**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: Harrison Senior Living

DATE SURVEY COMPLETED: June 6, 2023

| SECTION | STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES | COMPLETION DATE |
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| | **The State Report incorporates by reference and also cites the findings specified in the Federal Report.**<br><br>An unannounced Annual and Complaint Survey was conducted at this facility from May 30, 2023, through June 6, 2023. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents as indicated. The facility census on the first day of the survey was 101. The survey sample totaled 27 residents. | Cross Refer to the CMS 2567-L survey completed June 6, 2023: F550, F609, F623, F625, F656, F677, F684, F695, F730, F812, F868 and F943. | |
| 3201 | **Regulations for Skilled and Intermediate Care 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.**<br><br>This requirement is not met as evidenced by:<br><br>Cross Refer to the CMS 2567-L survey completed June 6, 2023: F550, F609, F623, F625, F656, F677, F684, F695, F730, F812, F868 and F943. | | |

Provider's Signature Amanda Joseph FOR NHA Frank Beech Title DON Date 6/30/23

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| HARRISON SENIOR LIVING OF GEORGETOWN, LLC | 110 W. NORTH STREET GEORGETOWN, DE 19947 |

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| E 000 | Initial Comments<br><br>An unannounced Annual and Complaint Survey was conducted at this facility from May 30, 2023 through June 6, 2023. The facility census was 101 on the first day of the survey.<br><br>In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, Emergency Preparedness deficiencies were cited. | E 000 | | |
| E 037 SS=D | EP Training Program<br>CFR(s): 483.73(d)(1)<br><br>§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).<br><br>*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]<br>(1) Training program. The [facility] must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least every 2 years. | E 037 | | 7/20/23 |

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

Electronically Signed | 06/29/2023

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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| E 037 | Continued From page 1<br>(iii) Maintain documentation of all emergency preparedness training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.<br><br>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.<br>(ii) Demonstrate staff knowledge of emergency procedures.<br>(iii) Provide emergency preparedness training at least every 2 years.<br>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.<br>(v) Maintain documentation of all emergency preparedness training.<br>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.<br><br>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under | E 037 | | |

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| E 037 | Continued From page 2 | E 037 | | |

arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under

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| E 037 | Continued From page 3<br>arrangement, and volunteers, consistent with their expected role.<br>(ii) Provide emergency preparedness training at least annually.<br>(iii) Maintain documentation of all emergency preparedness training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br><br>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:<br>(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.<br><br>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, | E 037 | | |

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| E 037 | Continued From page 4<br>personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.<br><br>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of documents and interview, it was determined that for six (E5, E6, E7, E8, E9, and E10) out of sixteen sampled staff members, the facility failed to ensure that staff received initial Emergency Preparedness training upon hire or annual Emergency Preparedness training in the previous twelve months. Findings include:<br><br>- On 3/31/22, E5 (RN) and E9 (CNA) received the most recently documented Emergency | E 037 | A. There were six staff members identified in deficiency, 2 were hired for short term contracts through an agency and no longer work at facility. The four identified staff members will receive education on Emergency Preparedness by 6/30/23.<br><br>B. All staff members could potentially be affected by this deficiency. An audit of all | |

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| E 037 | Continued From page 5<br>Preparedness training.<br><br>- According to documents, the facility failed to provide the initial Emergency Preparedness training required upon hire for E6 (Laundry Attendant), E7 (CNA), E8 (Agency LPN), E9 (CNA), and E10 (LPN).<br><br>6/5/23 11:25 AM - Findings were confirmed with E1 (NHA) during a telephone interview. | E 037 | staff will be completed on Emergency Preparedness training by 6/30/23.<br><br>C. Emergency Preparedness training has been added to new hire orientation. A facility wide audit on Emergency Preparedness training will be completed. All current employees working in the facility will be trained on Emergency Preparedness by July 20, 2023. Employees who have not received this training will not be able to return to work in facility until training is completed. Emergency Preparedness training will be conducted annually for all staff. Documentation of training shall be maintained in facility and/or in the Relias training system. Emergency preparedness training will be included in mandatory education for individuals providing services under arrangement, and volunteers.<br><br>D. Audits will be conducted weekly x 4 weeks until 100% compliance is achieved for 4 consecutive weeks, then monthly x 2 months. | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Annual and Complaint Survey was conducted at this facility from May 30, 2023 through June 6, 2023. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents as indicated. The facility census on the first day of the survey was 101. The survey sample totaled | F 000 | | |

