

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145419	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/11/2024
NAME OF PROVIDER OR SUPPLIER Bria of Elmwood Park		STREET ADDRESS, CITY, STATE, ZIP CODE 7733 West Grand Avenue Elmwood Park, IL 60707	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34516</p> <p>Based on observation, interview, and record review, the facility failed to follow their abuse prevention policy and procedures by failing to protect 1 of 3 residents (R1) in the sample from abuse by a staff member. This failure resulted in R1 being pushed to the bed, forcibly restrained, and roughly suctioned by a respiratory therapist (V3) after a physical struggle. This failure also led to R1 expressing fear, anger, and frustration with facility for not preventing further contact with this staff member after the resident reported the incident to his nurse and family member. This resulted in an Immediate Jeopardy (IJ).</p> <p>The Immediate Jeopardy began on 12/25/2023 when V3 (Respiratory Therapist) physically abused R1 and satisfied interventions were not implemented to prevent it from happening again. The immediacy was removed on 01/07/2024.</p> <p>On 01/09/2024 the Administrator (V1) was notified of the Immediate Jeopardy and provided the IJ template. The facility presented an initial removal plan on 1/09/2024. After a modification of the plan was done and resubmitted the removal plan was approved on 01/10/2024.</p> <p>Although, the immediacy was removed the facility remains out of compliance at a level 2 until the facility has an opportunity to evaluate the effectiveness of the removal plan.</p> <p>Findings include:</p> <p>R1 is an alert and oriented [AGE] year-old with diagnosis of tracheotomy, gastrostomy, acute and chronic respiratory failure with hypoxia, and alcoholic liver disease.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 1/5/24 at 11:45 AM, R1 was observed in bed watching television, appeared alert and oriented, able to recall events of an incident, and able to respond to questions appropriately when asked. R1 stated that he was slapped by a respiratory therapist while he was being suctioned around Christmas time and that it happened on two separate occasions. R1 indicated he ignored the first time it had occurred but could not ignore the second time because he realized it was now done on purpose. R1 then appeared distraught and became emotional when describing the events that occurred and added that the respiratory therapist pushed him on the bed and fought with him to get a tube down his throat. Surveyor tried to calm the resident and asked the resident if he was able to write the events down on paper, so he didn't have to struggle to talk through his trachea. R1 wrote on a piece of paper a similar statement he made with the surveyor that the respiratory therapist slapped him for coughing two times and that he told a nurse supervisor the next day. R1 added on this statement that he saw the respiratory therapist the next day and proceeding days thereafter and that he did not feel safe when he saw him.</p> <p>1/5/24 at 12:30 PM, V1 Administrator stated, The incident was reported to me on Christmas day around 3 PM but the incident happened on Christmas eve. I interviewed V3 (Respiratory Therapist) on Christmas day over the phone and I suspended him that day. It was reported that V3-respiratory therapist was standing on the left-hand side of the bed and the resident coughed and mucus came out and that the respiratory therapist slapped him on the face. I asked him to describe the employee and R1 said he was tall with long straight white hair. He did identify him as V3. Every time I spoke with (R1) he told me the same story, so it was consistent. The only thing that changed was that was that it was the left side of the face, not the right. I spoke with his sister, and she requested that he (V3) not take care of the resident again, but I explained to her that if something happened, and that the resident needed care, that two people would come in just in case if it was an emergency. Surveyor asked why nurses or other staff couldn't respond to the emergency, V1 had no response except to say, We always have two respiratory therapists at night. Surveyor asked how she ensured that V3 never came into R1's room at night since there is no supervisor at night and the respiratory office is on the same floor close to R1's room, V1 stated, To my knowledge V3 has not come in to service (R1).