| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165580 | A. Building<br>B. Wing | 07/01/2024 |

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| Urbandale Health Care Center | 4614 NW 84th Street<br>Urbandale, IA 50322 |

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

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48886<br><br>Based on record review, resident interview, staff interview, collateral interview and policy review, the facility failed to assure each resident was treated with dignity and respect 1 of 2 residents reviewed for dignity (Resident #48). The facility reported a census of 80 residents.<br><br>Findings include:<br><br>The Admission Minimum Data Set (MDS) dated [DATE] documented Resident #48 had a Brief Interview for Mental Status score of 11, which indicated moderate cognitive impairment. The MDS further documented the resident had diagnoses to include hip and knee replacement, cancer, multiple sclerosis and glaucoma.<br><br>The Care Plan for Resident #48, with a revision date of 4/23/24, documented in the problem section the resident had a self-care deficit post-fall at home with fractured head of femur as evidenced by requiring assistance with transfers, impaired balance during transitions due to increased pain, and need for assistance with Activities of Daily Living (ADL's). In the intervention section, the resident is a one person assist for bed mobility and for dressing and undressing.<br><br>During an interview 6/25/24 at 9:16 AM, a family member stated approximately a week ago a male staff member roughly put Resident #48 into bed at night, grabbing her by the ankles. The family member stated bruising was observed on the resident's ankles last week. Resident #48 told the family member about this staff member, saying the staff person grabbed her by the ankles and said she was afraid of him and afraid he was going to beat her up. The family member advised she told the facility about the incident the resident described, and the observed injuries. The family member stated she talked to a member of the Administrative team and they told her they would look into it. The family member was told the staff member would no longer provide any care for the resident. This staff person worked the night shift. The family member advised there is a family friend who visited the resident almost daily, and the resident told this person about this incident as well and the family member asked the facility to reach out to this person for more information.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview 6/25/24 at 10:15 AM, the Administrator reported the facility did receive a call from a family member about this incident and the Social Services Director (SSD) took the call and talked to the family member. The Administrator had the SSD come into the office to talk about this incident. The SSD stated she received a call from a family member last Monday, the 17th of June. The family member reported Resident #48 had a rough weekend and wanted the SSD to call a family friend who had more information. The SSD stated the family member told her an incident happened either Friday or Saturday night (the SSD did not say at this point in the interview what the incident was). The SSD stated she called the family friend and left a voice mail message on the 17th, the family friend returned her phone call on the 18th of June. The family friend told the SSD Resident #48 was upset on the 15th when he came to visit her. The resident was upset about how an aide transferred her to bed the night before. The SSD stated she went down to the resident's room on the 18th after talking to the family friend and asked to look at the resident's feet. The SSD observed bruising on the resident's toe (cannot remember which foot) and swelling to her feet. The SSD asked the resident how she got the bruise on her toe and the resident said she dropped her cell phone on her foot. The SSD told the charge nurse about the swelling and bruising. They educated the resident on wearing proper footwear, such as tennis shoes. When asked what the family member told her specifically about what the resident said, the SSD said the family member told her the resident said she was transferred to bed roughly by an aide, she did not know the name of the aide but described him as being African American and did not speak English well. The SSD said they have several staff who fit this description. When asked if they narrowed it down by who worked that night, the SSD said yes, there was a male aide who worked that night on the unit where the resident resided who would have been the person alleged responsible. The SSD stated the family member told her that the staff member grabbed the resident by the ankles roughly. The SSD said she did not see bruising on the resident's ankles when she looked at her on the 18th of June. When asked what the resident reported to the family member and the family friend, the SSD said the resident reported the staff member transferred her roughly and she was nervous and anxious around him. When asked what the resident told the SSD when she talked to the resident, the SSD stated the resident told her the staff member moved fast with her during a transfer and she was anxious around him. When asked if the facility made a report to the Department of Inspections and Appeals and Licensing (DIAL), the Administrator stated they did not make a self report to DIAL, they did not feel it was abuse after they did an investigation. When asked if they interviewed the staff member alleged responsible, the Administrator said they did not, and he is still working at the facility. When asked if they had documentation regarding their investigation, the SSD said she did document this, however the Administrator cannot find the documentation at this moment, she will continue to look for this.<br><br>A Grievance Form with the date of grievance as 6/17/24 included the following documentation;<br><br>Summary of Grievance: Resident#48's family member and family friend reported that Saturday night the staff member transferred the resident to bed more roughly than usual, and the resident did not appreciate the staff's way of caring for her. The family member and family friend requested the facility look into the occurance.<br><br>Resolution to Greivance: The Social Worker interviewed the resident about the concerns that took place on Saturday night, and details of staff cares. Staff member was educated on caution of cares with transfering of residents.<br><br>The date of emplyee notification 6/18/24<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Investigator signature and date included the Social Workers signature on 6/18/24<br><br>Director of Nursing signature and dated was documented as 6/18/24<br><br>The signature of the Administrator was dated 6/21/24<br><br>Further documentation on the back of the form from the Director of Nursing included as follows;<br><br>The DON talked to the resident on 6/18/24 and observed her; documented resident had a bruise on toe area of her foot, resident stated she dropped her cell phone on it. Also noted the resident had faint bruises on bilateral knees and out upper calf region. Resident said these were from a fall. When asked about Saturday's interaction around a male staff, resident reported I don't know if he had somewhere to be, but he seemed to be in a hurry. When asked for further clarification on what rough meant, resident reported that her body doesn't get around or as fast as it use to and that she will frequently drop her cell phone, bump things, so when he helped get her legs into bed quickly and ran out of the room it was not very pleasant. The DON followed up with the male CNA (Certified Nursing Assistant), who reported he was with a new resident when seen her walking by herself, he assisted her to bed then saw other resident in the hall leaning forward out of a chair like he was getting ready to fall on his face, so he stated I needed to make sure she was safe. Staff educated to call for assistance explaining what you are doing and more mindful to slow down. This was the extent of what was documented on the back side of the form by the DON. Inquired from the Administrator if the male staff member had any disciplinary action, the Administrator stated there was no disciplinary action or write up. The Administrator provided the name of the male staff member, the staff member continue to be employed by the facility and continues to provide care for Resident #48.<br><br>On 06/25/24 12:28 PM the Administrator reported that the Grievance Form was the full extend of their internal investigation.<br><br>During an interview 6/25/24 at 1:35 PM, Resident #48 stated there was a staff person who was rough with her one time, she does not know why, resident said he was so rough that he left marks on me, on my ankles. Resident said the staff person, he, was going to put her to bed, he was tough and rough with me. When asked who this staff person was, the resident did not know his name, she said he was a male staff, he was African American and an average looking guy. Resident was observed to be wearing blue skid socks that went just right above her ankles. Resident pushed her socks down and stated she does not have any current bruising on her ankles, however stated she did have bruising after it happened. Resident said it happened this month, however she could not give a date. Resident was not observed to have bruising on her ankles. Resident said the staff member squeezed her ankles and her legs, stated this caused her to have injuries. When asked how this made the resident feel, the resident said this gave her anxiety.<br><br>Review of the June 2024 facility work schedule revealed Staff D, Certified Nurses Aide (CNA), the staff person allegedly responsible, worked the weekend of 6/14/24, working 6/14, 6/15 and 6/16. On 6/14, Staff D worked the 2pm to 10 pm shift on Hall A (in the 100's rooms). On 6/15 Staff D worked the 2pm to 10 pm shift on Hall C (in the 100's rooms), then the 10 pm to 6 am shift on Hall C (in the 300's rooms- where Resident #48 resides). On 6/16 Staff D worked the 10 pm to 6 am shift on Hall A (in the 100's rooms).<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 6/26/24 at 3:45 PM, the family member advised they were told by the facility that Staff D would not work on the unit with the resident anymore.<br><br>During an interview on 6/26/24 at 5:00 PM, Staff D, CNA reported he had worked at the facility for two years, he worked full time and worked on every unit in the building. Staff D stated he is not aware of any resident reporting that he had been rough with them. Staff D stated the DON talked to him recently about being in a hurry. Staff D stated he was told another resident in the 300 unit (Resident #6) reported he was in a hurry with her recently. Staff D stated the DON talked to him about this resident (Resident #6), not Resident #48. Staff D stated he was in a hurry one time recently with this other resident (Resident #6) as he thought another resident in the hallway was going to fall. He said he was helping this other resident after she used the bathroom. He did not move Resident #6's legs and was not rough with her, he was just in a hurry. Staff D reported Resident #48 is the only resident in her short hallway and she is usually in bed when he comes on for his shift at night, however he has repositioned her legs on her bed. Resident #48 did not push her call light very often. Given the lower number of residents in the 300 unit there is only one CNA on at at time, and one Registered Nurse (RN). Staff D stated he did work the weekend of the 14th of June, on Saturday (the 15th of June) he worked in the 300 unit from 10 PM to 6 AM. He said when he arrived to the unit Saturday night Resident #48 was already in bed. Staff D stated he was never talked to by anyone in Administration about Resident #48 saying he was rough with her, he stated he was only talked to about being fast with the other resident (Resident #6). Staff D advised he heard that Resident #48 had a bruise on her toe from dropping her cell phone on her toe. Staff D stated he gets along well with Resident #48 and denied ever being rough with her and stated he had never left an injury on her as far as he was aware. Staff D stated he had never been told that he cannot provide care to Resident #48, and he had provided care for her this past week, and is working on her unit today.