hygiene. Observation of the resident's room on 10/14/24 at 10:04 AM revealed R38 was in his room in his electric wheelchair, well dressed, alert and oriented. On the nightstand next to the bed, R38 had multiple bottles of water and a Keurig single use coffee maker. During an interview on 10/14/24 at 1:35 PM, R38 stated that he has had the Keurig for several years and he has never had a problem with it. He does not drink the water at the facility, which is used to make coffee, so that is why he has his own coffee maker. During an interview with the Assistant Director of Nursing (ADON) on 10/14/24 at approximately 2:30 PM, she stated she did not think the resident	F 689		

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F 689	Continued From page 38 used the Keurig, but staff made it for him. She did not know if the resident had been assessed for the use of the Keurig. She stated that she would observe R38 using the Keurig coffee maker for safety. Further review of the EMR revealed no documentation of an assessment for the safe use of the Keurig coffee maker.	F 689		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and facility policy review, the facility failed to provide pain management that met professional standards for one of one resident (Resident (R) 30) reviewed for pain out of a total sample of 34 residents. R30 experienced swelling of the right knee area and received non-narcotic pain medication (Tylenol) while waiting three days for an x-ray. The facility failed to assess the resident's pain, failed to conduct pre and post pain medication assessments, and failed to indicate why Tylenol was administered to the resident. The x-ray revealed the resident had sustained a fracture to the right distal femur. Cross-Reference F684. Findings include: Review of the Pain Management Policy, reviewed	F 697	A. R30 was treated for pain and is now stable. B. Medical Director completed full medication review of all residents since incident, to include proper and effective pain management. C. It was determined that the Root cause of event is education for staff surrounding thorough assessment for any adjustments to pain medication/management. Pain Management Policy/Procedure (attachment F687-1) has been updated to include a thorough pain assessment to be documented for all residents experiencing a change in condition with mobility, bedrest, or suspicion of injury. Nursing	12/10/24

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F 697	Continued From page 39 date 11/15/23, under "Key Procedural Point" indicated "Residents have a right to be free from pain." Review of R30's electronic medical record (EMR) "Admission Record" located under the "Profile" tab, indicated the resident was admitted to the facility on 10/26/16 with a diagnosis of Arthropathy (arthritis), Dementia, and Alzheimer's disease. Review of R30's EMR annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 06/28/24 indicated the resident had a "Brief Interview for Mental Status (BIMS)" score of three out of 15 which revealed the resident was cognitively impaired. The assessment indicated R30 was dependent on staff for transfer (movement from one surface to another) mobility and activities of daily living (ADL). Review of R30's EMR "Nurse's Notes" located under the "Progress Notes" tab, indicated that on 07/19/24 at 3:17 PM, R30 was noted to have swelling to her right knee. The physician was notified and ordered a 2-view x-ray of the right knee. On 07/19/24 at 10:02 PM "Nurse's Notes" indicated R30's right knee remained with swelling and "awaiting x-ray to be completed." Further review of the "Nurse's Notes" for 07/19/24 indicated R30 was medicated for pain with Tylenol. On 07/20/24 at 2:23 PM "Nurse's Notes" indicated an ice pack was applied to the right knee. Tylenol 325mg two tablets administered for pain. "waiting for x-ray to the R[right] knee."	F 697	staff will be educated to the changes made to policy/procedure. D. DON/designee will complete a record review of three residents daily receiving pain medicine to ensure proper assessment and documentation is in compliance for three consecutive days. The DON/designee will then conduct a record review of three residents receiving pain medicine weekly until 100% compliance is achieved for three consecutive weeks. DON/designee will then review three resident records of those residents receiving pain medications monthly to ensure proper assessment and documentation is in compliance until 100% compliance is achieved for three consecutive months. At this time monitoring will be considered complete. Outcomes to be reviewed with QAPI.	

