STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. Building B. Wing	08/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Holstein	505 West Second Street Holstein, IA 51025

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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, interview and record review the facility failed to ensure that residents were free from abuse for 1 of 1 resident reviewed. Staff F, Certified Nurse Aide (CNA), and Staff E, CNA, used punitive restrictions and restraints to control Resident #1 preventing her from moving about. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of July 29, 2024, on August 17, 2024 at 11:20 AM. The Facility Staff removed the IJ on August 17, 2024 through the following actions: a. Head to toe assessment on Resident #1 to include assessment for emotional distress. b. Abuse and Neglect education for all staff implemented through an online course. Team members instructed to review course prior to the next scheduled shift. Daily educational huddles completed daily for two weeks. It was identified during survey Staff I worked 9 times prior to taking course and Staff J worked 12 times prior to taking course. c. Leadership supervision in memory care implemented to include daily oversight of behaviors, staff management and increased activities and interaction with residents. d. All residents interviewed to ensure they were feeling safe. e. Further education regarding dementia related behaviors, management of behaviors, resident rights, providing meaningful activities, follow-up quizzes, training videos to determine how behaviors may indicate unmet needs in dementia residents. f. Leadership perform Angel Rounding to include resident interviews and observations to ensure resident care needs are addressed. g. Administrator and Director of Nursing or designees will audit through observation while staff care for residents with behaviors for appropriate response and management. 5 team members randomly on all shifts daily for 10 days. (continued on next page)

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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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	h. Administrator and Director of Nursing or designees will audit through resident right questionnaire 5 team members randomly on all shifts daily for 10 days to ensure staff education on resident rights. i. Audits will be taken to QAPI for further review and recommendations. The scope lowered from a J to D at the time of the survey after ensuring the facility implemented education and their policy and procedures. The facility identified a census of 51 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #1 had a Brief Interview for Mental Status (BIMS) score of 3 (severe cognitive deficit). She required substantial assistance with dressing, hygiene, toilet transfers and was able to walk with partial assistance. Her diagnosis included cancer, anemia, hip fracture and Alzheimer's Disease. She was admitted to the facility on [DATE]. The Care Plan revised on 7/30/24, showed Resident #1 had impaired cognitive function/dementia related to Alzheimer's disease and required 24/7 supervision. The resident was able to understand consistent, simple direct sentences. Staff were to provide Resident #1 with simple cues, to stop and return later if she was agitated, and to monitor for physical/nonverbal indicators of discomfort or distress. The resident required supervision with ambulation in hallways and common area. She had behavior symptoms with verbal aggression, cursing, pushing and at times she was resistive with cares. According to a facility Incident Report dated 7/29/24 at 4:30 PM, Staff B, Activities Director witnessed Staff E, Certified Nurse Aide (CNA) with her hand over the mouth of Resident #1. The Director of Nursing (DON) reviewed a video tape of the memory care area and found that Staff E had also pushed the resident back down in to the chair, and pushed the chair up to the table when she was attempting to stand. Staff F, CNA was sitting at the same table during these events but failed to intervene or report the interactions. Staff F also braced the table with her feet when Resident #1 pushed it to get out of her chair. The resident was described as restless, anxious and confused. A summary of the facility investigation showed that on 7/29/242 at 4:30 PM, when the DON learned of the incident, Staff E had already left for the day, and Staff F was escorted out and suspended around 5:00 PM. Staff B, Staff E and Staff B were all placed on suspension. A review of the video from the memory care unit on 8/16/24 at 11:30 AM, revealed the following: a. At 1:32 PM, on 7/29/24, Staff E and Resident #1 were in the dining room and Resident #1 was sitting in a chair up to a round table. Staff E was standing behind the chair with her leg braced up against the back of the chair and was scrolling through her phone. A couple of minutes later, Staff E sat in a chair next to the resident and several times, the resident put her hands on the arms of the chair, pushed up, and attempted to stand. Each time, Staff E pushed down on the resident's shoulder to get her to sit down. The resident looked agitated and turned toward the staff member and said something. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. At 1:35 PM, Staff E pushed her down into the chair and the resident swung at the CNA. Staff E then grabbed the resident's wrists and hands and held them down. Staff F then entered the room with another resident and sat on the opposite side of the table from the residents. Resident #1 continued to try to stand and each time, Staff E pushed her back down into the chair. c. At 1:39 PM, once again, the resident swung at Staff E and the CNA grabbed the resident's arms and held them down against the arm rest of the chair. The two exchanged words, and at 1:40 PM, Staff E put her hand over the resident's mouth, the resident swung at her and the CNA grabbed her arms again. As they exchanged more words, Staff E took a blanket from the back of the chair and put it on the back of the resident's head. This increased her agitation and she pulled it back off. Resident #1 then tried to take her sweater off, she had it partially off of one arm when Staff E reached over and tried to force her to put it back on. d. At 1:41 PM, Resident #1 pushed her chair back from the table and the CNA responded by pushing the chair back until her torso was up to the table. Three more times, the resident tried to stand, and Staff E pushed her back down into the chair. Resident #1 put her head down on the table and looked to be crying, at 1:47 PM, Staff E looked at Staff F on the other side of the table and they snickered. Resident #1 then swung out at the CNA, and Staff E grabbed her hands and arms. Staff E then got up out of her chair and stood behind the resident's chair with her leg braced up against the back of the chair. With her hands on the table, the resident tried to push her chair back, but the table moved across the floor. Staff E lifted the resident's hand off the table, and with her body, she shoved the chair up to the table and pinned her against it. e. At 1:50 PM, the residents head was down and she looked to be crying. Staff E then picked up the resident's sweater and placed it on her head, Resident #1 got agitated and threw it off. At 1:52 PM, the resident looked to be yelling, Staff E kept her body firmly at the back of the chair and placed her hand over the resident's mouth. Resident #1 tried to push her chair back again but the table moved instead. Staff F then braced her feet at the base of the table so it wouldn't move as Staff E pushed the resident's chair up to the table again. f. At 1:53 PM, Staff E put her hand over the resident's mouth again and that was when Staff B entered the room. Staff E then backed away from the resident, allowed her to stand and walk around the room. The CNA followed the resident for a short period of time but then went and sat at the nurse's station. On 8/16/24 at 9:49 AM, Staff B said that on 7/29/24, she came down the hallway of the locked memory unit and she heard a resident screaming and yelling. She said that this was not unusual, as Resident #1 did tend to become more anxious in the afternoons. When Staff B entered the eating area, she saw Staff F sitting in a chair up at the table and Resident #1 was on the opposite side of the table. Staff E was standing behind Resident #1, with hand over the resident's mouth. The CNA quickly took her hand off of the resident and backed away. Staff B said that she went on with her activities over the next couple of hours. She said that she attempted to talk to the Director of Nursing (DON) sooner, but she thought it was not a big concern or cause for immediate action. She was able to connect with the DON around 4:30 PM. Staff B said that after watching the video from the memory unit, she came to understand that there were more concerning actions that had taken place, and she should have addressed it right away. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/17/24 at 10:00 AM Staff E, CNA said that on 7/29/24, Resident #1 was having a rough day, and they had tried different interventions to calm her. She said they had been taking turns caring for her but the staff member that was working with her, was short tempered and couldn't handle Resident #1 for very long. The resident was anxious, agitated, screaming, and yelling for attention she likes attention, good or bad. Staff E said the nurse had given the resident a medication to help calm her, and that tended to affect her gait so they were watching her close because she was a fall risk. The resident didn't want to get into the recliner, and she had been known to approach other residents at times, so Staff E thought a chair at the table was the safest option. Staff F was with her at the table, and some of the chairs don't have the grippers attached on the bottom of the legs. She said that she was afraid that when the resident pushed her chair back, it could tip backwards so that was why she stood behind her to prevent her from pushing it. Staff E said that this was better than letting her stand up and risk falling. Staff E said that at one point, the resident started hitting her, and she was taught that it was okay to place the resident's hands in their laps to keep you and the resident safe. She acknowledged that she put her hand on the resident's mouth several times to shush her. She said that had worked in the past. When asked to describe what a restraint looks like, she said you can't force them to stay in bed, you can't restrict their motion unless they are a harm to you or themselves. When asked