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	255339	A. BUILDING _____ B. WING _____	C 04/14/2021

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Survey and nine (9) Complaint Investigations (CI) on 4-6-21 through 4-14-21. CI 00017537 related to Quality of Care (QOC) for residents not groomed was substantiated. During the survey and complaint investigations, the SA determined the facility was not in compliance with the Medicare and Medicaid Requirements of Participation. The SA cited deficiencies F600, F677, and F880 all at a D level. The investigations were (CI) 00017309 related to QOC for neglect and weight loss, (CI)00016788 related to QOC for unlicensed staff, (CI) 00017433 related to QOC for medications not being administered,(CI)00017459 related to QOC for residents being left wet for an extended time and neglect,(CI) 00017127 related to injury of unknown origin, (CI) 00017286 related to falls , 00017310 related to falls and (CI) 00017457 related to falls were all unsubstantiated. The facility census was 82 and licensed for 120 beds.	F 000		
F 600 SS=D	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	F 600		6/21/21

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

Electronically Signed | 06/04/2021

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F 600	Continued From page 1 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, record reviews and facility policy review, the facility failed to ensure one (1) of 19 residents are free from abuse. (Resident #19). Findings include: In a record review of the facility's "Abuse Policy", not dated, revealed, "It is the policy of this facility that all residents will be free from physical, mental and /or verbal abuse. Preventing resident abuse is a primary concern for this facility. It is our goal to achieve and maintain an abuse free environment." Resident #19 Review of the facility's "Statement on Accident/Incident", dated 04/12/2021, by the Assistant Director of Nursing revealed, Resident #19 complained to nurse supervisor on 04/08/2021 an Agency Certified Nurse Aide (CNA) #7 came into his room to change him and Resident told the CNA she would need two people to help change him and the CNA stated, "No, you can roll over." Resident complained the CNA #7 was rough with him and pushed his right shoulder causing it to hurt and he screamed. Resident further explained CNA #7 left and went to get another Agency CNA to help change him. He explained that when the CNAs turned, he over to clean him, he had another bowel movement and when this happened CNA #7 stated either, "I am not doing this anymore" or "I am through with this." Resident complained CNA #7 was very	F 600	A. For resident #19 Certified Nursing Assistant # 7 that the allegations were made against on 4/8/2021 was reported to the staffing agency and told she could not return to our facility until an investigation alleging abuse was completed. After completion of the investigation the agency was notified that the Certified Nursing Assistant #7 was to be taken off of our facility list. If any resident makes any allegations of abuse or neglect the staff member/ agency staff will be immediately suspended until completions of the investigation. Resident # 19 was assessed on 4/12 for any psychosocial harm by the Director Of Nursing. He reported that he suffered no harm. Residents that was under the care of Certified Nursing Assistant #7 was interview on 4/9 and no other reports of abuse were noted. *The facility determined that all residents of the facility could be affected by this alleged deficient practice. * The Staff Development Nurse held an in-service on 4/15/2021 on all types of abuse with the staff. A Directed In-Service was held on 6/2/2021 by Nurse Consultant to all staff. The Staff Development Director will in-service all staff on abuse and neglect upon hire. All agency staff must read and sign abuse	