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview 6/27/24 at 11:00 AM, a family friend advised he visited with Resident #48 at the facility almost daily. He recalled on the 16th of June (a Sunday) he was at the facility to visit with the resident, they were sitting outside having a cigarette. He checks her feet when he visits with her as he wants to check on swelling she had in her feet. While he was checking her feet he noted 2 bruises, one on each ankle, on the inside of each ankle. He said they were thumbprint size bruises. One was darker than the other one, but each bruise appeared to be surface bruising, and not deep tissue bruising. He asked the resident how she got the bruises and she said last night (Saturday night) the guy who worked was rough with her, a male staff member. She said the staff person put her feet back in bed roughly and said she was scared of him. The family friend stated Resident #48 needs help getting her feet back into bed when she sits on the edge of the bed. Resident #48 told the family friend the staff was rough with her, she kept saying how rough he was and she said she was scared of him. She told him she was scared this staff person would work again Sunday night and was scared he would be rough with her again. She did not know the staff person's name, she said he was a black man. He told her no staff should be rough with her. Resident #48 kept saying it happened last night, Saturday night. She was so worried on Sunday that this person would work again she kept talking about it and saying how scared she was. He came back to the facility Sunday night to spend the night in her room because she was so worried. He stayed until around midnight and did not see the staff person that she described working in the unit Saturday night. After talking with Resident #48, he called a family member, she said she would call the facility on Monday to talk to Administration. The family member called the facility on Monday and talked to the Social Services Director (SSD). The SSD left him a message on Monday and he was able to talk to her on Tuesday. He reported to the SSD everything that he just reported in our conversation, that he observed bruising on the resident's ankles and she stated a male staff member was rough with her and that she was scared. He stated he told the SSD that he did not want this person working with the resident again and the SSD told him that this person would not provide care to the resident again and that they would look into the concern. He stated he came to visit the resident later on Tuesday after talking to the SSD. He talked to the SSD at the facility and she told him she talked with the resident and the team observed her ankles. The SSD told him he and the family member did not have to worry, that the staff person would not provide care to the resident again. The SSD did not tell him the name of the staff person. He stated that he asked the resident 3 different ways on Sunday about what happened and she continued to stay consistent in her reporting that a staff person was rough with her, caused injuries on her ankles and that she was afraid of this staff person. She said she was scared. He advised he believed her. He stated he knows the resident has confusion at times, but she was not confused about this. He stated the bruising did not last very long, he did not take pictures of the bruising.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview 6/27/24 at 11:40 AM, the Administrator and the SSD were present. Inquired from the SSD what she was told specifically by the family friend regarding the concern with Resident #48. The SSD stated she talked to the family friend on Tuesday, the 18th of June. He told her that a CNA, a male staff, was working on the resident's unit Saturday night and she was upset about how a transfer went into bed. The SSD said the resident thought she had bruising, and the family friend said a possibility of bruising. When asked if the family friend reported to her he observed bruising on the resident's ankles, the SSD said she did not remember if he said this specifically, but he might have. The family friend did report he was concerned about what happened. The SSD stated she told the family friend that management meets every morning at 9:30 AM and that it would be brought up at the meeting and that she would talk to the Administrator and the management team. She told him she would get back in touch with him. The SSD stated she talked with the family friend again on Wednesday evening, the 19th, while he was at the facility. She told him that she talked to the management team and they did an assessment of the resident. She told him the staff person would be talked to, she did not tell him the staff person's name. They determined whom the staff person was as he was the only CNA working in that unit Saturday night. The SSD stated she never told the family member or the family friend that the staff person wouldn't have contact with the resident.<br><br>During an interview 6/27/24 at 12:45 PM, the DON stated she recalled the facility receiving a report that a male staff was rough with Resident #48 on a Saturday night and left bruising on her ankles. The DON stated she went to see the resident on June 18, 2024 (Tuesday). The incident was reported to have occurred on Saturday night, the 15th of June. The DON stated she did not observe bruising on the resident's ankles on Tuesday the 18th. She did observe a bruise on the resident's big toe and the resident said she dropped her cell phone on her toe. The DON stated she asked the resident about Saturday night, and the resident reported the staff person was in a hurry and it seemed like he had somewhere to go. The resident did not use the word rough with the DON and said she felt safe when the DON asked her. Staff D worked Saturday night on the 300 unit where the resident resides, and he was the only CNA working on the unit. The DON advised she talked to Staff D on the 18th, she told him the facility received a grievance on a resident in the 300 hallway about him being fast. She did not tell him the resident's name. The DON recalls Staff D saying oh, you're talking about Resident #48. He said he saw the resident walking on her own out of the bathroom and went to help her get into bed. He said he then saw another resident look like they were going to fall out of their wheelchair. He said he had Resident #48 on the edge of her bed and he did not think he could leave her on the edge of the bed so he hurried to get her legs on the bed. He said he felt he needed to be 1 on 1 with the other resident and said he picked up her feet quickly and put them on the bed. The DON stated she did education with Staff D about calling the charge nurse. The DON recalled talking to the Administrator after her interview with Staff D. The DON stated she felt Staff D said Resident #48, not Resident #6 who he was fast with that night. Discussed with the DON Staff D said he did not put Resident #48 into bed Saturday night and reported he was in a hurry with another resident, not Resident #48. DON said maybe he said Resident #6, but she thought he said Resident #48. Discussed with the DON Staff D stated he was never told a report had been made against him regarding Resident #48.<br><br>The facility policy titiled Promoting/Maintaining Resident Dignity witha reference copyright date of 2023 directed staff as follows;<br><br>It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident ' s quality of life by recognizing each resident ' s individuality |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42441<br><br>Based on clinical record review, policy review and staff interview, the facility failed to ensure code status between the Iowa Physician's for Scope of Treatment (IPOST) and Care Plan were congruent for 1 of 1 residents reviewed for advanced directives (Resident #64). The facility reported a census of 80 residents.<br><br>Findings include:<br><br>Review of Resident #64's physician orders revealed a Do Not Resuscitate (DNR) order effective [DATE].<br><br>Review of Resident #64's IPOST form dated [DATE] revealed a DNR status.<br><br>Review of Resident #64's Care Plan revised [DATE] revealed the resident and her responsible party requested a cardiopulmonary resuscitation (CPR)/full code status and the code status will be honored through the next review with a target date of [DATE]. The Care Plan directed staff to<br><br>provide emergency measures as appropriate including CPR.<br><br>Review of facility policy titled, Advanced Directives, revised [DATE], revealed changes or revocations of a directive may be made at any time and the care plan team will be informed of such changes and/or revocations so that appropriate changes can be made in the care plan. The policy further revealed the Director of Nursing Services (DON) or designee will notify the attending physician of advance directives so that appropriate orders can be documented in the resident ' s medical record and plan of care.<br><br>During an interview [DATE] at 2:19 PM, the Administrator revealed it would be an expectation that code status matched between the physician's orders and the Care Pan.<br><br>During an interview [DATE] at 8:30 AM, the Administrator acknowledged the code status between Resident # 64's IPOST and Care Plan did not match. The Administrator further revealed the staff usually refer to the IPOST for code status. |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48886<br><br>Based on record review, staff interview and policy review, the facility failed to notify the physician of a change in a resident's nutritional status for 1 of 2 residents reviewed for nutrition and weight loss (Resident #6). The facility reported a census of 80 residents.<br><br>Findings include:<br><br>The Admission Minimum Data Set (MDS) dated [DATE] documented Resident #6 had a Brief Interview for Mental Status (BIMS) of 9, which indicatyed moderate cognitive impairment. The MDS further documented the resident had diagnoses to include medically complex conditions, renal insufficiency, osteoporosis and depression.<br><br>The Care Plan for Resident #6, with an initiation date of 5/30/24, documented under the problem section resident is at risk for weight loss related to decreased appetite, with a goal the resident will weigh 160-170 pounds through the next review, with interventions to assess nutritional status quarterly and as needed, and to monitor weight and notify doctor of any significant change.<br><br>Review of the electronic health record for Resident #6 revealed the resident weighed 160.15 pounds on 5/15/24 at admission, and weighed 138.6 pounds on 6/20/24, a loss of 21.55 pounds in a month, a 13.43 percent weight loss.