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| F 000 | Continued From page 6<br>27 residents.<br><br>Abbreviations/definitions used in this report are as follows:<br><br>ADON - Assistant Director of Nursing;<br>CNA - Certified Nursing Assistant;<br>DON - Director of Nursing;<br>NHA - Nursing Home Administrator;<br><br>Activities of daily living (ADLs) - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing;<br>BID - twice a day;<br>Lymphedema - swelling in arm or leg most commonly caused by blockage in a blood vessel;<br>MDS assessment - Federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs;<br>Treatment Administration Record (TAR) - list of daily/weekly/monthly treatments to be performed. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's | F 550 | | 7/20/23 |

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| F 550 | Continued From page 7<br>individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, it was determined that for two (R51 and R455) out of three residents reviewed for dignity, the facility failed to promote dignity. Findings include:<br><br>The facility policy on dignity, last updated 10/2020, indicated that "staff shall speak respectfully to residents at all times... Staff shall promote dignity and assist residents as needed | F 550 | A. R455 no longer resides at the facility, however, following the referenced incident, the nurse was suspended, disciplined, and education was provided. This incident was reported to the Division of Health Care Quality on 1/5/2023.<br><br>B. All residents have the potential to be affected by this deficient practice. DON, or designee, will conduct audits of all | |

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| F 550 | Continued From page 8<br>by: helping the resident to keep urinary catheter bags covered."<br><br>1. 3/16/22 - R455 was admitted to the facility with multiple diagnoses including dementia, anxiety and psychotic disturbance.<br><br>R455's care plan for behavior problems related to agitation, last updated 10/14/22, included the intervention for staff to "avoid a power struggle, avoid arguing with resident, as it will worsen agitation, always avoid confrontation. Do not attempt reason or logic."<br><br>12/12/22 - A complaint was submitted by the facility to the State Agency, that alleged "Day-shift nurse was verbally inappropriate with resident."<br><br>Review of facility documentation related to the above complaint revealed a written statement dated 12/12/22 written by E18 (LPN) that documented R455 was, "Randomly yelling different things as he walked by the nursing desk. I asked the resident how old he was. After answering, I asked R455 why he was acting like a two year old."<br><br>During an interview on 6/5/23 at 12:13 PM, E1 (NHA) confirmed the finding.<br><br>2. The following was reviewed in R51's record:<br><br>R51's care plan related to the urinary catheter, last updated 6/2/23, included the intervention for staff to ensure the privacy bag was in place.<br><br>R51 was observed the following times in common areas without a privacy bag covering the urinary catheter bag: | F 550 | reported abuse allegations from the past 2 weeks to ensure that residents involved have behavior care plans with appropriate interventions to manage behaviors, if behaviors exist.<br><br>C. All staff to receive abuse education regarding mandatory reporting to be completed by July 5, 2023. All facility nurses will be educated on the use of individualized care plans to identify strategies and interventions to manage resident behaviors July 12, 2023.<br><br>D. DON, or designee, will audit abuse allegations for behavior care plan interventions, if behaviors exist, monthly x 3 months until 100% compliance is achieved. Audits will then be submitted and reviewed at the facility□s monthly QAPI meeting and the committee will then decide if further audits will be needed.<br><br>A. A foley catheter privacy bag was placed on R51□s catheter bag on Jun 6, 2023.<br><br>B. All residents with foley catheters have the potential to be affected. A facility wide audit of all residents with foley catheters will be completed by the Unit Managers, or designees, to identify any resident lacking a privacy bag. Audits to be completed by July 5, 2023.<br><br>C. All nursing staff members will be educated to place foley catheter privacy bags on all foley catheter bags by July 12, | |

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| F 550 | Continued From page 9<br><br>5/31/23 at 10:41 AM - In the activity room playing bingo.<br><br>6/1/23 at 11:27 AM - In the activity room doing chair exercises.<br><br>6/5/23 at 10:20 AM - In the hallway waiting for assistance to go to the activity room.<br><br>During an interview on 6/1/23 at 11:50 AM, E17 (LPN) confirmed that R51's urinary catheter bag did not have a privacy covering. E17 stated, residents are "Supposed to have a dignity bag, but I'm not sure where they keep them."<br><br>Findings were reviewed during the exit conference on 6/6/23 at 1:30 PM with E1 (NHA) and E2 (DON). | F 550 | 2023. A nursing task for all residents with foley catheters will be placed for CNA sign off every shift to ensure that privacy bags are in place. All tasks will be added to the residents□ tasks lists by July 12, 2023.<br><br>D. Unit Managers, or designees, will complete audits weekly x 4 weeks until 100% compliance is achieved for 4 consecutive weeks, then monthly x 2 months. Audits will then be submitted and reviewed at the facility□s monthly QAPI meeting and the committee will then decide if further audits will be needed. | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and | F 609 | | 7/20/23 |