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 1/5/24 at 2:20 PM, V3-Respiratory Therapist came to the facility to be interviewed by the surveyor. The VP of Clinical Operations (V 4) was requested to be present in the room. V3 stated, Everybody knows that since he has been here (referring to the resident) he's been giving a hard time to all the staff, nurses, staff CNA's. He is refusing everything as far as respiratory care is concerned. He is totally refusing suctioning and in short, he doesn't like to be bothered. Sometimes he's in good mood then he will let you suction him. Everybody knows this. I reported to V11(Respiratory Director) and when I reported it to her, she said try to make the best and don't force him. Also, he just doesn't cooperate. He fights and wants me to suction him while you are standing. That's not easy and he wants to lie down in bed. It has happened 2-3 times. I tried to get him in bed. He was standing so I had to push him to the bed. I struggled with him to put him in bed for his safety. I pushed him to bed and struggled and he still wanted to get up, so I had to hold him down and check his saturation. Surveyor asked if he asked for any assistance, V3 stated, I did not get any help. I suctioned him a little bit, he was very mad, and he was pulling my gown repeatedly and he was trying to push me away. I was trying to hold his hand and I pushed his hand away from my lab coat. I finished suctioning and tried to check his oxygen saturation. He coughed when he was lying down and when he coughed out his phlegm, I turned my face. I never touched his face when he coughed. Surveyor asked if he should have returned later when the resident calmed down, V3 stated, No, I struggled with him and he's stronger than me. I even told the administrator that I struggled with the man and that I was upset about the whole thing. Surveyor asked V3 how upset it made him, V3 stated, I was a little upset, but then I got very upset because I couldn't suction him thoroughly. He constantly fought me. I told the patient care tech and the nurse at the station as soon as I left the room, I told them to watch for that guy, he is out of control.</p> <p>Surveyor asked if at any point he had to manipulate the resident's face during suctioning that could have been construed as a slap, V3 stated, No I never touched his face. (V3 became argumentative with surveyor and began lecturing surveyor of the location of the trachea). V3 stated, If you knew where his trachea is then you'd know his trachea doesn't move so I didn't do anything to him like that. Surveyor asked V3 to go through the events again for clarity in case anything was missed, V3 stated, The resident coughed two to three times. At no time did his cough hit me. Because of the struggle and I suctioned him real hard, and I was upset, not frustrated. I had to press his hands down so I could suction him. I was moving his hand away and I did not stabilize his face. The trachea remains the same and I don't need to touch his face. I had to restrain his hands. There was another respiratory therapist on duty there but she was busy, so I did not get any help.</p> <p>During and after the interview, V3 affirmed and repeated his statements to the surveyor and to V4.</p> <p>On 1/6/24 at 12:45 PM, R1 was observed seated in a chair in an upright position and was asked how he was doing, R1 stated that he was still upset about the situation that happened to him on Christmas and that V3 was still around after that occurred. R1 became upset and stated that no one did anything to V3 after he was slapped by him and indicated that he felt the facility chose not to believe him when he reported it to the nurse of what happened. R1 stated, I told my sister, and she told me she would take care of it.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>G. A new investigation was immediately initiated to include interview of all staff who worked when the incident occurred. (Initiated on 1/5/2024 at 2:30 pm and expected date of completion will on or before 1/12/2024).</p> <p>An initial Abuse Reportable was submitted to the Illinois Department of Public Health on 1/5/2024 at 4:29 pm.</p> <p>2. Immediate Actions and Actions to prevent recurrence. (Initiated on 1/5/2024 at 5:46 pm and will continue until all staff are in-serviced and trained prior to the start of their shift.)</p> <p>The facility took the following immediate actions to address the citation and prevent any additional residents from suffering an adverse outcome.</p> <p>A. All residents who received care from the alleged perpetrator who are cognitively intact and interviewable were interviewed by the Administrator to identify for Abuse. If any of the residents who is cognitively intact and interviewable reports any allegation against the alleged perpetrator or any staff or resident, the facility's abuse policy will immediately be enacted. (Initiated on 1/5/2024 at 5:45 pm and Completed on 1/9/2024 at 1:30 pm)</p> <p>B. Skin assessments were completed by the Director of Nursing and the Assistant Director of Nursing to all residents who are cognitively impaired and/or not interviewable and who received care from the alleged perpetrator to identify any signs of injury. (Initiated on 1/6/2024 at 10 am and Completed on 1/9/2024 at 1:30 pm)</p> <p>C. All residents who received care from the alleged perpetrator will be monitored for adverse effects three (3) times a week for two (2) weeks. (Initiated on 1/5/2024 at 5:45 pm and will be completed on 1/19/2024)</p> <p>D. Based on the results of both assessments, the IDT (interdisciplinary team) which includes the DON, ADON, Social Service Director, Administrator, MDS (minimum data set) nurse, will determine the appropriate intervention to protect the residents. (Initiated on 1/5/2024 at 10:44 pm and Completed on 1/9/2024 at 12:00 noon).