<br><br>Review of the electronic health record for Resident #6 revealed a lack of documentation of notification to the physician of the change in the resident's nutritional status and significant change in the resident's weight.<br><br>During an interview 6/26/24 at 9:35 AM, Staff B, Dietician, advised they are monitoring Resident #6's weight and acknowledged the resident had a significant weight loss since her admission in May of this year. Staff B acknowledged the physician was not notified of the significant weight loss and stated an expectation that the physician be notified of the loss. Staff B advised she is the person responsible for getting the fax ready to send to the physician and acknowledged she did not complete the fax to notify the physician of the change in the resident's nutritional status.<br><br>Review of the facility policy Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol, with a revision date of September 2017, documented the staff will report to the physician significant weight gains or losses or any abrupt or persistent change from baseline appetite or food intake. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48886<br><br>Based on record review, resident interview, staff interview, collateral interview and policy review, the facility failed to report an allegation of alleged abuse to the State survey and certification agency for 1 of 1 residents reviewed for abuse (Resident #48). The alleged abuser also continued to work with residents. The facility reported a census of 80 residents.<br><br>Findings include:<br><br>The Admission Minimum Data Set (MDS) dated [DATE] documented Resident #48 had a Brief Interview for Mental Status score of 11, indicating moderate cognitive impairment. The MDS further documented the resident had diagnoses to include hip and knee replacement, cancer, multiple sclerosis and glaucoma.<br><br>The Care Plan for Resident #48, with a revision date of 4/23/24, documented in the problem section the resident has a self-care deficit post-fall at home with fractured head of femur as evidenced by requiring assistance with transfers, impaired balance during transitions due to increased pain, and need for assistance with ADL's (Activities of Daily Living). In the intervention section, the resident is a one person assist for bed mobility and for dressing and undressing.<br><br>During an interview 6/25/24 at 9:16 AM, a family member stated approximately a week ago a male staff member roughly put Resident #48 into bed at night, grabbing her by the ankles. The family member stated bruising was observed on the resident's ankles last week. Resident #48 told the family member about this staff member, saying the staff person grabbed her by the ankles and said she was afraid of him and afraid he was going to beat her up. The family member advised she told the facility about the incident the resident described, and the observed injuries. The family member stated she talked to a member of the Administrative team and they told her they would look into it. The family member was told the staff member would no longer provide any care for the resident. This staff person worked the night shift. The family member advised there is a family friend who visited the resident almost daily, and the resident told this person about this incident as well and the family member asked the facility to reach out to this person for more information.<br><br>(continued on next page) |

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| | 165580 | A. Building<br>B. Wing | 07/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Urbandale Health Care Center | 4614 NW 84th Street<br>Urbandale, IA 50322 |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview 6/25/24 at 10:15 AM, the Administrator reported the facility did receive a call from a family member about this incident and the Social Services Director (SSD) took the call and talked to the family member. The Administrator had the SSD come into the office to talk about this incident. The SSD stated she received a call from a family member last Monday, the 17th of June. The family member reported Resident #48 had a rough weekend and wanted the SSD to call a family friend who had more information. The SSD stated the family member told her an incident happened either Friday or Saturday night (the SSD did not say at this point in the interview what the incident was). The SSD stated she called the family friend and left a voice mail message on the 17th, the family friend returned her phone call on the 18th of June. The family friend told the SSD Resident #48 was upset on the 15th when he came to visit her. The resident was upset about how an aide transferred her to bed the night before. The SSD stated she went down to the resident's room on the 18th after talking to the family friend and asked to look at the resident's feet. The SSD observed bruising on the resident's toe (cannot remember which foot) and swelling to her feet. The SSD asked the resident how she got the bruise on her toe and the resident said she dropped her cell phone on her foot. The SSD told the charge nurse about the swelling and bruising. They educated the resident on wearing proper footwear, such as tennis shoes. When asked what the family member told her specifically about what the resident said, the SSD said the family member told her the resident said she was transferred to bed roughly by an aide, she did not know the name of the aide but described him as being African American and did not speak English well. The SSD said they have several staff who fit this description. When asked if they narrowed it down by who worked that night, the SSD said yes, there was a male aide who worked that night on the unit where the resident resided who would have been the person alleged responsible. The SSD stated the family member told her that the staff member grabbed the resident by the ankles roughly. The SSD said she did not see bruising on the resident's ankles when she looked at her on the 18th of June. When asked what the resident reported to the family member and the family friend, the SSD said the resident reported the staff member transferred her roughly and she was nervous and anxious around him. When asked what the resident told the SSD when she talked to the resident, the SSD stated the resident told her the staff member moved fast with her during a transfer and she was anxious around him. When asked if the facility made a report to the Department of Inspections and Appeals and Licensing (DIAL), the Administrator stated they did not make a self-report to DIAL, they did not feel it was abuse after they did an investigation. When asked if they interviewed the staff member alleged responsible, the Administrator said they did not, and he is still working at the facility. When asked if they had documentation regarding their investigation, the SSD said she did document this, however the Administrator cannot find the documentation at this moment, she will continue to look for this.<br><br>Resolution to Grievance: The Social Worker interviewed the resident about the concerns that took place on Saturday night, and details of staff cares. Staff member was educated on caution of cares with transferring of residents.<br><br>The date of employee notification 6/18/24<br><br>Investigator signature and date included the Social Workers signature on 6/18/24<br><br>Director of Nursing signature and dated was documented as 6/18/24<br><br>The signature of the Administrator was dated 6/21/24<br><br>Further documentation on the back of the form from the Director of Nursing included as follows;<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The DON talked to the resident on 6/18/24 and observed her; documented resident had a bruise on toe area of her foot, resident stated she dropped her cell phone on it. Also noted the resident had faint bruises on bilateral knees and out upper calf region. Resident said these were from a fall. When asked about Saturday's interaction around a male staff, resident reported I don't know if he had somewhere to be, but he seemed to be in a hurry. When asked for further clarification on what rough meant, resident reported that her body doesn't get around or as fast as it used to and that she will frequently drop her cell phone, bump things, so when he helped get her legs into bed quickly and ran out of the room it was not very pleasant. The DON followed up with the male CNA (Certified Nursing Assistant), who reported he was with a new resident when seen her walking by herself, he assisted her to bed then saw other resident in the hall leaning forward out of a chair like he was getting ready to fall on his face, so he stated I needed to make sure she was safe. Staff educated to call for assistance explaining what you are doing and more mindful to slow down. This was the extent of what was documented on the back side of the form by the DON. Inquired from the Administrator if the male staff member had any disciplinary action, the Administrator stated there was no disciplinary action or write up. The Administrator provided the name of the male staff member, the staff member continued to be employed by the facility and continues to provide care for Resident #48.<br><br>During an interview on 06/25/24 at 12:28 PM when queried if the male staff member had any disciplinary action, the Administrator stated there was no disciplinary action or write up. The Administrator provided the name of the male staff member, the staff member continued to be employed by the facility and continues to provide care for Resident #48. The Administrator advised this was the full extent of their internal investigation.<br><br>During an interview 6/25/24 at 1:35 PM, Resident #48 stated there was a staff person who was rough with her one time, she does not know why, resident said he was so rough that he left marks on me, on my ankles. Resident said the staff person, he, was going to put her to bed, he was tough and rough with me. When asked who this staff person was, the resident did not know his name, she said he was a male staff, he was African American and an average looking guy. Resident was observed to be wearing blue skid socks that went just right above her ankles. Resident pushed her socks down and stated she does not have any current bruising on her ankles, however stated she did have bruising after it happened. Resident said it happened this month, however she could not give a date. Resident was not observed to have bruising on her ankles. Resident said the staff member squeezed her ankles and her legs, stated this caused her to have injuries. When asked how this made the resident feel, the resident said this gave her anxiety.<br><br>Review of the June 2024 facility work schedule revealed Staff D, Certified Nurses Aide (CNA), the staff person allegedly responsible, worked the weekend of 6/14/24, working 6/14, 6/15 and 6/16. On 6/14, Staff D worked the 2 pm to 10 pm shift on Hall A (in the 100's rooms). On 6/15 Staff D worked the 2 pm to 10 pm shift on Hall C (in the 100's rooms), then the 10 pm to 6 am shift on Hall C (in the 300's rooms- where Resident #48 resides). On 6/16 Staff D worked the 10 pm to 6 am shift on Hall A (in the 100's rooms).<br><br>During an interview 6/26/24 at 3:45 PM, the family member advised they were told by the facility that Staff D would not work on the unit with the resident anymore.