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| F 609 | Continued From page 10<br>adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, it was determined that for one (R455) out of two residents reviewed for abuse, staff failed to immediately report an allegation of abuse to the Administrator and the State Agency. Findings include:<br><br>The facility policy on abuse, undated, indicated, "The facility ensures that all alleged violations involving mistreatment, neglect, or abuse including injuries of unknown source and misappropriation of resident property is reported immediately."<br><br>11/15/22 - E19 (CNA) received abuse training that included content on reporting.<br><br>1/8/23 - A report was submitted to the State Agency by the facility that alleged resident abuse and stated, "This NHA arrived at the facility at 12:15 PM to the office and found a statement under the door dated 1/5/23 at 8:20 PM. CNA statement alleged allegation of verbal abuse...".<br><br>Review of facility documentation related to the | F 609 | A. The facility is unable to correct the deficiency as R455 no longer resides at the facility.<br><br>B. All residents have the potential to be affected by this deficient practice. DON, or nursing designee, will audit all reports of abuse submitted in the past two weeks for timely reporting of allegations. Audit to be completed by July 5, 2023<br><br>C. Facility house wide abuse education to be completed by July 5, 2023. In addition, nursing administration telephone numbers will be posted on the daily schedule for staff availability.<br><br>D. DON, or nursing designee, will audit all submitted reports of abuse for timely reporting. Audits will be conducted weekly x 4 weeks until 100% compliance is achieved for 4 consecutive weeks, then monthly x 2 months. Audits will then be submitted and reviewed at the facility□s monthly QAPI meeting and the committee | |

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| F 609 | Continued From page 11<br>above complaint revealed a statement written by E19 (CNA), dated 1/5/23, with an incident date of the same. The written statement contained contents of alleged verbal abuse in the form of profanity from an employee to R455.<br><br>During an interview on 6/5/23 at 11:54 AM, E19 (CNA) confirmed receiving abuse identification and training "When I first started." E19 then confirmed placing a written statement of an allegation of abuse underneath E1 (NHA)'s door. E19 confirmed that she did not report the allegations to any other staff.<br><br>During an interview on 6/5/23 at 12:13 PM, E1(NHA) confirmed the finding and stated, "E19 (CNA) should have notified us, I was the manager on duty that Sunday and that's how I found it."<br><br>Findings were reviewed during the exit conference on 6/6/23 at 1:30 PM with E1 (NHA) and E2 (DON). | F 609 | will then decide if further audits will be needed. | |
| F 623 SS=D | Notice Requirements Before Transfer/Discharge<br>CFR(s): 483.15(c)(3)-(6)(8)<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; | F 623 | | 7/20/23 |

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and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how

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| F 623 | Continued From page 13 | F 623 | | |

to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate

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| F 623 | Continued From page 14<br>relocation of the residents, as required at § 483.70(l).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, it was determined that for two (R3 and R81) out of two sampled residents reviewed for hospitalization, the facility failed to provide written notice to the resident and/or the resident's representative of the resident's transfer. Findings include:<br><br>1. Review of R3's clinical record revealed:<br><br>12/8/21 - R3 was admitted to the facility.<br><br>12/31/22 - R3 was transferred emergently to the hospital.<br><br>The facility lacked evidence that written notice was given to the resident or resident representative for R3.<br><br>6/5/23 12:17 PM - During an interview, E1 (NHA) confirmed that written notice was not provided.<br><br>2. Review of R81's clinical record revealed:<br><br>6/14/22 - R81 was admitted to the facility.<br><br>5/20/23 - R81 was transferred emergently to the hospital.<br><br>The facility lacked evidence to indicate that a written notice was given to the resident or resident representative for R81.<br><br>6/1/23 2:32 PM - During an interview, E1 and E16 (Clinical Liaison) confirmed the written notice | F 623 | A. These residents were not adversely affected by this practice.<br><br>B. All residents have the potential to be affected by this practice. The admission□s director, or designee, to audit discharges and transfers from the past 2 weeks to determine if proper notification of the discharge/ transfer was given to the resident and/ responsible party. This audit will completed by the admission□s director by July 14, 2023.<br><br>C. A root cause analysis has been completed and revealed a lack of staff knowledge relating to the regulations regarding Notice Requirements Before Transfer/ Discharge. The admission□s director, or designee, will in-service admissions staff members and social services staff on the process of providing the transfer/ discharge notice. This education will be completed by July 20, 2023.<br><br>D. The admissions director, or designee, will perform weekly audits on all discharges/ transfers to ensure that the discharge transfer notice was given to the resident or POA. Audits will be conducted weekly x 4 weeks until 100% compliance is achieved for 4 consecutive weeks, then monthly x 2 months. The audits will be submitted and discussed at the facility's monthly QAPI meeting and the committee | |