</p> <p>E. All staff who worked during the shift (including Agency staff) when the alleged incident occurred were interviewed by the administrator. (Initiated on 1/5/2024 at 5:45 pm and Completed on 1/7/2024 at 5:00 pm)</p> <p>F. All staff who worked in the unit (including Agency staff) were interviewed by the administrator. (Initiated on 1/5/2024 5:45 pm and completed on 1/7/2024 at 1:00 pm)</p> <p>G. The VP of Policies & Staff education/VP of Regulatory Compliance & Clinical Services will provide the Administrator/DON/SSD (social service director)/ADON/RT Director with education related to the above-mentioned Policies. (Initiated and completed on 1/5/2024 at 4 pm)</p> <p>H. The Administrator and DON reviewed the facility's policies which includes but not limited to:</p> <p>a. Abuse</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34516</p> <p>Based on observation, interview, and record review, the facility failed to follow their abuse prevention investigation procedures by failing to conduct a thorough investigation of an alleged abuse by a staff member; Failed to remove access by the alleged perpetrator to the victim; and failed to provide ongoing assurances of protection after appeals from the resident and family member to disallow alleged staff member access to the resident. This failure affects 1 of 3 residents (R1) in the sample and led to R1 being physically abused, restrained, and roughly suctioned by a staff person, and continued fearfulness of staff person's return.</p> <p>Findings include:</p> <p>On 1/5/24 at 12:30 PM, V1 Administrator and designated abuse prohibition designee stated, An incident of abuse was reported to me on Christmas day around 3 PM about a staff person slapping R1 but the incident happened on Christmas eve. I interviewed V3 (Respiratory Therapist) on Christmas day over the phone and I suspended him that day. It was reported that V3 was standing on the left-hand side of the bed and the resident coughed and mucus came out and that the therapist slapped him on the face. I asked him to describe the employee and R1 said he was tall man with long straight white hair. He did identify him as (V3). Every time I spoke with (R1) he told me the same story, so it was consistent. The only thing that changed was that it was the left side of the face, not the right. I spoke with his sister, and she requested that he (V3) not take care of the resident again, but I explained to her that if something happened and that the resident needed care, that two people would come in just in case if it was an emergency. Surveyor asked why nurses or other staff couldn't respond to the emergency, V1 had no response except to say, We always have two respiratory therapists at night. Surveyor asked how she ensured that V3 would never come into R1's room at night since there is no supervisor at night and the respiratory office is on the same floor close to R1's room, V1 stated, To my knowledge (V3) has not come in to service (R1).</p> <p>R1 is an alert and oriented [AGE] year-old with diagnosis of tracheotomy, gastrostomy, acute and chronic respiratory failure with hypoxia, and alcoholic liver disease.</p> <p>On 1/5/24 at 11:45 AM, R1 was observed in bed watching television, appeared alert and oriented, able to recall events of the incident, and able to respond to questions appropriately when asked. R1 stated that he was slapped by a respiratory therapist while he was being suctioned around Christmas time and that it happened on two separate occasions. R1 indicated he ignored the first time it had occurred but could not ignore the second time because he realized it was now done on purpose. R1 then appeared distraught and became emotional when describing the events that occurred and added that the respiratory therapist pushed him on the bed and fought with him to get a tube down his throat. Surveyor tried to calm the resident and asked the resident if he was able to write the events down on paper, so he didn't have to struggle to talk through his trachea. R1 wrote on a piece of paper a similar statement he made with the surveyor that the respiratory therapist slapped him for coughing two times, and that he told a nurse supervisor the next day. R1 added on this statement that he saw the respiratory therapist the next day and on following days thereafter, and that he did not feel safe when he saw him.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Bria of Elmwood Park		STREET ADDRESS, CITY, STATE, ZIP CODE 7733 West Grand Avenue Elmwood Park, IL 60707	