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview 6/26/24 at 5:00 PM, Staff D was in work status and working on the 300 unit, where Resident #48 resides. Staff D stated he has worked at the facility for two years, he works full time and works on every unit in the building. Staff D stated he has worked on the 300 unit where Resident #48 resides and has provided care to the resident. Staff D stated he is not aware of any resident reporting that he has been rough with them. Staff D stated the DON talked to him recently about being in a hurry. Staff D stated he was told another resident in the 300 unit (Resident #6) reported he was in a hurry with her recently. Staff D stated the DON talked to him about this resident (Resident #6), not Resident #48. Staff D stated he was in a hurry one time recently with this other resident (Resident #6) as he thought another resident in the hallway was going to fall. He said he was helping this other resident after she used the bathroom. He did not move Resident #6's legs and was not rough with her, he was just in a hurry. Staff D advised Resident #48 is the only resident in her short hallway and she is usually in bed when he comes on for his shift at night, however he does and has repositioned her legs on her bed. Resident #48 does not push her call light very often. Given the lower number of residents in the 300 unit there is only one CNA on at that time, and one Registered Nurse (RN). Staff D stated he did work the weekend of the 14th of June, on Saturday (the 15th of June) he worked in the 300 unit from 10 PM to 6 AM. He said when he arrived to the unit Saturday night Resident #48 was already in bed. Staff D stated he was never talked to by anyone in Administration about Resident #48 saying he was rough with her, he stated he was only talked to about being fast with the other resident (Resident #6). Staff D advised he heard that Resident #48 had a bruise on her toe from dropping her cell phone on her toe. Staff D stated he gets along well with Resident #48 and denied ever being rough with her and stated he has never left an injury on her as far as he is aware. Staff D stated he has never been told that he cannot provide care to Resident #48 and he has provided care for her this past week, and is working on her unit today.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview 6/27/24 at 11:00 AM, a family friend advised he visits with Resident #48 at the facility almost daily. He recalled on the 16th of June (a Sunday) he was at the facility to visit with the resident, they were sitting outside having a cigarette. He checks her feet when he visits with her as he wants to check on swelling she has in her feet. While he was checking her feet he noted 2 bruises, one on each ankle, on the inside of each ankle. He said they were thumbprint size bruises. One was darker than the other one, but each bruise appeared to be surface bruising and not deep tissue bruising. He asked the resident how she got the bruises and she said last night (Saturday night) the guy who worked was rough with her, a male staff member. She said the staff person put her feet back in bed roughly and said she was scared of him. The family friend stated Resident #48 needs help getting her feet back into bed when she sits on the edge of the bed. Resident #48 told the family friend the staff was rough with her, she kept saying how rough he was and she said she was scared of him. She told him she was scared this staff person would work again Sunday night and was scared he would be rough with her again. She did not know the staff person's name, she said he was a black man. He told her no staff should be rough with her. Resident #48 kept saying it happened last night, Saturday night. She was so worried on Sunday that this person would work again she kept talking about it and saying how scared she was. He came back to the facility Sunday night to spend the night in her room because she was so worried. He stayed until around midnight and did not see the staff person that she described working in the unit Saturday night. After talking with Resident #48, he called a family member, she said she would call the facility on Monday to talk to Administration. The family member called the facility on Monday and talked to the Social Services Director (SSD). The SSD left him a message on Monday and he was able to talk to her on Tuesday. He reported to the SSD everything that he just reported in our conversation, that he observed bruising on the resident's ankles and she stated a male staff member was rough with her and that she was scared. He stated he told the SSD that he did not want this person working with the resident again and the SSD told him that this person would not provide care to the resident again and that they would look into the concern. He stated he came to visit the resident later on Tuesday after talking to the SSD. He talked to the SSD at the facility and she told him she talked with the resident and the team observed her ankles. The SSD told him he and the family member did not have to worry, that the staff person would not provide care to the resident again. The SSD did not tell him the name of the staff person. He stated that he asked the resident 3 different ways on Sunday about what happened and she continued to stay consistent in her reporting that a staff person was rough with her, caused injuries on her ankles and that she was afraid of this staff person. She said she was scared. He advised he believed her. He stated he knows the resident has confusion at times, but she was not confused about this. He stated the bruising did not last very long, he did not take pictures of the bruising.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview 6/27/24 at 11:40 AM, the Administrator and the SSD were present. Inquired from the SSD what she was told specifically by the family friend regarding the concern with Resident #48. The SSD stated she talked to the family friend on Tuesday, the 18th of June. He told her that a CNA, a male staff, was working on the resident's unit Saturday night and she was upset about how a transfer went into bed. The SSD said the resident thought she had bruising, and the family friend said a possibility of bruising. When asked if the family friend reported to her he observed bruising on the resident's ankles, the SSD said she did not remember if he said this specifically, but he might have. The family friend did report he was concerned about what happened. The SSD stated she told the family friend that management meets every morning at 9:30 AM and that it would be brought up at the meeting and that she would talk to the Administrator and the management team. She told him she would get back in touch with him. The SSD stated she talked with the family friend again on Wednesday evening, the 19th, while he was at the facility. She told him that she talked to the management team and they did an assessment of the resident. She told him the staff person would be talked to, she did not tell him the staff person's name. They determined whom the staff person was as he was the only CNA working in that unit Saturday night. The SSD stated she never told the family member or the family friend that the staff person wouldn't have contact with the resident.<br><br>Inquired from the Administrator if the team came back together after Tuesday, the 18th of June, to discuss this concern further and the Administrator stated they did not staff it again.<br><br>During an interview 6/27/24 at 12:45 PM, the DON stated she recalls the facility receiving a report that a male staff was rough with Resident #48 on a Saturday night and left bruising on her ankles. The DON stated she went to see the resident on Tuesday, the 18th. The incident was reported to have occurred on Saturday night, the 15th of June. The DON stated she did not observe bruising on the resident's ankles on Tuesday the 18th. She did observe a bruise on the resident's big toe and the resident said she dropped her cell phone on her toe. The DON stated she asked the resident about Saturday night and she said the staff person was in a hurry and it seemed like he had somewhere to go. The resident did not use the word rough with the DON and said she felt safe when the DON asked her. Staff D worked Saturday night on the 300 unit where the resident resides. He was the only CNA working on the unit. The DON advised she talked to Staff D on the 18th, she told him the facility received a grievance on a resident in the 300 hallway about him being fast. She did not tell him the resident's name. The DON recalls Staff D saying oh, you're talking about Resident #48. He said he saw the resident walking on her own out of the bathroom and went to help her get into bed. He said he then saw another resident look like they were going to fall out of their wheelchair. He said he had Resident #48 on the edge of her bed and he did not think he could leave her on the edge of the bed so he hurried to get her legs on the bed. He said he felt he needed to be 1 on 1 with the other resident and said he picked up her feet quickly and put them on the bed. The DON stated she did education with Staff D about calling the charge nurse. The DON recalls talking to the Administrator after her interview with Staff D. The DON stated she felt Staff D said Resident #48, not Resident #6 who he was fast with that night. Discussed with the DON Staff D said he did not put Resident #48 into bed Saturday night and reported he was in a hurry with another resident, not Resident #48. DON said maybe he said Resident #6, but she thought he said Resident #48. Discussed with the DON Staff D stated he was never told a report had been made against him regarding Resident #48.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of facility policy and procedure Abuse and Neglect prevention, with a revision date of August 2016 documents under the investigation section the Administrator and/or designee are responsible for initiation of the investigation immediately upon notification of alleged events or findings. The facility will document investigation findings, including witness statements, corrective actions and conclusions in administrative file. Should an incident or suspected incident of resident abuse, mistreatment or neglect, or injury of unknown source be reported, the Administrator will appoint a member of management to investigate the alleged incident. The Administrator will file an initial report to the State agency and others as required by state and local laws. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48886<br><br>Based on record review, resident interview, staff interview, collateral interview and policy review, the facility failed to initiate and complete a thorough investigation of alleged abuse for 1 of 1 residents reviewed for abuse (Resident #48). The facility reported a census of 80 residents.<br><br>Findings include:<br><br>The Admission Minimum Data Set (MDS) dated [DATE] documented Resident #48 had a Brief Interview for Mental Status score of 11, indicating moderate cognitive impairment. The MDS further documented the resident had diagnoses to include hip and knee replacement, cancer, multiple sclerosis and glaucoma.<br><br>The Care Plan for Resident #48, with a revision date of 4/23/24, documented in the problem section the resident has a self-care deficit post-fall at home with fractured head of femur as evidenced by requiring assistance with transfers, impaired balance during transitions due to increased pain, and need for assistance with ADL's (Activities of Daily Living). In the intervention section, the resident is a one person assist for bed mobility and for dressing and undressing.