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| F 623 | Continued From page 15<br>was not provided.<br><br>6/6/23 1:30 PM - Findings were reviewed with E1 and E2 (DON) during the exit conference. | F 623 | will decide if further audits will be needed. | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for | F 656 | | 7/20/23 |

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| F 656 | Continued From page 16<br>future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, it was determined that for one (R5) out of twenty residents reviewed for care plans, the facility failed to update or revise R5's care plan to include refusal of care. Findings include:<br><br>Review of R5's clinical record revealed:<br><br>Cross Refer to F677<br><br>9/4/10 - R5 was admitted to the facility.<br><br>4/13/23 - A review of R5's MDS assessments lacked evidence of refusals of care.<br><br>Review of R5's TAR revealed that nail trim was signed off that it was completed every month on the 12th day on the 7:00 PM to 7:00 AM shift. An observation of R5's toenails on 5/30/23 and 6/1/23 revealed that nails were unkept.<br><br>6/02/23 10:09 AM - During an interview, E12 (CNA) and E13 (CNA) confirmed that R5 frequently refused care and only certain staff can | F 656 | A. Upon review, resident R5 noted to have comprehensive care plan for care refusals initiated on 1/11/2013 and revised on 3/20/23.<br><br>B. All residents that refuse care have the potential to be affected by this practice. All residents with noted care refusals will have their care plans audited to ensure that they are care planned appropriately for care refusals. Initial audit to be completed by MDS Coordinator, or designee, July 7, 2023.<br><br>C. Nursing staff will receive education regarding the process of care refusal documentation. New resident behaviors of care refusals will be reported to the nurse and added by the nurse to the 24 hour report. The 24 hour report will be reviewed by the unit manager or charge nurse, who will ensure that the resident is care planned appropriately for refusal of care. Education to be completed by the facility | |

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| F 656 | Continued From page 17<br>complete care based on her refusals. E12 and E13 were unable to vocalize interventions related to R5's care plan.<br><br>6/2/23 10:20 AM - An interview with E22 (LPN) confirmed that R5 refuses care and her care plan does not reflect interventions personalized to refusals.<br><br>6/6/23 1:30 PM - These findings were reviewed during the exit conference with E1 (NHA) and E2 (DON). | F 656 | CNE by July 14, 2023.<br><br>D. DON, or designee, will review the 24 hour report daily for new onset behaviors of care refusals and appropriate care plan initiation/ revision. Audits will be conducted weekly x 4 weeks until 100% compliance is achieved for 4 consecutive weeks, then monthly x 2 months. Audits will then be submitted and reviewed at the facility□s monthly QAPI meeting and the committee will then decide if further audits will be needed. | |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, it was determined that for one (R5) out of seven residents reviewed for ADL's, the facility failed to provide nail care for dependent residents.<br>Findings include:<br><br>Review of R5's clinical record revealed:<br><br>Cross Refer to F656<br><br>9/4/10 - R5 was admitted to the facility.<br><br>4/13/23 - A review of R5's MDS assessment revealed that R5 was an extensive assist for ADLs. | F 677 | A. A podiatry consult was offered to R5 and refused by the resident. Toe nail care has, also, been offered and refused. Resident education provided.<br><br>B. All residents have the potential to be affected by this deficient practice. Unit managers, or designees, will complete an initial audit of all facility residents to determine the need for toe nail care. This audit will be completed by July 11, 2023. Toe nail care and/ or podiatry care will be offered, if indicated.<br><br>C. All nursing staff will be educated as to facility process for refusal of toe nail care | 7/20/23 |