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<p>F 0610</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/5/24 at 11:45 AM, surveyor affirmed R1's room to be on the same floor and in close proximity to the respiratory therapist office.</p> <p>On 1/5/24 at 2:20 PM, V3 (RT/ Respiratory Therapist) came to the facility to be interviewed by surveyor with V4 (VP of Clinical Operations) present during the interview. During this interview, V3 indicated that R1 was a difficult resident for all staff to contend with and that he struggled with the resident during care. V3 stated that he pushed the resident to the bed, struggled with the resident throughout in an effort to suction the resident but did not obtain any assistance from anyone or return at a different time to conduct care. V3 added that during the struggle with the resident he had to forcibly restrain R1's hands and that the resident became mad. V3 went on to say that he became upset to the extent he had to suction the resident in a hard manner.</p> <p>On 1/6/24 at 1:15 PM, R1's sister V15 requested to meet with surveyor. V15 stated, I was informed by the facility you were here. I just got back from the police station. I've been telling the administrator (V1) that I did not want V3 to ever come in to take care of my brother, but she kept giving me excuses as if they didn't believe my brother. V1 told me that in case of an emergency that V3 needed to go into my brothers room, but he would take someone with him. I was like, why couldn't anyone else do that in an emergency, the guy slapped my brother! I told her (V1) why can't you just call 911?</p> <p>On 1/5/24 at 11:45 AM surveyor affirmed R1's room to be on the same floor and in close proximity to the respiratory therapist office.</p> <p>Reviews of respiratory ventilator flow sheets showed V3 returned on duty 12/31/23 with easy access to the resident.</p> <p>Review of V3's employee file showed one abuse Inservice training upon hire in 2022 and no other abuse prohibition training provided throughout 2023, and no abuse training immediately after the alleged incident occurrence on 12/25/23 or upon V3's return to duty.</p> <p>On 1/6/24 at 1:55 PM, V9 (Social Service Director) stated, I met with the resident last night and checked on him on his well-being and how he was doing. I checked to see if he felt safe and felt comfortable in the building and he said he did. He mouthed words and it was very brief, and he didn't want to elaborate too much and said he was ok. He seemed calm and seemed comfortable and didn't see any distress that I saw. I was prompted to see him due to the investigation. The administrator told me to do this. Surveyor asked if it was her role to conduct a psychosocial assessment during these types of incidents and V9 affirmed that it was. Surveyor asked why no such assessment was conducted during the first alleged incident that was reported by R1 on 12/25/23, V9 stated, I was on vacation the whole week, so I was not aware of it. I have an assistant V13 but from my knowledge no one directed him to be seen after the initial allegation. Surveyor asked what type of abuse training she received, V9 stated, As directed by the administrator our procedure is to follow up after any alleged abuse. I was not informed of the one that happened on Christmas day.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/6/24 at 2:30 PM, V4 (VP of Clinical Operations) stated, I told the Administrator and Director of Nursing to take V3 off the schedule and we walked him out. Our plan is to terminate V3 and train our staff. The administrator should've brought him in to conduct an in-person for interview. We're changing that process moving forward. At 3:00 PM, V4 returned to surveyor and stated, We terminated him. I'm going to refer the Administrator (V1) and DON (V2) for training on how to conduct a thorough investigation including calling the police for any physical abuse, investigate alleged perpetrators in person, and Inservice when a resident indicates that they do not want to be taken care of by particular staff. We have to consider that to prevent psychosocial effect on a resident. I will have the Assistant DON (V12) conduct the in-services for the whole staff on behavioral management.</p> <p>On 1/9/24 at 2:10 PM, V14 (Medical Director) stated, I've been discussing this incident the last few days and am very aware of what happened. I was told by administration about this RT (respiratory therapist-V4) and about his history. That is a pattern. I did discuss with facility with the abuse situation on our aspect that has to be answered. Sometimes this therapist or any staff they are not children and should know how to respond to abuse. They all know abuse and should know how respond. When the new company took over the operations, they let this facility go down and didn't pay any attention. After this new operation, I took medical directorship about a month ago, so I have been working with management including abuse prevention. protecting residents is what I am working with the facility, and I am working closely with the facility. I have scheduled a meeting next Thursday. Abuse will be included in the QAPI meeting.