<br><br>During an interview 6/25/24 at 9:16 AM, a family member stated approximately a week ago a male staff member roughly put Resident #48 into bed at night, grabbing her by the ankles. The family member stated bruising was observed on the resident's ankles last week. Resident #48 told the family member about this staff member, saying the staff person grabbed her by the ankles and said she was afraid of him and afraid he was going to beat her up. The family member advised she told the facility about this, about what the resident told her happened and the observed injuries. The family member stated she talked to a member of the Administrative team and they told her they would look into it. The family member was told the staff member would no longer provide any care for the resident. This staff person worked the night shift. The family member advised there is a family friend who visited the resident almost daily and the resident told this person about this incident as well and the family member asked the facility to reach out to this person for more information.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview 6/25/24 at 10:15 AM, the Administrator advised the facility did receive a call from a family member about this incident and the Social Services Director (SSD) took the call and talked to the family member. The Administrator had the SSD come into the office to talk about this incident. The SSD stated she received a call from a family member last Monday, the 17th of June. The family member reported Resident #48 had a rough weekend and wanted the SSD to call a family friend who would have more information. The SSD stated the family member told her an incident happened either Friday or Saturday night (the SSD did not say at this point in the interview what the incident was). The SSD stated she called the family friend and left a voice mail message on the 17th, the family friend returned her phone call on the 18th of June. The family friend told the SSD Resident #48 was upset on the 15th when he came to visit her. She was upset about how an aide transferred her to bed the night before. The SSD stated she went down to the resident's room on the 18th after talking to the family friend and asked to look at the resident's feet. The SSD observed bruising on the resident's toe (cannot remember which foot) and swelling to her feet. The SSD asked the resident how she got the bruise on her toe and the resident said she dropped her cell phone on her foot. The SSD told the charge nurse about the swelling and bruising. They educated the resident on wearing proper footwear, such as tennis shoes. When asked what the family member told her specifically about what the resident said, the SSD said the family member told her the resident said she was transferred to bed roughly by an aide, she did not know the name of the aide but described him as being African American and did not speak English well. The SSD said they have several staff who fit this description. When asked if they narrowed it down by who worked that night, the SSD said yes, there was a male aide who worked that night on the unit where the resident resides who would have been the person alleged responsible. The SSD stated the family member told her that the staff member grabbed the resident by the ankles roughly. The SSD said she did not see bruising on the resident's ankles when she looked at her on the 18th of June. When asked what the resident reported to the family member and the family friend, the SSD said the resident reported the staff member transferred her roughly and she was nervous and anxious around him. When asked what the resident told the SSD when she talked to the resident, the SSD stated the resident told her the staff member moved fast with her during a transfer and she was anxious around him. When asked if the facility made a report to the Department of Inspections and Appeals and Licensing (DIAL), the Administrator stated they did not make a self report to DIAL, they did not feel it was abuse after they did an investigation. When asked if they interviewed the staff member alleged responsible, the Administrator said they did not, and he is still working at the facility. When asked if they had documentation regarding their investigation, the SSD said she did document this, however the Administrator cannot find the documentation at this moment, she will continue to look for this.<br><br>A Grievance Form with the date of grievance as 6/17/24 included the following documentation;<br><br>Summary of Grievance: Resident#48's family member and family friend reported that Saturday night the staff member transferred the resident to bed more roughly than usual, and the resident did not appreciate the staff's way of caring for her. The family member and family friend requested the facility look into the occurrence.<br><br>Resolution to Grievance: The Social Worker interviewed the resident about the concerns that took place on Saturday night, and details of staff cares. Staff member was educated on caution of cares with transferring of residents.<br><br>The date of employee notification 6/18/24<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Investigator signature and date included the Social Workers signature on 6/18/24<br><br>Director of Nursing signature and dated was documented as 6/18/24<br><br>The signature of the Administrator was dated 6/21/24<br><br>Further documentation on the back of the form from the Director of Nursing included as follows;<br><br>The DON talked to the resident on 6/18/24 and observed her; documented resident had a bruise on toe area of her foot, resident stated she dropped her cell phone on it. Also noted the resident had faint bruises on bilateral knees and out upper calf region. Resident said these were from a fall. When asked about Saturday's interaction around a male staff, resident reported I don't know if he had somewhere to be, but he seemed to be in a hurry. When asked for further clarification on what rough meant, resident reported that her body doesn't get around or as fast as it used to and that she will frequently drop her cell phone, bump things, so when he helped get her legs into bed quickly and ran out of the room it was not very pleasant. The DON followed up with the male CNA (Certified Nursing Assistant), who reported he was with a new resident when seen her walking by herself, he assisted her to bed then saw other resident in the hall leaning forward out of a chair like he was getting ready to fall on his face, so he stated I needed to make sure she was safe. Staff educated to call for assistance explaining what you are doing and more mindful to slow down. This was the extent of what was documented on the back side of the form by the DON. Inquired from the Administrator if the male staff member had any disciplinary action, the Administrator stated there was no disciplinary action or write up. The Administrator provided the name of the male staff member, the staff member continued to be employed by the facility and continues to provide care for Resident #48.<br><br>On 06/25/24 12:28 PM the Administrator reported that the Grievance Form was the full extend of their internal investigation.<br><br>During an interview on 06/25/24 at 12:28 PM when queried if the male staff member had any disciplinary action, the Administrator stated there was no disciplinary action or write up. The Administrator provided the name of the male staff member, the staff member continue to be employed by the facility and continues to provide care for Resident #48. The Administrator advised this was the full extent of their internal investigation.<br><br>During an interview 6/25/24 at 1:35 PM, Resident #48 stated there was a staff person who was rough with her one time, she does not know why, resident said he was so rough that he left marks on me, on my ankles. Resident said the staff person, he, was going to put her to bed, he was tough and rough with me. When asked who this staff person was, the resident did not know his name, she said he was a male staff, he was African American and an average looking guy. Resident was observed to be wearing blue skid socks that went just right above her ankles. Resident pushed her socks down and stated she does not have any current bruising on her ankles, however stated she did have bruising after it happened. Resident said it happened this month, however she could not give a date. Resident was not observed to have bruising on her ankles. Resident said the staff member squeezed her ankles and her legs, stated this caused her to have injuries. When asked how this made the resident feel, the resident said this gave her anxiety.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the June 2024 facility work schedule revealed Staff D, Certified Nurses Aide (CNA), the staff person allegedly responsible, worked the weekend of 6/14/24, working 6/14, 6/15 and 6/16. On 6/14, Staff D worked the 2pm to 10 pm shift on Hall A (in the 100's rooms). On 6/15 Staff D worked the 2pm to 10 pm shift on Hall C (in the 100's rooms), then the 10 pm to 6 am shift on Hall C (in the 300's rooms- where Resident #48 resides). On 6/16 Staff D worked the 10 pm to 6 am shift on Hall A (in the 100's rooms).<br><br>During an interview 6/26/24 at 3:45 PM, the family member advised they were told by the facility that Staff D would not work on the unit with the resident anymore.<br><br>During an interview 6/26/24 at 5:00 PM, Staff D was in work status and working on the 300 unit, where Resident #48 resides. Staff D stated he has worked at the facility for two years, he works full time and works on every unit in the building. Staff D stated he has worked on the 300 unit where Resident #48 resides and has provided care to the resident. Staff D stated he is not aware of any resident reporting that he has been rough with them. Staff D stated the DON talked to him recently about being in a hurry. Staff D stated he was told another resident in the 300 unit (Resident #6) reported he was in a hurry with her recently. Staff D stated the DON talked to him about this resident (Resident #6), not Resident #48. Staff D stated he was in a hurry one time recently with this other resident (Resident #6) as he thought another resident in the hallway was going to fall. He said he was helping this other resident after she used the bathroom. He did not move Resident #6's legs and was not rough with her, he was just in a hurry. Staff D advised Resident #48 is the only resident in her short hallway and she is usually in bed when he comes on for his shift at night, however he does and has repositioned her legs on her bed. Resident #48 does not push her call light very often. Given the lower number of residents in the 300 unit there is only one CNA on at at time, and one Registered Nurse (RN). Staff D stated he did work the weekend of the 14th of June, on Saturday (the 15th of June) he worked in the 300 unit from 10 PM to 6 AM. He said when he arrived to the unit Saturday night Resident #48 was already in bed. Staff D stated he was never talked to by anyone in Administration about Resident #48 saying he was rough with her, he stated he was only talked to about being fast with the other resident (Resident #6). Staff D advised he heard that Resident #48 had a bruise on her toe from dropping her cell phone on her toe. Staff D stated he gets along well with Resident #48 and denied ever being rough with her and stated he has never left an injury on her as far as he is aware. Staff D stated he has never been told that he cannot provide care to Resident #48 and he has provided care for her this past week, and is working on her unit today.