about pushing the chair up to the table and trapping the resident, she said that this was a better plan than letting the chair tip backwards. Staff E said that her training on caring for dementia residents included watch videos, and following another CNA on the floor for about a week. She said they really didn't have hands-on training or competency tests to determine if they had learned the skills. Staff E said that she should have probably tried some different repositioning when Resident #1 continued to escalate. She said that they didn't have many staff in the unit and she still felt the safest option for Resident #1 was to keep her from standing and pushed up to the table. She thought the shushing would help, but when it didn't, that's when she decided to give the resident some space and let her walk. On 8/16/24 at 12:20 PM, Staff F, CNA said that she had been suspended from work because her coworker covered a resident's mouth and she didn't have a chance to report it. The resident was yelling out, so Staff E put her hand over the resident's mouth. She said that it wasn't very forceful and said that she told her to stop but she didn't know if she heard her, because the resident was yelling so much. When asked about not allowing the resident to get up out of the chair, Staff F said that was the case and she was pushing her back into the chair. She said that the resident had been swinging at Staff E but she did not see her holding down the resident's arms. When asked if she had seen anything that she would describe as a restraint, Staff F said that when the residents chair had been pushed against the table, that was probably a restraint. She did not know why she braced the table when the resident pushed it, trying to get up. I just wasn't thinking very clearly. Staff F acknowledged that by preventing the resident from getting up and walking around, her agitation and yelling had increased. Staff F said that she didn't have a chance to intervene or to report the incident. She said that they are provided on-line training on how to handle residents with dementia and agitation. She didn't remember much about it or any of the specific techniques that were taught. On 8/17/24 at 8:23 AM, a family member for Resident #1 said that the resident did not like to be touched and any attempts to redirect her by putting hands on, would only escalate her. They advised the staff to just walk with her and try not to touch her. She said that at times, the staff would try to talk her into sitting down, and that did not work. She understood that Resident #1 was a fall risk, but trying to force her just made things worse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/17/24 at 7:50 AM Staff H, Assistant Director of Nursing (ADON) said that she had watched the video and acknowledged that holding the resident's chair up against the table was a restraint. No staff or residents had ever come to her with concerns about Staff F or Staff E. She said they do random observations of staff interactions with residents. If they see concerns, or something that could be done differently, they take that opportunity to do education with them. On 8/16/24 at 11:30 AM Staff D, Quality Assurance (QA) nurse acknowledged that the pinning of the chair against the table and the holding down of arms and hands would be described as a restraint. She also acknowledged that staff had no reason to be on the phone while caring for the residents. According to the facility policy titled: Abuse and Neglect dated 7/22/24, the purpose of the policy was to ensure that employees were knowledgeable regarding the reporting and investigative process of abuse and neglect allegations. To ensure that the facility had an effective system in place that prevents mistreatment, neglect exploitation and abuse of residents. Resident have the right to be free from abuse .this includes freedom from corporal punishment and involuntary seclusion. Alleged or suspected violations involving any mistreatment, neglect, exploitation or abuse including injuries of unknown origin would be reported immediately to the administrator.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on record, policy and video review, and interviews, the facility failed to report suspected abuse immediately, and failed to separate an alleged abuser from the residents immediately. A staff member witnessed a Certified Nurse Aide (CNA) with her hand covering the mouth of an agitated resident. She failed to report the suspicious activity for over 2 hours. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of July 29, 2024, on August 17, 2024 at 11:20 AM. The Facility Staff removed the IJ on August 17, 2024 through the following actions: a. Head to toe assessment on Resident #1 to include assessment for emotional distress. b. Abuse and Neglect education for all staff implemented through an online course. Team members instructed to review course prior to the next scheduled shift. Daily educational huddles completed daily for two weeks. c. Leadership supervision in memory care implemented to include daily oversight of behaviors, staff management and increased activities and interaction with residents. d. All residents interviewed to ensure they were feeling safe. e. Further education regarding dementia related behaviors, management of behaviors, resident rights, providing meaningful activities, follow-up quizzes, training videos to determine how behaviors may indicate unmet needs in dementia residents. f. Leadership perform Angel Rounding to include resident interviews and observations to ensure resident care needs are addressed. g. Administrator and Director of Nursing or designees will audit through observation while staff care for residents with behaviors for appropriate response and management. 