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F 697	Continued From page 40 On 07/20/24 at 9:55 PM "Nurse's Notes" indicated affected leg supported with pillow, "awaiting x-ray of right leg." On 07/21/24 at 3:19 PM "Nurse's Notes" indicated Tylenol administered for right knee pain. Attempted to reach Mobilex [x-ray] to know when staff was coming for x-ray "no response." On 07/21/24 at 9:19 PM "Nurse's Notes" indicated resident continues with swelling to R knee, pain medication administered. "Awaiting x-ray of the right knee." On 07/22/24 at 9:51 AM nurse's notes indicated "resident continued with right knee pain with movement, Tylenol administered as needed. [name of x-ray facility] contacted requesting estimated time of arrival for x-ray. The physician was notified [that the x-ray had yet to be completed], resident to remain on bedrest until x-ray is completed." Further review of the "Nurse's Notes" indicated that the x-ray to the right knee was completed on 07/22/24 at 10:41 PM, three days after the x-ray was ordered. Review of R30's "Medication Administration Record (MAR)" for the month of July 2024 revealed R30 received five doses of Tylenol 325mg II tablets from July 19, 2024 - July 23, 2024, for pain management prior to her visit to the Emergency Department on July 23, 2024. There was no documentation the resident's pain was assessed before the Tylenol was administered or afterwards to determine if relief had been obtained.	F 697		

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F 697	Continued From page 41 On 07/23/24 at 7:28AM nurse's notes indicated x-ray results received with following conclusion "acute fracture of right distal femur [thigh bone are close to the knee] with modest displacement and angulation [fractured bone segments at an angle], old fracture of right mid patella [kneecap] with modest displacement without callus formation. Intact right knee Arthroplasty. MD [physician] made aware. On 07/23/24 at 10:14AM nurse's notes indicated "Oxycodone 1 tablet po Q 6H PRN for Pain . . . " Oxycodone is a narcotic pain medication. In addition, the nurse's notes dated 07/23/24 indicated R30 was diagnosed with a fractured femur and sent to the Emergency Department for evaluation of the right knee and swelling, and her pain management was adjusted to better regulate her pain. While R30 had initially been receiving Tylenol for pain relief, a stronger medication, Morphine was prescribed upon her return to the facility to more effectively address the pain associated with the fractured femur. On 07/23/24 at 12:14 PM nurse's notes indicated R30 was sent to the Emergency Department for an "Ortho consult" and further evaluation and treatment. On 07/23/24 at 4:14 PM nurse's notes indicated R30 was to be discharged from the hospital and returned to the facility with an order for Morphine one tablet by mouth every six hours as needed for Moderate pain. Review of R30's Medication Administration Record (MAR) for the month of July 2024	F 697		

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F 697	Continued From page 42 revealed R30 received Morphine Sulfate 15mg for pain from July 24, 2024 - July 28, 2024, for a total of six doses after returning to the facility from the Emergency Department. Per the MAR July 2024 the resident had two orders: Morphine Sulfate 15mg one tablet every 6 hours: 07/24/24 Morphine 15mg one tablet administered at 9:26 AM for a pain level "6" and at 9:55 PM for a pain level "3" 07/25/24 Morphine 15mg one tablet was administered at 2:19 PM for a pain level "7" Morphine Sulfate 15mg one tablet every 4 hours for Right femur fracture for moderate pain 1-5. 07/27/24 Morphine 15mg for a pain level of "5". 07/28/24 Morphine at 9:42 AM for a pain level "8" and at 8:00 PM for a pain level of "3" Interview on 10/19/24 at 12:30 PM, the Director of Nursing (DON) confirmed that obtaining the x-ray was delayed.	F 697		
F 880 SS=E	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:	F 880		12/10/24

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F 880	Continued From page 43 §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 §483.71 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 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	F 880		

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F 880	Continued From page 44 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 observation, staff interviews, and review of the facility's policy, the facility failed to 1.) ensure staff changed gloves, performed hand hygiene, and followed proper cleaning techniques for one of one resident (Resident (R) 30) observed during incontinence care and one of one resident (R88) observed during wound care from a sample of 34 residents, and 2.) ensure staff followed recommended disinfectant drying times to disinfect a multi-use glucometer for two residents (R1 and R6) observed during medication pass. These failures increased the risk of cross contamination. Findings include: 1. Review of the facility's policy titled, "Handwashing" review date 02/28/24, revealed, "Purpose To prevent or minimize the transfer of pathogens. 1. Hand washing is the most important procedure used to prevent the spread of pathogens." Review of the facility's policy titled, "Peri Care of the Female Resident" review date 01/03/24, revealed under "Purpose To provide cleanliness	F 880	A. R30 showed no signs or symptoms of infection due to this practice. R88 has been discharged from the facility. R1 and R6 have no negative outcomes due to this practice. B. A review of infection control log has been completed and determined no other residents were impacted by this practice. C. Root cause has been identified as increased education and competency checks to ensure policy/procedures are being followed. Handwashing policy/procedure (attachment F880-1) was updated to include washing of hands during peri care after cleaning resident and before applying clean brief, pull up or undergarment. An additional section was also added to reflect the need for handwashing during wound care between the removal of soiled bandage and before applying clean dressings. An update was made to the policy/procedure of Cleaning of Glucometers (attachment F880-2) to call attention to the importance of allowing	