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview 6/27/24 at 11:00 AM, a family friend advised he visits with Resident #48 at the facility almost daily. He recalled on the 16th of June (a Sunday) he was at the facility to visit with the resident, they were sitting outside having a cigarette. He checks her feet when he visits with her as he wants to check on swelling she has in her feet. While he was checking her feet he noted 2 bruises, one on each ankle, on the inside of each ankle. He said they were thumbprint size bruises. One was darker than the other one, but each bruise appeared to be surface bruising and not deep tissue bruising. He asked the resident how she got the bruises and she said last night (Saturday night) the guy who worked was rough with her, a male staff member. She said the staff person put her feet back in bed roughly and said she was scared of him. The family friend stated Resident #48 needs help getting her feet back into bed when she sits on the edge of the bed. Resident #48 told the family friend the staff was rough with her, she kept saying how rough he was and she said she was scared of him. She told him she was scared this staff person would work again Sunday night and was scared he would be rough with her again. She did not know the staff person's name, she said he was a black man. He told her no staff should be rough with her. Resident #48 kept saying it happened last night, Saturday night. She was so worried on Sunday that this person would work again she kept talking about it and saying how scared she was. He came back to the facility Sunday night to spend the night in her room because she was so worried. He stayed until around midnight and did not see the staff person that she described working in the unit Saturday night. After talking with Resident #48, he called a family member, she said she would call the facility on Monday to talk to Administration. The family member called the facility on Monday and talked to the Social Services Director (SSD). The SSD left him a message on Monday and he was able to talk to her on Tuesday. He reported to the SSD everything that he just reported in our conversation, that he observed bruising on the resident's ankles and she stated a male staff member was rough with her and that she was scared. He stated he told the SSD that he did not want this person working with the resident again and the SSD told him that this person would not provide care to the resident again and that they would look into the concern. He stated he came to visit the resident later on Tuesday after talking to the SSD. He talked to the SSD at the facility and she told him she talked with the resident and the team observed her ankles. The SSD told him he and the family member did not have to worry, that the staff person would not provide care to the resident again. The SSD did not tell him the name of the staff person. He stated that he asked the resident 3 different ways on Sunday about what happened and she continued to stay consistent in her reporting that a staff person was rough with her, caused injuries on her ankles and that she was afraid of this staff person. She said she was scared. He advised he believed her. He stated he knows the resident has confusion at times, but she was not confused about this. He stated the bruising did not last very long, he did not take pictures of the bruising.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview 6/27/24 at 11:40 AM, the Administrator and the SSD were present. Inquired from the SSD what she was told specifically by the family friend regarding the concern with Resident #48. The SSD stated she talked to the family friend on Tuesday, the 18th of June. He told her that a CNA, a male staff, was working on the resident's unit Saturday night and she was upset about how a transfer went into bed. The SSD said the resident thought she had bruising, and the family friend said a possibility of bruising. When asked if the family friend reported to her he observed bruising on the resident's ankles, the SSD said she did not remember if he said this specifically, but he might have. The family friend did report he was concerned about what happened. The SSD stated she told the family friend that management meets every morning at 9:30 AM and that it would be brought up at the meeting and that she would talk to the Administrator and the management team. She told him she would get back in touch with him. The SSD stated she talked with the family friend again on Wednesday evening, the 19th, while he was at the facility. She told him that she talked to the management team and they did an assessment of the resident. She told him the staff person would be talked to, she did not tell him the staff person's name. They determined whom the staff person was as he was the only CNA working in that unit Saturday night. The SSD stated she never told the family member or the family friend that the staff person wouldn't have contact with the resident.<br><br>Inquired from the Administrator if the team came back together after Tuesday, the 18th of June, to discuss this concern further and the Administrator stated they did not staff it again.<br><br>During an interview 6/27/24 at 12:45 PM, the DON stated she recalls the facility receiving a report that a male staff was rough with Resident #48 on a Saturday night and left bruising on her ankles. The DON stated she went to see the resident on Tuesday, the 18th. The incident was reported to have occurred on Saturday night, the 15th of June. The DON stated she did not observe bruising on the resident's ankles on Tuesday the 18th. She did observe a bruise on the resident's big toe and the resident said she dropped her cell phone on her toe. The DON stated she asked the resident about Saturday night and she said the staff person was in a hurry and it seemed like he had somewhere to go. The resident did not use the word rough with the DON and said she felt safe when the DON asked her. Staff D worked Saturday night on the 300 unit where the resident resides. He was the only CNA working on the unit. The DON advised she talked to Staff D on the 18th, she told him the facility received a grievance on a resident in the 300 hallway about him being fast. She did not tell him the resident's name. The DON recalls Staff D saying oh, you're talking about Resident #48. He said he saw the resident walking on her own out of the bathroom and went to help her get into bed. He said he then saw another resident look like they were going to fall out of their wheelchair. He said he had Resident #48 on the edge of her bed and he did not think he could leave her on the edge of the bed so he hurried to get her legs on the bed. He said he felt he needed to be 1 on 1 with the other resident and said he picked up her feet quickly and put them on the bed. The DON stated she did education with Staff D about calling the charge nurse. The DON recalls talking to the Administrator after her interview with Staff D. The DON stated she felt Staff D said Resident #48, not Resident #6 who he was fast with that night. Discussed with the DON Staff D said he did not put Resident #48 into bed Saturday night and reported he was in a hurry with another resident, not Resident #48. DON said maybe he said Resident #6, but she thought he said Resident #48. Discussed with the DON Staff D stated he was never told a report had been made against him regarding Resident #48.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of facility policy and procedure Abuse and Neglect prevention, with a revision date of August 2016 documents under the investigation section the Administrator and/or designee are responsible for initiation of the investigation immediately upon notification of alleged events or findings. The facility will document investigation findings, including witness statements, corrective actions and conclusions in administrative file. Should an incident or suspected incident of resident abuse, mistreatment or neglect, or injury of unknown source be reported, the Administrator will appoint a member of management to investigate the alleged incident. The Administrator will file an initial report to the State agency and others as required by state and local laws. |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48886<br><br>Based on record review, staff interview, and policy review the facility failed to notify the Long Term Care Ombudsman of discharge/transfer of residents as required for 1 of 3 residents reviewed who were discharged /transferred from the facility (Resident #26). The facility reported a census of 80 residents.<br><br>Findings include:<br><br>Review of the MDS (Minimum Data Set) assessment dated [DATE] and the facility's computer software program used for electronic medical record documentation revealed Resident #26 had discharged from the facility on 12/25/23, and hospitalized until reentered the facility on 12/29/23.<br><br>The clinical record lacked documentation of notification to the LTC Ombudsman that Resident #26 had discharged to the hospital as required by federal regulation.<br><br>During an interview 06/27/24 at 08:34 AM the Administrator stated the facility had not notified the Ombudsman when the resident discharged to the hospital.<br><br>Review of the facility policy Transfer and Discharge, with a copyright date of 2023, documented notice must be provided to the LTC ombudsman as soon as practicable before the transfer or discharge and the facility will maintain evidence that the notice was sent to the Ombudsman. |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44972<br><br>Based on clinical record review and staff interview, the facility failed to refer a resident (Resident #78) with a Level I Preadmission Screening and Resident Review (PASARR) with a diagnosed serious mental disorder for evaluation of a Level II PASARR at the time the diagnosis was known to the facility for 1 of 1 residents reviewed for PASARR. The facility reported a census of 80.<br><br>Findings include:<br><br>The Minimum Data Set (MDS) for Resident #78 dated 3/28/24 documented a Brief Interview for Mental Status (BIMS) of 6, indicating severe cognitive impairment. The MDS further documented diagnoses of acute diastolic heart failure, stage 3 chronic kidney disease, protein-calorie malnutrition, dementia, major depressive disorder and post-traumatic stress disorder (PTSD). The MDS reflected the resident was taking an antidepressant medication.<br><br>The care plan dated 10/6/23 for Resident #78 documented a focus area related to resident being at risk for emotional and/or physical distress related to Post Traumatic Stress Disorder (PTSD) due to she and her family having to leave Bosnia in the early 1990's because of war and were refugees in [NAME] before moving the United States. Resident was taking an antidepressant medication to aide in treatment of his PTSD.<br><br>The Level I PASARR for Resident #78 was completed 10/6/23 prior to admission to the facility, this was the last PASARR screening completed for Resident #78. The Level I PASARR documented no Level II PASARR was required as the resident had no serious mental impairment, intellectual disability or other related conditions. The Level I PASARR documented the resident to have a diagnosis of depression/depressive disorder and further documented the Resident #78 received sertraline 50 milligrams (mg) for depression. In addition, this screening documented no further PASARR screening was required unless there was a significant change.