5 team members randomly on all shifts daily for 10 days. h. Administrator and Director of Nursing or designees will audit through resident right questionnaire 5 team members randomly on all shifts daily for 10 days to ensure staff education on resident rights. i. Audits will be taken to QAPI for further review and recommendations. The scope lowered from a J to D at the time of the survey after ensuring the facility implemented education and their policy and procedures. The facility identified a census of 51 residents. Findings include: (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to the Minimum Data Set (MDS) dated [DATE], Resident #1 had a Brief Interview for Mental Status (BIMS) score of 3 (severe cognitive deficit). She required substantial assistance with dressing, hygiene, toilet transfers and was able to walk with partial assistance. Her diagnosis included cancer, anemia, hip fracture and Alzheimer's Disease. She was admitted to the facility on [DATE]. The Care Plan revised on 7/30/24, showed Resident #1 had impaired cognitive function/dementia related to Alzheimer's disease and required 24/7 supervision. The resident was able to understand consistent, simple direct sentences. Staff were to provide Resident #1 with simple cues, to stop and return later if she was agitated, and to monitor for physical/nonverbal indicators of discomfort or distress. The resident required supervision with ambulation in hallways and common area. She had behavior symptoms with verbal aggression, cursing, pushing and at times she was resistive with cares. According to a facility Incident Report dated 7/29/24 at 4:30 PM, Staff B, Activities Director witnessed Staff E, Certified Nurse Aide (CNA) with her hand over the mouth of Resident #1. The Director of Nursing (DON) reviewed a video tape of the memory care area and found that Staff E had also pushed the resident back down in to the chair, and pushed the chair up to the table when she was attempting to stand. Staff F, CNA was sitting at the same table during these events but failed to intervene or report the interactions. Staff F also braced the table with her feet when Resident #1 pushed it to get out of her chair. The resident was described as restless, anxious and confused. A summary of the facility investigation showed that on 7/29/242 at 4:30 PM, when the DON learned of the incident, Staff E had already left for the day, and Staff F was escorted out and suspended around 5:00 PM. Staff B, Staff E and Staff B were all placed on suspension. A review of the video from the memory care unit on 8/16/24 at 11:30 AM, revealed the following: a. At 1:32 PM, on 7/29/24, Staff E and Resident #1 were in the dining room and Resident #1 was sitting in a chair up to a round table. Staff E was standing behind the chair with her leg brace up against the back of the chair and was scrolling through her phone. A couple of minutes later, Staff E sat in a chair next to the resident and several times, the resident put her hands on the arms of the chair, pushed up, and attempted to stand. Each time, Staff E pushed down on the resident's shoulder to get her to sit down. The resident looked agitated and turned toward the staff member and said something. b. At 1:35 PM, Staff E pushed her down into the chair and the resident swung at the CNA. Staff E then grabbed the resident's wrists and hands and held them down. Staff F then entered the room with another resident and sat on the opposite side of the table from the residents. Resident #1 continued to try to stand and each time, Staff E pushed her back down into the chair. c. At 1:39 PM, once again, the resident swung at Staff E and the CNA grabbed the resident's arms and held them down against the arm rest of the chair. The two exchanged words, and at 1:40 PM, Staff E put her hand over the resident's mouth, the resident swung at her and the CNA grabbed her arms again. As they exchanged more words, Staff E took a blanket from the back of the chair and put it on the back of the resident's head. This increased her agitation and she pulled it back off. Resident #1 then tried to take her sweater off, she had it partially off of one arm when Staff E reached over and tried to force her to put it back on. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d. At 1:41 PM, Resident #1 pushed her chair back from the table and the CNA responded by pushing the chair back until her torso was up to the table. Three more times, the resident tried to stand, and Staff E pushed her back down into the chair. Resident #1 put her head down on the table and looked to be crying, at 1:47 PM, Staff E looked at Staff F on the other side of the table and they snickered. Resident #1 then swung out at the CNA, and Staff E grabbed her hands and arms. Staff E then got up out of her chair and stood behind the resident's chair with her leg braced up against the back of the chair. With her hands on the table, the resident tried to push her chair back, but the table moved across the floor. Staff E lifted the resident's hand off the table, and with her body, she shoved the chair up to the table and pinned her against it. e. At 1:50 PM, the residents head was down and she looked to be crying. Staff E then picked up the resident's sweater and placed it on her head, Resident #1 got agitated and threw it off. At 1:52 PM, the resident looked to be yelling, Staff E kept her body firmly at the back of the chair and placed her hand over the resident's mouth. Resident #1 tried to push her chair back again but the table moved instead. Staff F then braced her feet at the base of the table so it wouldn't move as Staff E pushed the resident's chair up to the table again. f. At 1:53 PM, Staff E put her hand over the resident's mouth again and that was when Staff B entered the room. Staff E then backed away from the resident, allowed her to stand and walk around the room. The CNA followed the resident for a short period of time but then went and sat at the nurse's station. On 8/16/24 at 9:49 AM, Staff B said that on 7/29/24, she came down the hallway of the locked memory unit and she heard a resident screaming and yelling. She said that this was not unusual, as Resident #1 did tend to become more anxious in the afternoons. When Staff B entered the eating area, she saw Staff F sitting in a chair up at the table and Resident #1 was on the opposite side of the table. Staff E was standing behind Resident #1, with hand over the resident's mouth. The CNA quickly took her hand off of the resident and backed away. Staff B said that she went on with her activities over the next couple of hours. She said that she attempted to talk to the Director of Nursing (DON) sooner, but she thought it was not a big concern or cause for immediate action. She was able to connect with the DON around 4:30 PM. Staff B said that after watching the video from the memory unit, she came to understand that there were more concerning actions that had taken place, and she should have addressed it right away. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/17/24 at 10:00 AM Staff E, CNA said that on 7/29/24, Resident #1 was having a rough day, and they had tried different interventions to calm her. She said they had been taking turns caring for her but the staff member that was working with her, was short tempered and couldn't handle Resident #1 for very long. The resident was anxious, agitated, screaming, and yelling for attention she likes attention, good or bad. Staff E said the nurse had given the resident a medication to help calm her, and that tended to affect her gait so they were watching her close because she was a fall risk. The resident didn't want to get into the recliner, and she had been known to approach other residents at times, so Staff E thought a chair at the table was the safest option. Staff F was with her at the table, and some of the chairs don't have the grippers attached on the bottom of the legs. She said that she was afraid that when the resident pushed her chair back, it could tip backwards so that was why she stood behind her to prevent her from pushing it. Staff E said that this was better than letting her stand up and risk falling. Staff E said that at one point, the resident started hitting her, and she was taught that it was okay to place the resident's hands in their laps to keep you and the resident safe. She acknowledged that she put her hand on the resident's mouth several times to shush her. She said that had worked in the past. When asked to describe what a restraint looks like, she said you can't force them to stay in bed, you can't restrict their motion unless they are a harm to you or themselves. When asked about pushing the chair up to the table and trapping the resident, she said that this was a better plan than letting the chair tip backwards. Staff E said that her training on caring for dementia residents included watch videos, and following another CNA on the floor for about a week. She said they really didn't have hands-on training or competency tests to determine if they had learned the skills. Staff E said that she should have probably tried some different repositioning when Resident #1 continued to escalate. She said that they didn't have many staff in the unit and she still felt the safest option for Resident #1 was to keep her from standing and pushed up to the table. She thought the shushing would help, but when it didn't, that's when she decided to give the resident some space and let her walk. On 8/16/24 at 12:20 PM, Staff F, CNA said that she had been suspended from work because her coworker covered a resident's mouth and she didn't have a chance to report it. The resident was yelling out, so Staff E put her hand over the resident's mouth. She said that it wasn't very forceful and said that she told her to stop but she didn't know if she heard her, because the resident was yelling so much. When asked about not allowing the resident to get up out of the chair, Staff F said that was the case and she was pushing her back into the chair. She said that the resident had been swinging at Staff E but she did not see her holding down the resident's arms. When asked if she had seen anything that she would describe as a restraint, Staff F said that when the residents chair had been pushed against the table, that was probably