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	085047	A. BUILDING _____ B. WING _____	C 10/17/2024

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F 880	Continued From page 45 and comfort while enhancing infection and irritation prevention . . . Cleaning is always done anterior to posterior (front to back) . . . Staff must change gloves after direct exposure to bodily fluids or fecal matter and clean/disinfect hands prior to completing resident care and touching other clean surfaces." Review of R30's "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab revealed she was admitted to the facility with diagnoses of Arthropathy (arthritis), Dementia, and Alzheimer's disease. Review of R30's EMR annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 06/28/24 indicated the resident had a "Brief Interview for Mental Status (BIMS)" score of three out of 15 which revealed the resident was cognitively impaired. The resident required maximum assistance for toileting and was frequently incontinent of bowel and bladder. Review of R30's "Care Plan" located in the EMR under the "Care Plan" tab indicated the resident had bladder and bowel incontinence related to dementia, and impaired mobility with interventions to provide peri care after each incontinent episode. During an observation on 10/16/24 at 1:55 PM, Certified Nursing Assistant (CNA) 4 and (CNA) 5 provided incontinence care to R30. CNA 4 and CNA5 each donned a pair of gloves, removed the resident's pants and adult brief. After removing the adult brief, R30 was turned on her right side and was observed to be incontinent of bowel with brown fecal material noted on the resident's right and left buttocks. Using the same gloves, CNA 4	F 880	surface of glucometer to air-dry after cleaning with approved disinfecting towelette. All nursing staff will receive training on procedure revisions. Random competencies will be conducted throughout the year to ensure compliance with policy/procedure. D. DON/Designee will complete three competencies on handwashing/glucometer cleaning daily until 100% compliance is achieved for three consecutive days. DON/Designee will then complete three competencies for handwashing/glucometer cleaning weekly until 100% compliance is achieved for three consecutive weeks. DON/designee will then complete three competencies for handwashing/glucometer cleaning monthly until 100% compliance is achieved for three consecutive months. At that time, monitoring will be considered complete. Outcomes to be reviewed with QAPI.	

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F 880	Continued From page 46 cleaned the top of the resident's perineal area in a downward motion. CNA 4 did not separate R30's labia. CNA4 then discarded the soiled used wipes directly onto the floor. CNA 4 and CNA5 then turned R30 on her left side and CNA 5 cleaned the resident left and right buttock cheek and anal area in a back to front motion towards the labia with disposable wipes removing large amounts of fecal material. Resident R30 was then turned on her back, CNA 4 then repeated to clean the top of the peri area in a downward motion removing fecal material. After cleaning the resident, R30 was turned on her right side and a clean adult brief was applied. With the same soiled gloves, the resident's pants were pulled up and her white blouse was adjusted. CNA4 and CNA5 then adjusted the resident's pillows and pulled up the blue comforter, adjusted to call light within reach of the resident. CNA 4 then moved the resident's bed in place (against the wall) moving the bed by the footboard with the same soiled gloves. After picking up the soiled disposable wipes from the floor, CNA 4 removed and discarded her soiled gloves, CNA 4 was observed to leave R30's room without washing her hands. During an interview with CNA 4 and CNA5, immediately after the observation, CNA 4 and CNA5 confirmed they should have cleaned the peri area from top to bottom, separating the labia and cleaning the buttock and rectal area from front to back to avoid contamination of the vaginal/peri-area. The CNAs stated that they should have removed their soiled gloves after cleaning the resident's soiled body areas, and before putting on a clean brief and adjusting the resident's clothing and, pillow, comforter and before repositioning the call-light.	F 880		