<br><br>Review of the electronic health records for Resident #78 under medical diagnoses reflected the resident carried a diagnosis of PTSD that she had upon admission to the facility but the facility failed to submit a Level II PASARR with the diagnosis.<br><br>Review of Medication Administration Record (MAR) for Resident #78 documented the resident received the psychotropic medication sertraline HCL oral tablet 25 mg give 1.5 tablets (37.5 mg) one time a day for major depressive disorder with a start date of 4/26/24.<br><br>In an interview on 6/27/24 at 8:32 AM, the Administrator stated the facility did not have a policy relating to PASARR's but the facility followed the guidelines for PASARR completion.<br><br>In an interview on 6/27/24 at 1:56 PM the Administrator stated the facility has a part time social worker that is responsible for the PASARR process and ensuring they are completed. She stated it was the expectation this social worker completed all PASARR's and ensures they are submitted accurately and timely. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48886<br><br>Based on record review, resident interview, staff interview and policy review, the facility failed to develop and implement a comprehensive person-centered care plan for a resident with a urostomy and urostomy bag (a surgical procedure that creates an opening in the abdomen to redirect urine away from the bladder and into a bag outside the body for collection) for 1 of 3 residents reviewed for urinary catheter (Resident #17). The facility reported a census of 80 residents.<br><br>Findings include:<br><br>The Admission Minimum Data Set (MDS) dated [DATE] documented Resident #17 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident is cognitively intact. The MDS further documented the resident had diagnoses to include other neurological conditions, neurogenic bladder and paraplegia. The MDS documented that the resident had ostomy under the bladder and bowel section.<br><br>The Care Plan for Resident #17, with a revision date of 6/5/24, documented under the problem section the resident is at risk for medical complications due to urostomy related to diagnosis of neuromuscular dysfunction of bladder. The Care Plan directed staff as follows;<br><br>a. to allow resident time to vent feelings and frustrations regarding urostomy<br><br>b. nursing to observe urostomy for signs of infection, decreased output and report if noted, observe for abdominal distention, decreased output, diarrhea, nausea and/or vomiting, abdominal pain and report to physician if indicted and promote adequate nutrition/hydration.<br><br>The Care Plan further documented in the problem section the resident had a self-care deficit as evidenced by requiring assistance with ADLs (Activities of Daily Living), impaired balance during transitions requiring assistance and /or walking and incontinence. The Care Plan documented in the intervention section under the toileting ADL, resident does not use a toilet, bed pan or bed side commode, please assist with checking and changing brief and provide peri-care with every incontinent episode and as necessary as resident allows.<br><br>The residents Care Plan did not provide instruction on care of the urostomy bag or monitoring/documenting intake and output.<br><br>During an interview 6/24/24 at 11:29 AM, Resident #17 stated she had what she referred to as a catheter bag, stated staff do not come to empty the bag very often and the bag gets really full. Resident #17 stated staff might empty it once a day, but only when it is really full.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview 7/01/24 at 9:17 AM, the Director of Nursing (DON) advised the resident admitted to the facility with a urostomy tube. The drainage bag should be emptied at least once a shift, and more if it is noted that the bag is full. Staff should check the bag when they enter the resident's room. The bag should be emptied at least 3 times a day and the output documented. The DON stated it is standard of care to empty the bag every shift, 3 times a day, if not more. The DON acknowledged the Care Plan did not contain instruction on the care of the urostomy bag, or instruction on changing the bag and documenting intake and output.<br><br>During an interview 7/01/24 at 10:33 AM, the DON advised the urostomy bag for Resident #17 holds 2000 cc's (cubic centimeters) of fluid. The DON stated they are transitioning over to charting in their electronic health care system for the tasks and will no longer do charting on paper. The DON provided paper charting for catheter care for Resident #17 for emptying the bag and documenting the amount. The paper charting started on 5/23/24 (day of admission for the resident) and ended on 6/16/24, when they transitioned to electronic charting.<br><br>Review of the paper charting for Resident #17 for the task of emptying the urostomy bag and documenting the amount revealed the bag was emptied 2-3 times per day (most days 3 times) with amounts ranging from 490 cc's up to 1,980 cc's.<br><br>Review of the electronic health record for Resident #17 for the task of emptying the catheter bag (urostomy bag) and documenting the amount revealed on the 17th of June, there is only entry, there are no entries on the 18th of June, there is only one entry on the 19th of June, there are no entries on the 20th, 21st, or 22nd of June. There is one entry on the 23rd and one entry on the 24th of June. On the 25th of June there are two entries, for the second entry at 23:08, the output was documented to be 2000 cc's. There is one entry on the 27th, no entries on the 28th, one entry on the 29th and one entry on the 30th of June.<br><br>During an interview 7/1/24 at 10:45 AM, the DON stated an expectation for the documentation to be completed by staff for the emptying of the bag and the output. The output should be monitored. The DON believed staff were completing this task, however were not documenting or monitoring the task. The DON further advised the Care Plan should comprehensively address the urostomy and urostomy bag and be implemented fully by staff.<br><br>Review of facility policy Care Plans, Comprehensive Person-Centered, with a revision date of September 2022, documented the Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal<br><br>representative, develops and implements a comprehensive, person-centered care plan for each resident. The comprehensive, person-centered care plan will include measurable objectives and timeframes. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44972<br><br>Based on observation, record review, resident, family, and staff interview and policy review, the facility failed to provide services that met professional standards regarding following physician orders related to flushing catheters, proper medication administration with insulin pens and allowing a resident to self-administer a cream without a physician order for 4 of 18 residents observed. (Resident #21, #40, and #61). The facility reported a census of 80 residents.<br><br>Findings include:<br><br>1. The Quarterly Minimum Data Set (MDS) assessment for Resident #21 dated 5/28/24 included diagnoses of multiple sclerosis, anxiety disorder, chronic cystitis, peripheral vascular disease, major depressive disorder and chronic pain. The MDS identified a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented the resident was dependent on staff for all activities of daily living and had a catheter.<br><br>The Care Plan dated 10/12/16 with a revision date of 1/18/24 revealed a focus area for indwelling suprapubic catheter and interventions including: catheter care every shift, change suprapubic catheter every 4 weeks, cleanse catheter site with wound cleanser, empty catheter bag every shift and as needed and irrigate catheter daily per orders.<br><br>The Treatment Administration Record (TAR) for April, May and June 2024 revealed an order dated 2/17/24 to flush catheter with 60 milliliters (ML) of acetic acid daily and as needed.<br><br>Review of the TAR for April 2024 revealed the daily catheter flush was not completed on 4/1/24.<br><br>Review of the TAR for May 2024 revealed the daily catheter flush was not completed on 5/5/24, 5/19/24, and 5/26/24.<br><br>Review of the TAR for June 2024 revealed the daily catheter flush was not completed on 6/1/24, 6/2/24, 6/6/24, 6/14/24, 6/18/24, 6/19/24 and 6/24/24.<br><br>On 6/27/24 at 1:23 PM, the Director of Nursing (DON) reported it was the expectation catheter irrigation be completed as ordered. If the resident refused it should be documented and the appropriate people notified. The resident should receive education on the risks of refusing the flush and the staff were to monitor the resident's output.<br><br>The facility provided Policy titled Catheter Care dated 12/1/23 which directed the facility staff to ensure residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use.<br><br>2. The Quarterly MDS assessment for Resident #40 dated 6/13/24 included diagnoses of diabetes mellitus, stroke, high blood pressure, and depression. The MDS identified a BIMS of 15 indicating intact cognition. The MDS documented the resident required substantial assistance with showering and toileting, total assistance with transfers and set up assistance with eating and personal hygiene. The MDS documented the resident received insulin injections.<br><br>(continued on next page) |

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| | 165580 | A. Building<br>B. Wing | 07/01/2024 |

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| Urbandale Health Care Center | 4614 NW 84th Street<br>Urbandale, IA 50322 |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Care Plan with a revision date of 12/12/23 revealed a focus area related to Resident #40's diagnosis of diabetes mellitus with frequent infections, visual impairment, renal implications and interventions that included administering medications as ordered by the physician and blood sugar checks as ordered by the physician.<br><br>An observation on 6/26/24 at 8:15 AM revealed Staff A, Registered Nurse (RN), administered Resident #50's scheduled insulin. Staff A, RN obtained resident's Lantus flex pen and Humalog flex pen from the medication cart and put the needles on both pens. The resident was to receive 45 units of Humalog. She dialed the pen to 45 units and did not prime the pen prior to administering. She administered the insulin into the resident's left lower quadrant of her abdomen and left the needle under the skin for a count of ten before removing. The resident was also to receive 66 units of Lantus but the pen only had 59 units left in it so she went and obtained a new Lantus flex pen and placed a needle on it. She then dialed the initial pen to 59 units and the new pen to 7 units. She did not prime either of the pens with 2 units. The RN proceeded to administer the insulin into residents right lower quadrant of her abdomen. She failed to leave either of the pens under the skin for a count of ten after injecting the medication and before removing the needle.