a restraint. She did not know why she braced the table when the resident pushed it, trying to get up. I just wasn't thinking very clearly. Staff F acknowledged that by preventing the resident from getting up and walking around, her agitation and yelling had increased. Staff F said that she didn't have a chance to intervene or to report the incident. She said that they are provided on-line training on how to handle residents with dementia and agitation. She didn't remember much about it or any of the specific techniques that were taught. On 8/17/24 at 7:50 AM Staff H, Assistant Director of Nursing (ADON) said that she had watched the video and acknowledged that holding the resident's chair up against the table was a restraint. No staff or residents had ever come to her with concerns about Staff F or Staff E. She said they do random observations of staff interactions with residents. If they see concerns, or something that could be done differently, they take that opportunity to do education with them. (continued on next page)

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	165207	A. Building B. Wing	08/17/2024

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Good Samaritan Society - Holstein	505 West Second Street Holstein, IA 51025

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/16/24 at 11:30 AM Staff D, Quality Assurance (QA) nurse acknowledged that the pinning of the chair against the table and the holding down of arms and hands would be described as a restraint. She also acknowledged that staff had no reason to be on the phone while caring for the residents. According to the facility policy titled: Abuse and Neglect dated 7/22/24, the purpose of the policy was to ensure that employees were knowledgeable regarding the reporting and investigative process of abuse and neglect allegations. To ensure that the facility had an effective system in place that prevents mistreatment, neglect exploitation and abuse of residents. Resident have the right to be free from abuse .this includes freedom from corporal punishment and involuntary seclusion. Alleged or suspected violations involving any mistreatment, neglect, exploitation or abuse including injuries of unknown origin would be reported immediately to the administrator.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on interviews, video, record and policy review, the facility failed to ensure staff displayed competent dementia care and safe interventions for 1 of 1 resident reviewed. Staff F, Certified Nurse Aide (CNA), and Staff E, CNA, used punitive restrictions and restraints to control Resident #1 preventing her from moving about. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of July 29, 2024, on August 17, 2024 at 11:20 AM. The Facility Staff removed the IJ on August 17, through the following actions: a. Head to toe assessment on Resident #1 to include assessment for emotional distress. b. Abuse and Neglect education for all staff implemented through an online course. Team members instructed to review course prior to the next scheduled shift. Daily educational huddles completed daily for two weeks. c. Leadership supervision in memory care implemented to include daily oversight of behaviors, staff management and increased activities and interaction with residents. d.All residents interviewed to ensure they were feeling safe. e. Further education regarding dementia related behaviors, management of behaviors, resident rights, providing meaningful activities, follow-up quizzes, training videos to determine how behaviors may indicate unmet needs in dementia residents. f. Leadership perform Angel Rounding to include resident interviews and observations to ensure resident care needs are addressed. g. Administrator and Director of Nursing or designees will audit through observation while staff care for residents with behaviors for appropriate response and management. 5 team members randomly on all shifts daily for 10 days. h. Administrator and Director of Nursing or designees will audit through resident right questionnaire 5 team members randomly on all shifts daily for 10 days to ensure staff education on resident rights. i.Audits will be taken to QAPI for further review and recommendations. The scope lowered from a K to E at the time of the survey after ensuring the facility implemented their policy and procedures, and staff education. The facility identified a census of 51 residents. Findings include: (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the Minimum Data Set (MDS) dated [DATE], Resident #1 had a Brief Interview for Mental Status (BIMS) score of 3 (severe cognitive deficit). She required substantial assistance with dressing, hygiene, toilet transfers and she was able to walk with partial assistance. Her diagnosis included cancer, anemia, hip fracture and Alzheimer's Disease. She was admitted to the facility on [DATE] The Care Plan revised on 7/30/24, showed Resident #1 had impaired cognitive function/dementia related to Alzheimer's disease and required 24/7 supervision. The resident was able to understand consistent, simple direct sentences. Staff were to provide Resident #1 with simple cues, to stop and return later if she was agitated, and to monitor for physical/nonverbal indicators of discomfort or distress. The resident required supervision with ambulation in hallways and common area. She