</p> <p>On 1/11/24 at 11:15 AM, V14 Medical Director met with surveyor and stated, I am working closely with administration to improve their function. This incident should not have happened and even though the resident and the respiratory therapist stories don't match we still know that some abuse occurred. Surveyor asked whether administration acted effectively and efficiently to maintain the safety and psychosocial well-being of the resident, V14 stated, Well in hindsight not for this instance, that is why I am here as part of quality assurance meeting to discuss changes moving forward. Surveyor asked since the original incident occurred last year on 12/24/23, whether a doctor should have examined him by then, V14 stated, I have not seen him yet, but I am on my way to see R1 after this meeting.</p> <p>Facility policy on abuse preventions dated 2/2017 reads in part, The facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property and mistreatment of residents. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is a willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident.</p> <p>(continued on next page)</p>		

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F 0610 Level of Harm - Actual harm Residents Affected - Few	Investigation Procedures: a review of the initial written reports; completion of a written report on the status of the investigation within 24 hours of the occurrence; An interview with the persons reporting the incident; Interviews with any witnesses to the incident; Where appropriate, an interview with the resident's attending physician or psychiatrist; A review of the medical records of any residents involved in the occurrence, including care plans and medications; If the accused individual is an employee, a review of the personnel file to check for references, background check, and documentation of orientation and training; Interviews with the resident's roommate, family members, visitors or others who were in the vicinity of the incident; interviews with other residents to which the accused individual has regular contact; An interview with the accused individual; A review of all circumstances surrounding the incident.		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34516</p> <p>Based on observation, interview and record review, the facility failed to follow their policy for tracheotomy suctioning, failed to follow physician orders to provide adequate and appropriate respiratory and tracheal suctioning consistent with professional standards of practice for 1 of 3 residents (R1) in the sample. This failure resulted in R1 not receiving sufficient suctioning to maintain tracheal airway free from mucus/phlegm and failed to conduct tracheal suctioning care by being forcibly suctioned in a harsh and non-gentle manner by the respiratory therapist who caused pain and fear to the resident.</p> <p>Findings include:</p> <p>R1 is an alert and oriented [AGE] year-old with diagnosis of tracheotomy, gastrostomy, acute and chronic respiratory failure with hypoxia, and alcoholic liver disease.</p> <p>On 1/5/24 at 11:48 AM, R1 was in bed watching television. Surveyor tried to interview R1, but his tracheotomy appeared gray, and phlegm filled. R1 was coughing and tried to cover the tracheal opening to talk with the surveyor but was unable to due to the phlegm accumulation in his tracheotomy. Surveyor then searched for staff assistance.</p> <p>On 1/5/24 at 11:50 AM, V6 (LPN/ Licensed Practical Nurse) stated, R1 is alert and oriented times three. The resident is relatively calm when I work with him, and he receives trachea care from the respiratory therapist. Surveyor asked if she had recently conducted tracheal care such as suctioning of the resident, V6 stated, Nurses don't do that here, it's the respiratory therapists job. V5 (RT/Respiratory therapist) is here today for R1.</p> <p>On 1/5/24 at 11:55 AM, V5 stated, I suctioned R1 an hour ago but I will suction him again if needed and I see he does. Surveyor asked how often R1 needed to be suctioned in order for R1 to breath freely, V5 stated, We suction him once a shift and PRN (as needed). Surveyor asked where in the record the therapists record their tracheal care and suctioning when done, V5 stated, We document it each time we do it on a flow sheet.</p> <p>On 1/5/24 at 2:20 PM, V3 (RT/ Respiratory Therapist) came to the facility to be interviewed by surveyor with V4 (VP of Clinical Operations) present during the interview. During this interview, V3 indicated that R1 was a difficult resident for all staff to contend with and that he struggled with the resident during care. V3 stated that he pushed the resident to the bed, struggled with the resident throughout in an effort to suction the resident but did not obtain any assistance from anyone or return at a different time to conduct care. V3 added that during the struggle with the resident he had to forcibly restrain R1's hands and that the resident became mad. V3 went on to say that he became upset to the extent he had to suction the resident in a hard manner.