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F 600	Continued From page 2 rough and when he asks her name and told her he was going to report her, CNA #7 said, "Be quiet, I am not talking to you." Resident was seen by Nurse Practitioner due to complaints of shoulder pain and x-rays where clear. The resident's roommate was interviewed, and reported CNA #7 was very rude to his roommate and they do not need or want her to come back. The staff ' s response to the incident was noted the facility contacted (Formal Name) Stafing Agency immediately and informed the Agency that CNA #7 or the other CNA, who is believed to have knowledge of the incident will not return to facility. The investigator interviewed CNA #7. The facility's action to prevent the incident from occurring in the future was to notify the staffing agency representative and notify her of the incident and the two CNAs will not be allowed to return to the facility. The facility's "Statement of Accident/Incident" revealed the Administrator and Physician was notified of the incident. The Department of Health and State Attorney General was notified. On 04/12/21 at 10:30 AM, during an interview with Resident #19, he asked the State Agency (SA) if they were a social worker. The SA explained to the resident that she was a registered nurse but could help with any concerns. The resident ask did the SA hear about the abuse incident last week with the Agency certified nurse aide (CNA) and him. The SA explained I am so sorry but no and can you explain the situation. The resident explained that last week on the 11-7 shift, agency CNA #7 came in to clean him after he had a bowel movement. He explained he told CNA #7 she would need help to clean him up and turn him and she said she can turn him herself, she has been a CNA for	F 600	and neglect policy prior to their first shift working in our facility. The Director of Nursing/Assistant Director of Nursing will meet with the residents quarterly beginning 6/8 to in-service on how to report abuse and neglect. The Social Service Director will incorporate into her interview questions on Minimum Data Set time on 6/7 to determine if they have experienced any abuse or neglect that they may not have reported and will give any complaints to Director of Nursing/Assistant Director of Nursing in writing immediately. *Beginning on 6-7-2021 all allegations of abuse or neglect will be placed on a flow sheet to be managed by the Director of Nursing/Assistant Director of Nursing. The Director of Nursing will receive a weekly report given to her by the Social Service Director on the interview with residents at the Minimum Data Set time. She will immediately report any claims of abuse or neglect to the Director of Nursing/Assistant Director of Nursing in writing. The flow sheets and reports will be brought to the quarterly Quality Assurance/Performance meeting beginning 5/27. Any needed changes to policies or reporting methods will be discussed at that time.	

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15 years and knows what she is doing. She told him he could grab well to the side bed rail and that they are going to do it. The resident further explained CNA #7 was rude and rough during care. She grabbed his right shoulder to turn him and pushed hard. He screamed out due to pain to his shoulder and she flipped him quickly back on his back and caused his left knee to twist causing knee pain. He explained that during this time CNA #7 was breathing heavy and talking under her breath as she went out of his room. He explained CNA #7 came back in the room with another CNA to clean him up. She came back in with the other CNA, and he asked CNA #7 what her name was, and she said, "Be quiet, I am not talking to you." He explained the other CNA #6 was very quiet while helping with care. He explained that while they were turning and cleaning him, he had a second bowel movement, and CNA #7 slung him back, walked out of the room, and said, "I don't need this shit." He further explained he started to doze off when waiting on them to return and then the two (2) CNAs came back in to clean him up and said CNA #7 was talking very sweet and nice to him this time. He explained he was not going to say anything but told CNA #5 on day shift and she reported it to the nurse and unit manager.

Review of the Face Sheet for Resident #19, the facility admitted Resident #19 on 7/16/20 with the diagnoses of Major Depressive Disorder, Venous insufficiency, Morbid obesity, Body mass index 70 or greater, and need for assistance with personal care.

Review of the Quarterly MDS, with the Assessment Reference Date (ARD) of 1/14/21, for Resident #19, revealed for Section C Resident

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#19 had a BIMS score of 14, which indicated he was cognitively intact. Review of Section G revealed Resident #19 needs extensive assistance with two (2) plus persons for bed mobility and toileting.

Review of Resident #19's Admission Care Plan Record dated for 11/23/20 that the CNAs use on the floor from the ADL book on the unit, Resident #19 requires extensive assistance with bed mobility and turn and reposition with three (3) persons. The Admission Care Plan Record also revealed that Resident #19 was incontinent and has not refused care.

Review of Resident's #19 Care Plans revealed Resident #19 is care planned for scheduled care, total dependence with the assistance of 2 or more staff members with ADL's.

Resident #78

On 04/13/21 at 9:00 AM, in an interview with Resident #19's roommate, Resident #78, he explained he was awaken when CNA #7 came into their room to cleanup his roommate on 4/08/21 during 11-7 shift. He explained the agency CNA #7 came in and he heard her being rude, talking loud to Resident #19 and then he heard his roommate scream out. He explained that it scared and startled him. He further explained CNA #7 was rude the whole night and he does not want her back in his room and we do not need her.