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| F 677 | Continued From page 18<br>5/30/23 10:46 AM - An observation of R5's toenails revealed nails were yellow in color, thick and nails were protruding over the tips of the toes.<br><br>6/1/23 10:00 AM - An observation of R5's toenails remained the same from above.<br><br>A review of R5's TAR revealed that nail care was signed off that it was completed every month on the 12th day on the 7:00 PM to 7:00 AM shift.<br><br>A review of R5's nursing notes revealed no evidence of refusals related to nail care.<br><br>6/2/23 10:09 AM - During an interview, E12 (CNA) and E13 (CNA) confirmed that R5 frequently refused care and only certain staff can complete care based on her refusals. E13 stated she will try to cut R5's toenails today and also revealed that R5 will not see the Podiatrist when offered.<br><br>6/2/23 10:20 AM - An interview with E22 (LPN) confirmed that R5 refuses care and will not see the Podiatrist when offered.<br><br>6/6/23 1:30 PM - These findings were reviewed during the exit conference with E1 (NHA) and E2 (DON). | F 677 | and/ or podiatry consultation. Any resident that refuses toe nail care and/ or a podiatry consult will be educated as to the risks of refusal and benefits of receiving care. The refusal will be reported on the 24 hour report, and notifications will be made to the physician and POA/ family, if appropriate.<br><br>D. Facility 24 hour reports will be audited for toe nail care refusals and appropriate follow up weekly x 4 weeks and then monthly x2 months to achieve 100% compliance. Audits will be submitted and reviewed at the facility monthly QAPI meeting and the committee will determine if further audits are needed. | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>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 | F 684 | | 7/20/23 |

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| F 684 | Continued From page 19<br>that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, it was determined that for one (R355) of three residents reviewed for ADL care for dependent residents, the facility failed to consistently apply the lymphedema pumps, as prescribed for R355. Findings include:<br><br>Review of R355's clinical record revealed:<br><br>R355 was admitted to the facility on June 8, 2021.<br><br>2/8/23 - A quarterly MDS assessment reflected that R355 required extensive assistance with personal hygiene and was dependent on staff for it.<br><br>Review of R355's TAR for March 2023 revealed an order to "apply lymphedema pumps to bilateral legs BID ...". There were 17 missed opportunities out of 62 possible opportunities for the pumps to be applied.<br><br>6/6/23 10:29 AM - During an interview with E3 (ADON) regarding the missed opportunities for application of R355's lymphedema pumps, E3 confirmed that if there was no corresponding nurse's note under "progress notes", which there were not, and the treatment was not signed off by a Nurse, the activity was not completed. She acknowledged that this resident declined care, and was care planned for this behavior, but there was no documentation of R355's refusals on the TAR or in the progress notes. | F 684 | A. R355 no longer resides at the facility. Facility is unable to correct the deficient practice.<br><br>B. All residents with ordered lymphedema treatments have the potential to be affected by this deficient practice. Unit Managers, or designees, will audit lymphedema treatment records from the last week for treatment completion and sign off/ documentation of refusal. Audit to be completed by July 7, 2023.<br><br>C. Root cause analysis was completed and identified a lack of knowledge regarding correct documentation of lymphedema treatment refusals. Nurses to be educated regarding treatment completion and correct documentation of administration and treatment refusals. Education to be completed by July 14, 2023.<br><br>D. The Unit Managers, or designees, will audit treatment records of residents receiving lymphedema treatments for correct sign off on the TAR and documentation of refusals, if appropriate. Audits will be conducted weekly x 4 weeks until 100% compliance is achieved for 4 consecutive weeks, then monthly x 2 months. Audits will then be submitted and reviewed at the facility□s monthly QAPI | |