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F 880	Continued From page 47 During an interview with the Director of Nursing (DON) on 10/17/24 at 10:00 AM, she confirmed the CNAs should have changed her gloves and washed their hands. 2. Review of the facility's policy titled, "Dressing Change," dated 04/18/24, revealed, ". . . Purpose to prevent contamination of wound, while restoring skin integrity and monitor healing process . . . create clean field with paper towels or drape . . . Open dressing pack . . . Put on first pair of disposable gloves . . . Remove soiled dressing and discard in plastic bag . . . Dispose of gloves in plastic bag . . . Wash hands . . . Put on second pair of disposable gloves . . . Pour prescribed solution onto gauze to be used for cleaning . . . Cleanse wound with prescribed solution . . . Apply prescribed medication if ordered . . . Apply dressings and secure with tape . . . Remove gloves and discard with all unused supplies in plastic bag . . . Wash hands . . ." Review of R88's "Face Sheet," located in the electronic medical record (EMR) under the "Profile" tab, revealed R88 was admitted on 06/19/23 with diagnosis of diabetes mellitus, muscle weakness, atrial fibrillation, malignant neoplasm of left kidney, peripheral vascular disease, and a stage III pressure sore. During an observation on 10/16/24 at 9:10 AM, LPN1, LPN2, and Certified Nursing Assistant (CNA) 3 were observed performing wound care for R88's stage III sacral pressure sore. LPN1 had placed her dressing change supplies on top of the overbed table. A protective barrier was not observed under the supplies. Prior to beginning the wound care, LPN2 suggested cleaning the	F 880		

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resident before wound care to minimize the time she needed to be turned. A wash basin was placed on the same overbed table with the supplies and was used to wash the resident. After the bath was completed, the basin was removed from the overbed table which left a wet spot in the same area. Without cleaning the table, LPN1 proceeded to begin with the dressing change. She put on a pair of disposable gloves, removed the soiled dressing from the resident's sacral area and removed the gauze from the wound bed. LPN1 placed the soiled dressing in a plastic bag and removed her soiled gloves. Without performing hand hygiene, she put on a new pair of gloves and used a clean gauze and wound cleaner from the overbed table to clean the resident's wound. After cleaning the wound, LPN1 disposed of the gauze and gloves in the plastic bag and, without performing hand hygiene, she put on another pair of disposable gloves and placed a medicated ointment on top of a medicated gauze in the wound bed and covered the wound with a dressing. After completing the wound care, LPN1 removed her gloves and placed the remaining dressing supplies in the plastic bag and washed her hands.

During an interview on 10/16/24 at 9:10 AM, LPN1 stated that she did not disinfect the top of the overbed table after CNA 3 removed the wash basin that left water on the table. LPN1 confirmed that she did not wash her hands between changing from soiled to clean gloves and stated she should have.

During an interview with the Infection Preventionist (IP) on 10/16/24 at 3:14 PM, the IP stated that the nurse performing the wound care should have washed her hands between

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changing her soiled gloves to clean gloves and the overbed table should have been disinfected again after removing the wash basin.

3. Review of the facility's policy titled, "Cleaning of Glucometers," dated 08/27/24, revealed, ". . . The purpose of this procedure is to prevent the spread of infection . . . clean glucometers after every use . . . clean glucometer with approved product . . . allow appropriate amount of time for product to dry before using equipment on another resident . . ."

Review of the "Clorox Healthcare Bleach Germicidal Wipes" manufacturer's guidelines, located on the product's container, revealed the recommended drying times ranged from 30 seconds to kill bacteria to one minute to kill bloodborne pathogens.

During an observation on 10/14/24 at 10:49 AM, Licensed Practical Nurse (LPN)4 prepared a blood glucose monitor to check the blood glucose level for RRe1. Using a disinfecting wipe, LPN4 wiped the monitor several times. Without allowing the disinfecting solution to dry, she used a tissue to wipe the monitor dry. LPN4 completed the blood glucose test for R1 and placed the monitor back on top of her medication cart. LPN4 used another disinfectant wipe on the same blood glucose monitor and approached R6 in the hallway. Before allowing enough time for the monitor to dry, LPN4 again used a tissue to dry the monitor before conducting the blood glucose test for R6. After obtaining the test, LPN4 placed the blood glucose monitor directly on top of the medication cart without a protective barrier underneath the monitor.

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F 880	Continued From page 50 During an interview on 10/15/24 at 2:34 PM, LPN4 was asked what process she followed for disinfecting the blood glucose monitor. She stated, "I wiped the monitor, I was supposed to leave it for three minutes. I used the tissue because [the surveyor] was there." LPN4 stated, "Usually, I would wait three minutes to air dry." She stated she had worked at the facility for four years and received training on blood glucose monitors when she was hired. During an interview on 10/15/24 at 1:42 PM, the Director of Nursing (DON) stated that the nurses are trained to allow three minutes for the disinfectant to dry on the blood glucose monitors when cleaning. She stated this was included in their policy.	F 880		