A record review of Resident #78's Annual Minimum Data Set (MDS), with the Assessment Reference Date (ARD) of 3/19/21 revealed for section C, Resident #78 had a Brief Interview for

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Mental Status (BIMS) score of 12, which indicated he is mildly cognitively impaired.

Resident #28

On 04/13/21 at 9:30 AM, in an interview with Resident #28, when asked if she has had any problems with Agency staff being rude or rough with her, she explained that the agency CNAs can be very rude, especially on night shifts and weekends. Resident denies any rough care. When ask if she knew the CNAs names, she explained no, there are a lot of agency workers.

Record review of Resident #28's Annual MDS with an ARD of 2/4/21, revealed a BIMS of 12 indicating a moderately impaired cognitive status.

Resident #33

On 04/13/21 at 9:45 AM, in an interview with Resident #33, when ask if the agency staff are nice to her during care, she explained that the agency CNAs can be very short and rude, especially on night shift but does not know their names because they have different ones.

Record review of Resident #33'a Quarterly MDS with an ARD of 2/4/21, revealed a BIMS of 15, indicating intact cognitive skills for daily decision making.

Resident #16

On 04/13/21 at 9:50 AM, in an interview with Resident #16, when ask has she ever had any problems with staff being rude to her during any care, the resident explained she is lucky that she can do mostly for herself, but the agency aides

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are very lazy and rude. She further explained that there are always agency workers here and she does not like the staff schedule. She explained the regular staff works Monday through Friday and the agency staff just works whenever but frequently.

Record review of Resident #16's Quarterly MDS with an ARD of 1/18/21, revealed a BIMS of of 15, indicating intact cognition.

Resident #38

On 04/13/21 at 2:00 PM, in an interview with Resident #38, when ask how the staff treats her, she explained that the regular staff is nice and helpful, and she does not understand why they can not just have them instead of agency. She explained the agency aides and nurses are rude and very short when taking care of them but does not know their names.

Record review of Resident #38's Annual MDS with an ARD of 2/12/21, revealed a BIMS of 15, indicating intact cognitive skills.

Resident #13

On 04/13/21 at 2:30 PM, in an interview with Resident #13, when ask does she have any problems with the staff not respecting her, she explained the has had trouble with the agency aides on the night shift and reported it to the administrator. She explained that last week one aide was rude when getting her ready for dialysis and did not clean her properly and did not make sure her pants were not crooked and would not straighten them up and it was uncomfortable. She explained she reported it to the nurse and

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the nurse helped her with fixing her pants.

Record review of Resident #13's Annual MDS with an ARD of 1/12/21, revealed a BIMS of 15, which indicated intact cognition.

On 04/13/21 at 10:15 AM, in an interview with CNA #5, when ask can she explain what Resident #19 complained to her about last week, she explained he told me that the agency aide on 11-7 shift tried to turn him by herself and would not listen to him when he explained that she needed help. He told her that when she went to turn him, she hurt his right shoulder and the CNA was rude to him during his care. She explained the resident told her that he was scared to report the incident to anyone. She further explained she reported the resident's complaints to the LPN #1 and RN #3.

On 04/13/21 at 11:30 AM, in an interview with the Unit Manager, RN #3, she explained LPN #1 came to her and told her that the resident had a bad night and complained the aide was rude to him and hurt his right shoulder and left knee. She further explained she interviewed Resident #19 and he complained the aide was rude to him and tried to turn him by herself. She notified the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) and they further investigated.

On 04/14/2021 at 10:15 AM, in an interview with the Administrator, she confirmed that the facility uses one primary agency for staffing. She explained that after the incident with agency aides last week, both aides are not returning to the facility and were reported to the proper authority. She further explained that in the past the

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residents have come to her about the agency staff but was not able to give any names of the workers and in other times if the names were given those workers are not allowed to return.