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| F 684 | Continued From page 20<br><br>6/6/23 1:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference. | F 684 | meeting and the committee will then decide if further audits will be needed. | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, it was determined that for two (R33 and R66) out of three residents reviewed for respiratory care, the facility failed to ensure the oxygen humidifier bottle and tubing were changed weekly. In addition, for R66, the tubing and nasal cannula were not placed in a zip lock bag when not in use. Findings include:<br><br>1. Review of R33's clinical record revealed:<br><br>2/5/17 - R33 was admitted to the facility with several diagnoses including heart failure and lung disease.<br><br>12/16/22- A Physicians order was written for R33's oxygen cannula, O2 tubing and zip lock bag to be changed weekly on Fridays on the 11:00 PM-7:00 AM shift.<br><br>1/19/23 - The Physicians order for weekly | F 695 | A. Residents were not adversely affected by this practice. Humidification bottles and tubing were changed and dated appropriately.<br><br>B. All residents who require oxygenation, nebulization, and/ or respiratory treatments have the potential to be affected. DON, or designee, to complete facility wide audit of all residents who receive respiratory treatments for accuracy of physician orders, correct labeling of tubing and humidification bottles, presence of storage bags, and treatment record documentation. This audit will be completed by July 12, 2023.<br><br>C. A root cause analysis was completed and a knowledge deficit regarding respiratory treatment orders, tubing, and storage was identified. Nurses are to | 7/20/23 |

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| F 695 | Continued From page 21<br>changing of R33's oxygen cannula, tubing, and mask was incorrectly discontinued.<br><br>During an interview on 6/2/23 at 11:11 AM, E21 (LPN) stated that R33's order for weekly changing of oxygen equipment must have "accidentally fallen off" and was discontinued.<br><br>R33 was observed the following times in bed wearing oxygen:<br>-6/5/23 12:16 PM - Oxygen tubing was undated and the humidifier bottle was dated "5/27."<br>-6/6/23 10:46 AM -Oxygen tubing was undated and the humidifier bottle was dated "5/27."<br><br>6/6/23 10:49 AM - E21 (LPN) accompanied the Surveyor to R33's bedside and confirmed that the oxygen tubing remained undated and the humidifier bottle was still dated 5/27. Weekly changing would have been completed on 6/4/23.<br><br>These findings were reviewed during the exit conference on 6/6/23 at 1:30 PM with E1 (NHA) and E2 (DON).<br>2. Review of R66's clinical record revealed:<br><br>4/26/23 - R66 was admitted to the facility with a diagnosis of Chronic Obstructive Pulmonary Disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs. Symptoms include breathing difficulty, cough, sputum production and wheezing).<br><br>4/26/23 - Physician orders included:<br>- "Change oxygen humidification bottle weekly and as needed. Change every Friday on 11-7 shift. Label bottle with date and initials."<br>- "Place oxygen tubing, nasal cannula or facemask in zip lock bag when not in use every | F 695 | receive education regarding respiratory physician orders, respiratory treatments, labeling, and storage. This education will be completed by July 20, 2023.<br><br>D. The DON, or designee, will complete weekly audits of all residents who receive respiratory treatments for accuracy of physician orders, correct labeling of tubing and humidification bottles, presence of storage bags, and treatment record documentation. Audits will be conducted weekly x 4 weeks until 100% compliance is achieved for 4 consecutive weeks, then monthly x 2 months. Audits will then be submitted and reviewed at the facility□s monthly QAPI meeting and the committee will then decide if further audits will be needed. | |

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| F 695 | Continued From page 22<br>shift."<br>- "Oxygen cannula/ mask, O2 tubing and zip lock bag to be changed weekly on Fridays 11-7 shift every night shift every Fri Label cannula/ mask, tubing and zip lock bag with date and initials."<br><br>5/31/23 through 6/2/23 - Random observations of R66's oxygen concentrator, tubing and humidifier revealed:<br>- Oxygen tubing was labeled 5/13/23 and placed on top of the concentrator uncovered.<br>- Humidifier bottle was labeled 7/26.<br>- No zip lock bag in R66's room.<br><br>Review of the Treatment Administration Record indicated that the oxygen tubing, humidifier bottle and zip lock bag were changed on 5/13/23.<br><br>6/2/23 9:32 AM - During a joint observation and interview, E20 (LPN) confirmed the oxygen tubing was labeled 5/13/23 and the humidifier bottle was labeled 7/26 and no zip lock bag was present in R66's room. E20 immediately replaced the outdated equipment.<br><br>6/6/23 1:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference. | F 695 | | |
| F 730 SS=D | Nurse Aide Peform Review-12 hr/yr In-Service<br>CFR(s): 483.35(d)(7)<br><br>§483.35(d)(7) Regular in-service education.<br>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g).<br>This REQUIREMENT is not met as evidenced | F 730 | | 7/20/23 |