had behavior symptoms including; verbal aggression, cursing, pushing and at times she was resistive with cares. According to a facility Incident Report dated 7/29/24 at 4:30 PM, Staff B, Activities Director, witnessed Staff E, Certified Nurse Aide (CNA) with her hand over the mouth of Resident #1. The Director of Nursing (DON) reviewed a video tape of the memory care area and found that Staff E had also pushed the resident down into the chair when she tried to get up, and pushed the chair up to the table to prevent the resident from standing. Staff F, CNA was sitting at the same table during these activities, but she failed to intervene or report the interactions. Staff F also restricted the resident by holding her feet on the base of the table to prevent it from moving. The resident was described as restless, anxious and confused. A review of the video from the memory care unit on 8/16/24 at 11:30 AM, revealed the following: a. At 1:32 PM, on 7/29/24, Staff E and Resident #1 were in the dining room and Resident #1 was sitting in a chair up to a round table. Staff E was standing behind the chair with her leg brace up against the back of the chair and was scrolling through her phone. A couple of minutes later, Staff E sat in a chair next to the resident and several times, the resident put her hands on the arms of the chair, pushed up, and attempted to stand. Each time, Staff E pushed down on the resident's shoulder to get her to sit down. The resident looked agitated and turned toward the staff member and said something. b. At 1:35 PM, Staff E pushed her down into the chair and the resident swung at the CNA. Staff E then grabbed the resident's wrists and hands and held them down. Staff F then entered the room with another resident and sat on the opposite side of the table from the residents. Resident #1 continued to try to stand and each time, Staff E pushed her back down into the chair. c. At 1:39 PM, once again, the resident swung at Staff E and the CNA grabbed the resident's arms and held them down against the arm rest of the chair. The two exchanged words, and at 1:40 PM, Staff E put her hand over the resident's mouth, the resident swung at her and the CNA grabbed her arms again. As they exchanged more words, Staff E took a blanket from the back of the chair and put it on the back of the resident's head. This increased her agitation and she pulled it back off. Resident #1 then tried to take her sweater off, she had it partially off of one arm when Staff E reached over and tried to force her to put it back on. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. At 1:41 PM, Resident #1 pushed her chair back from the table and the CNA responded by pushing the chair back until her torso was up to the table. Three more times, the resident tried to stand, and Staff E pushed her back down into the chair. Resident #1 put her head down on the table and looked to be crying, at 1:47 PM, Staff E looked at Staff F on the other side of the table and they snickered. Resident #1 then swung out at the CNA, and Staff E grabbed her hands and arms. Staff E then got up out of her chair and stood behind the resident's chair with her leg braced up against the back of the chair. With her hands on the table, the resident tried to push her chair back, but the table moved across the floor. Staff E lifted the resident's hand off the table, and with her body, she shoved the chair up to the table and pinned her against it. e. At 1:50 PM, the residents head was down and she looked to be crying. Staff E then picked up the resident's sweater and placed it on her head, Resident #1 got agitated and threw it off. At 1:52 PM, the resident looked to be yelling, Staff E kept her body firmly at the back of the chair and placed her hand over the resident's mouth. Resident #1 tried to push her chair back again but the table moved instead. Staff F then braced her feet at the base of the table so it wouldn't move as Staff E pushed the resident's chair up to the table again. f. At 1:53 PM, Staff E put her hand over the resident's mouth again and that was when Staff B entered the room. Staff E then backed away from the resident, allowed her to stand and walk around the room. The CNA followed the resident for a short period of time but then went and sat at the nurse's station. On 8/16/24 at 9:49 AM, Staff B said that on 7/29/24, she came down the hallway of the locked memory unit and she heard a resident screaming and yelling. She said that this was not unusual, as Resident #1 did tend to become more agitated in the afternoons. When Staff B entered the eating area, she saw Staff F, CNA sitting in a chair up at the table and Resident #1 was on the opposite side of the table. Staff E was standing behind Resident #1, with her hand over the resident's mouth. The CNA quickly took her hand off of the resident and backed away from her. Staff B said that she was concerned that Staff F was not engaged with the residents as she had a picture or something in her hand and was not paying attention. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/17/24 at 10:00 AM Staff E, CNA said that on 7/29/24, Resident #1 was having a rough day, and they had tried different interventions to calm her. She said they had been taking turns caring for her but the staff member that she was working with her was short tempered and couldn't handle Resident #1 for very long. The resident was anxious, agitated, screaming, and yelling for attention she likes attention, good or bad. Staff E said the nurse had given the resident a medication to help calm her, and that tended to affect her gait so they were watching her close because she was a fall risk. The resident didn't want to get into the recliner, and she had been known to approach other residents at times, so Staff E thought a chair at the table was the safest option. Staff F was with her at the table, and some of the chairs don't have the grippers attached on the bottom of the legs. She said that she was afraid that when the resident pushed her chair back, it could tip backwards so that was why she stood behind her to prevent her from pushing it. Staff E said that this was better than letting her stand up and risk falling. Staff E said that at one point, the resident started hitting her, and she was taught that it was okay to place the resident's hands in their laps to keep you and the resident safe. She acknowledged that she put her hand on the resident's mouth several times to shush her. She said that had worked in the past. When asked to describe what a restraint looks like, she said you can't force them to stay in bed, you can't restrict their motion unless they are a harm to you or themselves. When asked about pushing the chair up to the table and trapping the resident, she said that this was a better plan than letting the chair tip backwards. Staff E said that her training on caring for dementia residents included watch videos, and following another CNA on the floor for about a week. She said they really didn't have hands-on training or competency tests to determine if they had learned the skills. Staff E said that she should have probably tried some different repositioning when Resident #1 continued to escalate. She said that they didn't have many staff in the unit and she still felt the safest option for Resident #1 was to keep her from standing and pushed up to the table. She thought the shushing would help, but when it didn't, that's when she decided to give the resident some space and let her walk. On 8/16/24 at 12:20 PM, Staff F, CNA said that she had been suspended from work because her coworker covered a resident's mouth and she didn't have a chance to report it. The resident was yelling out, so Staff E put her hand over the resident's mouth, but she told Staff F to stop but she didn't know if she heard her because the resident was yelling so much. When asked about not allowing the resident to get up out of the chair, Staff F said acknowledged that Staff E was pushing the resident back into the chair. She said that the resident had been swinging at Staff E, but she did not see her holding down the resident's arms. When asked if she had seen anything that she would describe as a restraint, Staff F said that when the resident's chair was pinned up to the table, that was probably a restraint. She said that they have on-line training on how to handle residents with dementia and agitation. She didn't remember much about it or any of the specific techniques that were taught. Staff F acknowledged that by preventing the resident from getting up and walking around, her agitation and yelling had increased. Staff F said that she didn't have a chance to intervene or to report the incident. She wasn't sure why she didn't intervene and said she wasn't thinking clearly that day. On 8/16/24 at 12:30 PM, Resident #2 (BIMS of 15) said that there wasn't much interaction between staff and residents. She said that she'd had several roommates that were totally dependent on staff and the only time they would interact with them was to put them to bed or get them up for meals. They didn't get much stimulation. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/17/24 at 8:23 AM, a family member for Resident #1 said the resident did not like to be touched and any attempts to redirect her by putting hands on, would only escalate her. They advised the staff to just walk with her and try not to touch her. She said that at times, the staff would try to talk her into sitting down, and that did not work. She understood that Resident #1 was a fall risk, but trying to force her just made things worse. On 8/17/24 at 7:50 AM Staff H, Assistant Director of Nursing (ADON) said that she had watched the video and acknowledged that Staff E was holding the chair up against the table and she would consider that as a restraint. She said that the staff have online trainings but no direct observations or competency testing. She said they just randomly observed staff interacting with the residents, and if they saw any concerns or something that could be done differently, they would take that opportunity to do education with them. On 8/17/24 at 4:00 PM, Staff D Quality Assurance (QA) nurse, said that the staff had online trainings, but they did not have quarterly in-services for the staff that worked in the memory unit. According to the facility policy titled: Employee Training-Special Care Unit. The special care unit employee would receive quarterly scheduled in-service education to: review information learned during initial training. Keep abreast of new information regarding Alzheimer's disease and other dementias. Improve skill training regarding caring for resident with Alzheimer's disease and other dementias.