On 04/14/2021 at 10:45 AM, in an interview with ADON, she explained that once she was notified about the incident, she began a full investigation regarding complaint including resident's statement, resident interviews, agency CNA information, and interview with the agency aides. She explained the incident was reported to the State Agency office on 4/9/21 at 9:45 AM. She explained the staffing agency was notified and informed that both aides are not to return to the facility. She explained that Resident #19 was seen by nurse practitioner on 4/09/21 and x-rays were obtained of the right shoulder and left knee. The results were negative, no abnormalities.

On 04/12/2021 at 11:05 AM, in an interview with DON, when ask about abuse training for agency workers, she explained that the Agency is responsible for the training and the facility obtains records on all workers that work in the facility. She further explained the facility's staff has abuse and neglect training on hire and annually. When ask about how agency CNAs know the care needed for each resident that they are responsible for during their shift, she explained the agency workers are to get report from other aide prior to starting their shift. When ask about an assistant cheat sheet, she explains sometimes the CNAs will use a report sheet and make notes about each resident on the sheet. She reports the CNAs have each resident's plan of care including activities of daily living are available in a book on the unit.

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On 04/14/2021 at 11:00 AM, in a phone interview with CNA #6, when ask to tell me about the incident last week with a resident and another agency CNA, she explained that the CNA #7 ask if she could help turn Resident #19 for peri care. She explained she went in to help, she never heard CNA #7 say anything rude, but the Resident #19 did ask CNA #7 several times what her name was, and CNA #7 never replied but did say to the resident, "You helped turn for me the other night, but you cannot tonight." She explained that she did not know anything was going on between the Resident #19 and CNA #7. She explained the resident was cooperative with care and did not complain of any pain. She explained the only thing the resident complained of was getting tired and short of breath while being on side during peri care. She further explained that she did not know that she should have told the nurse about the resident asking for the other CNA's name, and if she would have seen anything she would have reported it to the nurse.

On 04/14/2021 at 11:20 AM, in a phone interview with CNA #7, when ask to tell me about what happened last week with Resident #19, she explained the resident had ask for a urinal and when she removed the urinal, she noticed the resident had a bowel movement and told him will need to change and clean him up. She further explained she lowered the head of the bed and went to turn resident by herself. She reported that she did grab the resident's right shoulder and buttocks to turn the resident. The resident told her that he could not turn over and she would need help. She explained she first tried to lower the head of the bed lower and attempted to turn him again by herself but could not turn him and

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F 600	Continued From page 10 clean him without help so she went to get another aide to help her. She further reported she has worked with the resident before but not often. When ask how to does she know what assistance with care a resident requires, she explained that she always gets reports from a full-time worker and uses an assistant cheat sheet that has the resident's assistance needed including limited, excessive, or total assistance. She explained the roommate was resting but she asked him if he needed anything, and he replied he was okay. She reported that the resident nor his roommate had any complaints and if they would have, she would have gone to the nurse. In a record review of the facility's, "Nursing Staffing Agreement", the agreement began 12/3/2020 and the agreement explained that Precision Healthcare Staffing agrees to meet qualifications required by the facility. In a record review of annual in-services update, CNA #7 had annual elder abuse and lifting and moving patients safely on 12/20/21. In a record review of annual in-service update, CNA #6 had annual elder abuse and lifting and moving patients safely on 9/20/2020.	F 600		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, record review and review of the facility policy, the facility failed to provide the necessary	F 677	* Resident #78 nails were cleaned and cut on 4/13/2021 by the 7/3 Charge Nurse. For resident #28 her hair was	6/21/21