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| F 730 | Continued From page 23<br>by:<br>Based on interview and record review, it was determined that for one (E15) out of five CNA's reviewed for annual performance evaluations, the facility lacked evidence that a performance review was completed at least every twelve months. Findings include:<br><br>Review of E15's (CNA) personnel records revealed:<br><br>4/26/22 - The first day of employment at the facility for E15.<br><br>6/1/23 12:15 PM - An interview with E1 (NHA) confirmed the facility did not have the required review completed for E15 by 4/26/23.<br><br>6/6/23 1:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference. | F 730 | A. E15's annual review was completed 6/2023 by DON.<br><br>B. All facility CNAs have the potential to be affected by this deficient practice. An audit of all facility CNA annual performance evaluations to be completed by the Human Resources Director to ensure evaluation completeness.<br><br>C. Root cause analysis was completed and identified a knowledge deficit. DON and ADON to receive education from Human Resource's Department. This education to be completed by July 12, 2023.<br><br>D. DON or ADON to complete audit of CNA yearly evaluations for timely completion. Audits will be completed monthly x 3 months until 100 % compliance is achieved. Audits will then be submitted and reviewed at the facility's monthly QAPI meeting and the committee will then decide if further audits will be needed. | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State | F 812 | | 7/20/23 |

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| F 812 | Continued From page 24<br>and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, it was determined that the facility failed to ensure safe sanitary storage of food, protect the quality of food, and maintain consistent food temperature logs. Findings include:<br><br>5/30/23 9:16 AM - During the initial tour of the kitchen a sticky residue was observed on the floors in the kitchen and the dry storage room. Crumbs and other food debris were observed on the floors in the dry storage room and the walk-in refrigerator.<br><br>5/30/23 9:18 AM - During a review of the food temperature logs, the Surveyor observed the facility kitchen records had no food temperatures recorded for five-hundred forty six (546) meals out of five-hundred forty six (546) meals sampled. Temperatures of cooked foods and cold ready to eat foods were not being consistently recorded prior to being served. Fish, meat, and poultry must be heated to an appropriate specific temperature depending on the type of food and the method used to prepare it. Vegetables must be heated to one hundred thirty-five (135) degrees Fahrenheit (F) and cold ready to eat | F 812 | A. All kitchen floors, equipment, and refrigerators were thoroughly cleaned immediately. All food items that were not labeled and/ or dated were thrown away. Food temperature recordings began consistently being documented on 5/25/2023. Maintenance was made aware of the repairs needed to the kitchen tiles/ loose screw and those repairs were completed 6/21/2023.<br><br>B. No residents were adversely affected by this deficient practice.<br><br>C. Root cause analysis indicated a department knowledge deficit. All dietary staff members will receive education regarding the department cleaning schedule, to include, but not limited to, routine cleaning of equipment, floors, walls, and all surfaces. All dietary staff members will receive education regarding food temperature log for the tray line, how to take proper food temperatures, proper recording temperatures, minimum internal temperatures for specific foods. All dietary | |

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| F 812 | Continued From page 25<br>foods must be held below forty-one (41) degrees (F) to maintain food safety.<br><br>5/30/23 9:27 AM - In the beverage refrigerator, opened bottles of cranberry juice, tomato juice, and an opened carton of thickened juice were not marked with a discard by date.<br><br>5/30/23 9:40 AM - In a salad/sandwich prep table numerous ready to serve salads were undated, numerous other foods were observed to be uncovered, such as tuna salad, egg salad, canned peaches, and other leftovers. Twenty-three (23) ready to eat sandwiches of several different varieties located on the top of the prep table were undated or misdated. When the sandwiches were removed, a significant amount of a clear gel-like substance was observed.<br><br>5/30/23 9:42 AM - Two large wall tiles adjacent to the walk-in refrigerator were buckled and bowed away from the wall, and a loose screw was hanging from one of the tiles.<br><br>5/30/23 10:15 AM - All findings were confirmed by E4 (Dining Services Director).<br><br>6/6/23 1:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference. | F 812 | staff will receive education regarding proper labeling and dating of all inventory and proper food covering and storage. All dietary staff members will receive education regarding routine environmental rounding checklist and communication of maintenance needs. All education will be provided by the dietary director, or designee, and will be completed by July 20, 2023.<br><br>D. The following audits will be completed; (1) department cleaning schedule completeness, (2) food temperature assessment and documentation, (3) Food item labeling, dating, and storage, and (4) environmental rounding completeness with appropriate maintenance follow up, if indicated. All audits will be completed by the dietary director, or designee, weekly X 4 weeks, then monthly X 2 months until 100% compliance is achieved. Audits will be reviewed at facility QAPI meetings to determine continued need. | |
| F 868 SS=D | QAA Committee<br>CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)<br><br>§483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: | F 868 | | 7/20/23 |