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/6/24 at 12:40 PM, R1 was observed sitting up in a chair with a plastic bib on his chest. R1's tracheotomy again appeared gray with thick mucus/phlegm buildup. A sponge around the tracheal opening was discolored, yellowish, and wet with what appeared to be secretions and mucus buildup. Surveyor asked whether anyone came to provide him suctioning, R1 covered his tracheal opening to speak, coughed up phlegm and informed the surveyor that someone came in earlier this morning but only one time. Surveyor asked if he needed to be suctioned again, R1 nodded yes.</p> <p>On 1/6/24 at 12:45 PM, V8 (RT) was asked by surveyor if she could suction the resident. V8 stated, I did him already this morning around 8 but I can do it again if you'd like. Surveyor asked how often R1 needed to suctioning, V8 stated, We mostly do it once a shift and whenever the resident asks us to do it. Surveyor asked if the resident had to ask in order to be suctioned or if the respiratory therapists check, V8 stated, Well, sometimes R1 refuses.</p> <p>Surveyor asked V8 to ask or observe whether R1 needed additional suctioning. V8 asked R1 and R1 nodded yes.</p> <p>Review of physician orders dated 11/2/23 states, Suction resident each shift and as needed. Trachea care each shift and PRN (as needed).</p> <p>A review of respiratory care flow sheets titled Ventilator/Aerosol Flow sheet from 12/23/23 to 1/5/24 showed R1 received suctioning and trachea care a majority of once a shift with multiple days of no documented suctioning or tracheal care rendered. The flow sheets appeared that the physician order for PRN (as needed) order was not followed.</p> <p>Policy titled Tracheal Suctioning reads in part, The facility will ensure that residents who need respiratory care, including tracheal suctioning, are provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences. Tracheal suctioning is performed by a licensed nurse to clear the throat and upper respiratory tract of secretions that may block the airway. Procedure: Gather equipment and set up, attach suction tubing to canister. Explain the procedure to the resident and screen for privacy. Remember suctioning can be a frightening experience. Reassure resident and allow the resident an opportunity to catch his/her breath between episodes of suctioning, providing oxygenation as indicated. Insert catheter into tracheotomy tube opening gently during inspiration until resistance is felt. Repeat suctioning if necessary. Document procedure and any significant findings.</p> <p>On 1/11/24 at 11:15 AM, V14 Medical Director met with surveyor and stated, I am working closely with administration to improve their function. This incident should not have happened and even though the resident and the respiratory therapist stories don't match we still know that some abuse occurred. Surveyor asked whether administration acted effectively and efficiently to maintain the safety and psychosocial well-being of the resident, V14 stated, Well in hindsight not for this instance, that is why I am here as part of quality assurance meeting to discuss changes moving forward. Surveyor asked about an order for suctioning every shift and as needed, V14 indicated that doctor's orders should always be followed. Surveyor asked since the original incident occurred last year on 12/24/23, whether a doctor should have examined him by then, V14 stated, I have not seen him yet, but I am on my way to see R1 after this meeting.</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34516</p> <p>Based on observation, interview, and record review, the facility administration failed to take appropriate action to ensure the safety of 1 of 3 residents (R1) in the sample. The facility administration failed to protect a resident from harmful actions inflicted by staff, failed to conduct a thorough investigation of an allegation of abuse, and failed to honor the requests of the resident to remain safe and free from harm.</p> <p>Findings include:</p> <p>On 1/5/24 at 12:30 PM V1 Administrator and Abuse Prohibition Coordinator stated, I was informed of an incident that was reported to me on Christmas day around 3 PM and for an allegation of abuse that occurred on Christmas Eve by V3 RT/Respiratory Therapist When I interviewed the RT over the phone and I suspended him on the 25th and he returned on the 31st. Surveyor asked when the resident was interviewed, V1 stated, I interviewed the resident on Christmas day. He reported that a respiratory therapist slapped him on the left-hand side and he coughed and mucus came out and the RT slapped him on the face. I asked him to describe to employee and he said he was tall male with long straight, white hair. He identified him, it was close. Every