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F 677	Continued From page 11 services to maintain good grooming and personal hygiene as evidenced by failure to provide nail care and washing of hair for two (2) of nineteen (19) residents observed for Activities of Daily Living (ADL) care. Resident # 76 and # 28. Findings include Review of the facility's policy titled " Activities of Daily Living Policy" updated July 2014, revealed "Based on previous evaluations and current data, the nursing staff...will seek to identify the level of care a resident requires for ADLs...the nursing staff will assess the resident upon admission, quarterly and with significant changes to ensure proper assistance is provided." Resident # 76 On 4/6/21 at 10:13 AM, Resident #76 was up in his wheelchair in his room and his nails were long and dirty. He was asked about his nails and he said they are dirty. On 4/7/21 at 10:35 AM, Resident #76 was up his in wheelchair at the table in dayroom coloring. He was shaved, his nails were long, jagged and yellow. On 4/7/21 at 12:50 PM Resident # 76 was observed sitting up at table in dayroom coloring. His nails were not cut. His nails were long and jagged. On 04/08/21 at 08:23 AM, Resident # 76 was observed sitting up in his wheelchair in his room feeding himself breakfast. His nails were long and jagged.	F 677	washed and styled on 4/12/2021. Staff was in-serviced on 4/22/2021 on ADL care to include nail care and hair care. * The facility was able to determine that all residents requiring nail care and hair care by staff had the potential to be affected by this alleged deficient practice. * An audit of all residents fingernails was completed by 4/20/2021 by the 7/3 Charge Nurse. Nail care was immediately provided if needed. The Staff Development Director gave an in-service on 4/22/2021 on ADL care to include providing nail care as being a part of ADL care. An audit on all residents hair was completed by 4/20/2021. Any resident that appeared to need hair care immediately received a shampoo. The Staff Development Director gave an in-service 4/22/2021 on hair care/shampooing of hair being a part of ADL care. A monitoring system has been put into place to ensure that proper nail care and shampooing of hair is provided. The 7/3 Charge Nurse will monitor the nail care/hair care weekly for 3 months and then monthly for 3 months and then random audits will be done on nails and hair care. The audit will begin on 6/7/2021. The results of the monitoring will be reported to the Director of Nursing/Assistant Director of Nursing weekly. * The Director of Nursing/Assistant Director of Nursing will review the audits	

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F 677	Continued From page 12 On 04/12/21 at 09:20 AM, Resident # 76 was observed sitting up in day room. His nails were long, jagged, and dirty. On 4/12/21 at 2:37 PM, in an interview with Certified Nursing Assistance (CNA)# 1 revealed he does not resist nail care. The nurses cut his nails. State Agency (SA) asked why and she stated the nurse tell you who nails they will cut. On 4/12/21 at 3:16 PM, interview with CNA #2 revealed she has worked her for 2 years. Resident #76 does not refuse care. She further stated CNAs do not do his nail care, the nurses do. On 4/13/21 at 10:15 AM, resident was up in his wheelchair in dayroom. Fingernails were long dirty and jagged. Resident #76 stated "they are dirty." On 4 /13/21 at 2:49 PM, in an interview with the Administrator, it was confirmed the family calls and complains about his care a lot. The family also complained about his nails needing to be cut. SA and Administrator went Resident #76, and the Administrator confirmed his nails were very long. On 4/13/21 at 3:15 PM, SA went back to Resident # 76's room and asked him if the staff had trimmed his nails and he smiled and said "they sure did." Asked if he liked his nails that short and he stated "I sure do." Interview on 4/14/21 at 10:16 AM, with Registered Nurse (RN) #5, revealed nail care is trimming the nails, cleaning, and filing.. RN #5 reported "The	F 677	weekly for any care not being provided on 6/14/2021. The results of the audit will be reported to Quality Assurance/Performance Improvement committee quarterly beginning 5/26/2021 by the Director of Nursing/Assistant Director of Nursing to determine if compliance is maintained or if any changes in monitoring should be made.	

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RN's cut the residents nails if they are Diabetic."

On 4/14/21 at 11:20 AM, in an interview with the Director of Nurses (DON), revealed CNA's do nail care which involves cleaning the nails when they get a bath and trimming as needed.