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| F 868 | Continued From page 26<br>(i) The director of nursing services;<br>(ii) The Medical Director or his/her designee;<br>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and<br>(iv) The infection preventionist.<br><br>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:<br>(i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary.<br><br>§483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by:<br>Based on interview and review of facility documentation, it was determined that the facility failed to ensure the attendance of required members at two out of three quarterly meetings reviewed. Findings include:<br><br>The facility QAPI plan, last updated 3/1/22, | F 868 | A. No residents were directly affected by this practice. The facility will continue to have quarterly Quality Assurance meetings to monitor and review facility practices to ensure facility standard of care. | |

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| F 868 | Continued From page 27<br>indicated,"...Meeting at a minimum on a quarterly basis... (E11) Medical Director."<br><br>6/2/23 11:52 AM - A review of the QA/QAPI meeting sign in sheets revealed that the Medical Director was not present at the meetings on 9/26/22 and 1/25/23.<br><br>6/6/23 10:35 AM - An interview with E1 (NHA) confirmed that the Medical Director was not present on 9/26/22 or 1/25/23 at the quarterly QA/QAPI meetings.<br><br>6/6/23 1:30 PM - Findings were reviewed with E1 and E2 (DON) during the exit conference. | F 868 | B. All residents have the potential to be affected by quality assurance meeting attendees' presence, or lack of.<br><br>C. Education will be provided to the facility medical director regarding Quality Assurance meeting attendance to ensure medical director or his/ her designee is present as per regulation by July 7, 2023.<br><br>D. Quality assurance meeting attendance will be audited following each QAPI meeting to ensure the presence of all required committee members X 3 QAPI meetings. | |
| F 943 SS=D | Abuse, Neglect, and Exploitation Training<br>CFR(s): 483.95(c)(1)-(3)<br><br>§483.95(c) Abuse, neglect, and exploitation.<br>In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-<br><br>§483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.<br><br>§483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property<br><br>§483.95(c)(3) Dementia management and resident abuse prevention.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and review of facility documentation, it was determined that the facility | F 943 | A. Three agency staff members were identified in deficiency. Two were hired | 7/20/23 |

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| F 943 | Continued From page 28<br>failed to ensure that the required trainings on abuse, neglect, exploitation and dementia management were completed as required for three (E8, E10, E14) out of sixteen randomly sampled staff members. Findings include:<br><br>1. Review of E8's (LPN) personnel records revealed:<br><br>2/25/23 - E8, an agency Nurse, was hired to work in the facility.<br><br>6/5/23 10:33 AM - A review of facility records revealed that the facility lacked evidence that E8 received the required Dementia training.<br><br>2. Review of E10's (LPN) personnel records revealed:<br><br>3/13/23 - E10, an agency Licensed Practical Nurse, was hired to work in the facility.<br><br>6/5/23 10:33 AM - A review of facility records revealed that the facility lacked evidence that E10 received the required Abuse, Neglect, Exploitation, and Dementia training.<br><br>3. Review of E14's (RN) personnel records revealed:<br><br>3/7/23 - E14 was hired to work in the facility.<br><br>6/5/23 10:33 AM - A review of facility records revealed that the facility lacked evidence that E14 received the required Dementia training.<br><br>6/5/23 11:25 AM - During an interview, E1 (NHA) confirmed the findings. | F 943 | for short term contract through an agency and no longer work at facility. One agency staff member will receive education on Abuse, Neglect and Exploitation and Dementia management by 6/30/23.<br><br>B. All staff members could potentially be affected by this deficiency. An audit on Abuse, Neglect, Exploitation and Dementia management training will be completed by 6/30/23.<br><br>C. Education on Abuse, Neglect, Exploitation, and dementia management has been initiated. All staff will be educated on our policy and procedures by 6/30/23.<br><br>D. Audits will be conducted by nurse educator and designee monthly x3 months to ensure compliance with all staff, including agency staff. | |

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| F 943 | Continued From page 29<br>6/6/23 1:30 PM - Findings were reviewed with E1 and E2 (DON) during the exit conference. | F 943 | | |