time I spoke to R1 he told me the same story. The only thing that changed was that it was the left side that he was slapped. I also spoke with his sister (V15) and she requested that this therapist not take care of him but I explained that if something were to happen, that he needed care, that two people would come in in case of an emergency. Surveyor asked why V3 would have to be present at all since the resident and family expressed they didn't want V3 around the resident, V1 stated, We always have two RT's at night but I told the sister that I'd always have someone with V3 if he needed to go into the room. Surveyor asked how she ensured V3 did not go back to the room since the therapist worked at night and with no supervision, V1 stated, To my knowledge V3, has not come in to service the resident. Surveyor asked where the respiratory office was located in proximity to R1's room, V1 stated, R1 is on the same floor as the respiratory therapist office and it's several doors down. Surveyor asked how V3's interview was conducted, V1 stated, I called him on the phone, and he told me what happened. That's when I called his supervisor V11 who told him he was suspended. Surveyor asked why she conducted a telephone interview and not asked this staff member to come in person to be interviewed to obtain a more thorough investigation, V1 declined to comment. Surveyor asked how the conclusion of her investigation led no evidence of abuse, V1 stated, We didn't find any bruising or discoloration on the resident's face.</p> <p>A review of V3's incident folder on 1/5/24 at 10:35 AM pertaining to the allegations by R1 showed all statements from staff members including V3 were all written, signed, and generated by V1 Administrator. Missing from the records were interviews from V10 Agency Nurse and an unknown CNA on duty during the alleged incident.</p> <p>R1 is an alert and oriented [AGE] year-old with diagnosis of tracheostomy, gastrostomy, acute and chronic respiratory failure with hypoxia, and alcoholic liver disease.</p> <p>On 1/5/24 at 11:45 AM, surveyor affirmed R1's room to be on the same floor and in close proximity to the respiratory therapist office.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/5/24 at 2:20 PM, V3 (RT/ Respiratory Therapist) came to the facility to be interviewed by surveyor with V4 (VP of Clinical Operations) present during the interview. During the interview, V3 indicated that R1 was a difficult resident for all staff to contend with and that he struggled with the resident during care. V3 stated that he pushed the resident to the bed, struggled with the resident throughout in an effort to suction the resident but did not obtain any assistance from anyone or return at a different time to conduct care when the resident calmed down. V3 added that during the struggle with the resident, he had to forcibly restrain R1's hands and that the resident became mad. V3 went on to say that he became upset to the extent he had to suction the resident in a hard manner. During and after the interview, V3 affirmed and repeated his statements to the surveyor and to V4.</p> <p>On 1/6/24 at 1:15 PM, R1's sister V15 requested to meet with surveyor. V15 stated, I was informed by the facility you were here. I just got back from the police station. I've been telling the administrator (V1) that I did not want V3 to ever come in to take care of my brother, but she kept giving me excuses as if they didn't believe my brother. V1 told me that in case of an emergency that V3 needed to go into my brothers room, but he would take someone with him. I was like, why couldn't anyone else do that in an emergency, the guy slapped my brother! I told her (V1) why can't you just call 911?</p> <p>On 1/6/24 at 2:30 PM, V4 (VP of Clinical Operations) stated, We're changing that process on how we conduct incident investigations moving forward. I'm going to refer the Administrator (V1) and DON (V2) for training on how to conduct a thorough investigation including calling the police for any physical abuse, investigate alleged perpetrators in person and not over the phone, and Inservice when a resident indicates that they do not want to be taken care of particular staff. We have to consider that to prevent psychosocial effect on a resident. I will have the Assistant DON (V12) conduct the in-services for the whole staff on behavioral management.</p> <p>On 1/11/24 at 11:15 AM, V14 Medical Director met with surveyor and stated, I am working closely with administration to improve their function. This incident should not have happened and even though the resident and the respiratory therapist stories don't match we still know that some abuse occurred. Surveyor asked whether administration acted effectively and efficiently to maintain the safety and psychosocial well-being of the resident, V14 stated, Well in hindsight not for this instance, that is why I am here as part of quality assurance meeting to discuss changes moving forward.</p>		