Review of Resident #76's Quarterly Minimum Data Set (MDS) dated 3/18/21, revealed Resident #76 had a Brief Interview Mental Status (BIMS) of 10, indicating he was moderately impaired for cognition. He was also coded as being totally dependent for ADLs.

Review of Resident # 76 Nail Care Roster for 4/12/21 to 4/13/21 revealed he had received nail care on 4/12/21.

Resident #28

On 04/07/21 at 9:00 AM, in an observation of Resident # 28, revealed she was sitting in her wheelchair talking to her roommate in her room. Resident's hair was oily and greasy.

On 04/07/21 at 09:05 AM, in an interview with Resident # 28, she explained that she really likes living here and has lived here for many years. She further explained that she gets a bed bath daily but does not get her hair washed regularly. She further explained that the aides tried to wash her hair in the bed several times months ago and about drowned her and got water everywhere and does not wash her hair anymore. She explained that she and her roommate used to get their hair washed weekly in the beauty shop but since the COVID-19 virus the beauty shop has been closed and she has not got her hair washed in a long time. She reported that she would like to have

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her hair washed more frequently but cannot since the beauty shop is closed. She further explains that the nurses come around frequently and trim and clean nails and sometimes sneak her to the beauty shop to wash her hair. She explained that she has talked to the Administrator regarding get her hair washed.

On 04/08/21 at 09:50 AM, in an observation of Resident #28, resident is sitting in her wheelchair in the dining area listening and singing to music. Resident's hair is still oily and greasy. The hair is observed as so oily that it looks wet.

At 9:55 AM on 04/08/21, in an interview with Resident # 28, she explained that she got her bed bath again this morning but still not had her hair washed. She further explained that she really wishes the beauty shop would open back up.

On 04/12/21 at 11:00 AM, in an interview with Resident # 28, she reported that a nurse took her to the beauty shop on Friday and washed and styled her hair. Resident #28 reported it feels good to have her hair washed.

In an interview on 4/13/21 at 11:05 AM, with CNA #5, explained that she does give Resident #28 a daily bed bath. She further explained Resident #28 refuses to go into the shower and does not like to take showers. When asked CNA #5 about washing the resident's hair, she explained that the resident does not like to have her hair washed in the bed and refuses to let the CNAs wash her hair in the bed. CNA #5 further explained that she has not washed the resident's hair in over a month but that the Unit Manager has tried to wash Resident #28's hair.

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On 4/14/21 at 9:02 AM, in an interview with DON, she explained ADL consists of head-to-toe care and would think hair wash and bath would go together. The resident's hair should have been washed. If resident hair is not washed for 30 days, it can cause build up on the scalp and skin irritation. It can be a dignity issue for the resident. The ADL binder should have been updated. The MDS nurse is new. The MDS nurse is responsible to update the ADL binder. It should have been updated. The ADL binder is used by the CNAs for resident care. When it is not updated the CNA's will not know if something is new or if things have changed. The ADL binder should have been updated quarterly.

Review of the Face Sheet for Resident # 28 revealed, the facility admitted Resident #28 on 07/05/12 with the diagnoses of Chronic Obstructive Pulmonary Disease, High Blood Pressure, Major Depressive Disorder, Dementia, Anxiety, and Emphysema.

Review of the Annual Minimum Data Set (MDS), with the Assessment Reference Date (ARD) of 2/4/21, for Resident #28, revealed for Section C, Resident #28 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. Section E of the MDS indicated no behaviors noted in the seven (7) day look back period, with no rejection of care. Section F of the MDS revealed Resident #28 felt that the choice of her daily activities including showers and bath was very important. Section J of the MDS revealed Resident #28 required extensive assistance of one (1) person with personal hygiene and total dependence of one (1) person assistance with bathing.

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F 677	Continued From page 16 Complaint Investigation (CI) MS # 17537 related to Quality of Care for residents not groomed appropriately and CI# 17459 related to failure to monitor and services not provided were substantiated.	F 677		