<br><br>A facility provided policy titled Insulin Pen Administration with revised date January of 2018 revealed staff are to perform a safety test before each dose by completing the following:<br><br>a. Select a dose of 2 units by turning the dosage selector<br><br>b. Take off the outer needle cap. If using a non-safety needle, keep it to remove the used needle<br><br>after injection. In addition, if using a non-safety needle, take off the inner needle cap and<br><br>discard it<br><br>c. Hold the pen with the needle facing upwards<br><br>d. Tap the insulin reservoir so that any air bubbles rise up towards the needle<br><br>e. Press the injection button all the way in. Check if insulin comes out of the needle tip<br><br>f. If no insulin comes out, check for air bubbles and repeat the safety test up to two more times<br><br>g. If still no insulin comes out, the needle may be blocked. Change the needle and try again<br><br>h. If no insulin comes out after changing the needle, the pen may be damaged. Do not use this<br><br>It further stated, to inject the dose:<br><br>a. Insert the needle directly into the skin<br><br>b. Deliver the dose by pressing the injection button in all the way. The number in the dose<br><br>window will return to zero as you inject.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | c. Keep the injection button pressed all the way in and slowly count to ten before you withdraw<br><br>the needle from the skin. This ensures that the full dose will be delivered.<br><br>In an interview on 6/27/24 at 1:32 PM, the DON stated it was the expectation the staff prime the insulin pen with 3-4 units prior to administering the insulin and more if it was a new pen. They were to leave the needle under the skin after injecting for 10 seconds to make sure the insulin was all administered.<br><br>42441<br><br>3. A Quarterly MDS assessment dated [DATE] for Resident #61 revealed a BIMS had not been completed. The MDS further revealed the resident had renal (kidney) insufficiency and obstructive uropathy (urine flow).<br><br>Clinical record review revealed a physician's order dated 7/24/24 to flush Resident #61's catheter three times a day with 60 cubic centimeters (cc) of acidic acid.<br><br>During an interview 6/25/24 at 8:09 AM, Resident #61 reported staff are not consistently flushing his catheter 3 times a day.<br><br>Review of the June 2024 Treatment Administration Record (TAR) for Resident #61 revealed as of 6/26/24 at 10:27 AM, his catheter had not been flushed as ordered for a total of 20 times on the following dates and times:<br><br>6/1- AM<br><br>6/2- AM/PM/hour of sleep (HS)<br><br>6/6- AM/PM/HS<br><br>6/7- PM<br><br>6/14- AM/PM/HS<br><br>6/15-HS<br><br>6/18- AM/PM/HS<br><br>6/19- AM/PM<br><br>6/20- PM/HS<br><br>6/24-AM<br><br>Review of facility policy titled, Provision of Physician Ordered Services, dated February 2023 revealed professional standards of quality means that care and services are provided according to accepted standards of clinical practice.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview 6/27/24 at 8:20 AM, the Administrator revealed it is an expectation physician orders are followed as ordered. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48886<br><br>Based on observation, record review, resident interview, staff interview, and collateral interview, the facility failed to ensure a resident's environment was free from accident hazards for 1 of 1 residents reviewed for smoking (Resident #48). The facility reported a census of 80 residents.<br><br>Findings include:<br><br>The Admission Minimum Data Set (MDS) dated [DATE] documented Resident #48 had a Brief Interview for Mental Status score of 11, which indicated moderate cognitive impairment. The MDS further documented the resident had diagnoses to include hip and knee replacement, cancer, multiple sclerosis and glaucoma.<br><br>The Care Plan for Resident #48, with a revision date of 5/25/24, documented in the problem area the resident had acute delirium related to declining mental health status and instructed staff in the intervention section to engage resident in simple, structured activities that avoid overly demanding tasks, redirect and provide gentle reality orientation as required, reorient to person, place, time, and situation as required.<br><br>The Care Plan further documented in the problem area the resident is at risk for falls related to impaired balance, poor safety awareness, and decreased function related to diagnosis of left neck of femur fracture. One of the interventions for this problem area documented resident needs a safe environment.<br><br>The Care Plan further documented in the problem area the resident has impaired cognitive function and impaired decision making capabilities. Interventions for this problem area included staff to cue, orient and supervise as needed.<br><br>During an observation 6/24/24 at 1:36 PM, Resident #48 had 3 packs of cigarettes on her night stand by her bed.<br><br>During an interview 6/24/24 at 1:40 PM, Resident #48 stated she is a smoker and had to wait for other people who want to smoke to be able to go outside to smoke at the facility. Resident #48 could not say how often she smokes or where she goes to smoke at the facility.<br><br>During an interview 6/25/24 at 1:25 PM, the Administrator stated they do not allow smoking on their grounds, if a resident smokes they have to sign themselves out and leave the property to smoke, and then sign themselves back in. They do not have a smoking schedule and staff do not monitor or observe residents when they smoke. When asked where smoking supplies are kept, the Administrator stated residents keep their own smoking supplies with them. When asked if an assessment is completed on residents who smoke to ensure they have capacity to smoke safely or keep supplies safely in their rooms, the Administrator stated she did not know for sure. The Administrator stated if a resident had cognitive decline they would keep the cigarettes and smoking paraphernalia in the medication cart locked with the nurse. The Administrator acknowledged Resident #48 had cognitive decline. The Administrator stated she had a list of residents who smoke and advised Resident #48 is not on this list.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation and interview 6/25/24 at 1:40 PM, Resident #48 had 3 packs of cigarettes on the night stand next to the bed in her room. Inquired from the resident if she also keeps a lighter in her room, resident was wearing a fanny pack and reached into a pocket in her fanny pack and pulled out a lighter. Resident #48 stated she always has the lighter in her room, she said she used to have two lighters in her room, but one went missing. Resident #48 advised she has to have someone take her outside to smoke, she cannot go outside alone to smoke. Usually her daughter or family friend will take her outside to smoke. Resident #48 demonstrated that she could use the lighter and knowledge on how to use the lighter.<br><br>Review of the electronic health record for Resident #48 revealed the facility did not conduct a smoking safety assessment or evaluation for the resident.<br><br>During an interview 6/25/24 at 4:00 PM, the Administrator and Director of Nursing (DON) stated Resident #48 is not approved to go outside on her own. Both stated an awareness of the resident smoking. The Administrator and DON stated they were not aware of the resident having smoking supplies, to include a lighter, in her room, they thought the family brought her supplies in. The DON stated she would have concern for the resident having the supplies in her room given her cognitive impairment. The DON stated the resident fluctuates in her cognition and comprehension and is cognitively impaired. The DON stated she did not know the resident had the supplies in her room. The Administrator stated they are a non smoking facility and residents have to be able to sign themselves out to smoke. Resident #48 is not able to sign herself out, her family takes her out to smoke, they sign her out. The DON stated therapy does an evaluation upon admission to see if a resident can sign themselves out. The Administrator believed Resident #48 would have an evaluation.<br><br>During an interview 6/25/24 at 4:35 PM, the Administrator stated the therapy evaluation would be paper copy, however there is not an evaluation on Resident #48 as they only do an evaluation if a resident requests to go outside on their own and the resident has not requested to go outside on her own.<br><br>During an interview 6/26/24 at 3:45 PM, a family member advised Resident #48 has had her cigarettes in her room at the facility since her admission, stating the resident likes to have them by her, they have been out in her room, on the bedside table, since April of this year. The family member advised Resident #48 also has a lighter in her room. The family member stated a concern with the resident having a lighter in her room and has a concern about this because of a worry the resident will smoke in her room and forget what she is doing due to her cognitive impairment and harm herself or start a fire. The family member stated the cigarettes have always been in plain sight in the resident's room, and the resident will keep a lighter in her fanny pack in her room or on her person.<br><br>During an interview 6/27/24 at 9:30 AM, Staff C, CNA, advised she has worked on the unit where Resident #48 resides and has observed cigarettes in the resident's room. Staff C stated Resident #48 has always had cigarettes in her room, they have been on her bedside table since the resident was admitted . Staff C advised awareness the resident also had a lighter in her room.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview 6/27/24 at 11:00 AM, a family friend advised Resident #48 does smoke. A few days after her admission to the facility in April of this year, Resident #48 talked about wanting to smoke at the facility. The family friend stated no smoking signs were observed on the property, however other residents had been observed smoking on the property outside so the family friend asked at the front desk if the resident could smoke and was advised that someone would have to take the resident outside to smoke, off the property grounds. The family friend advised the resident kept her cigarette supplies in her room up until just a few days ago when the facility asked if they could keep them for her. The resident kept her cigarettes on her bedside table and also had a lighter, she liked to keep her lighter in her fanny pack. The family friend stated they were not thrilled about the resident having a lighter due to her cognition issues at times. The resident would always ask to have her lighter and kept it in her room. The family friend advised having a concern about the resident having a lighter in her room and felt it was a safety issue. The facility never said anything about the resident not being able to have her cigarettes and lighter in her room, and they were in plain sight.<br><br>The Administrator advised the facility does not have a smoking policy, the facility is a non-smoking facility. |

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| F 0868<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have the Quality Assessment and Assurance group have the required members and meet at least quarterly<br><br>42441<br><br>Based on facility record review and staff interview, the facility failed to have the minimum required members present at their quarterly Quality Assurance (QA) meetings as directed by Centers for Medicare and Medicaid Services (CMS). The facility reported a census of 80 residents.<br><br>Findings include:<br><br>Record review reviewed revealed QA meetings were conducted on the following dates:<br><br>1. 4/20/23<br><br>2. 7/20/23<br><br>3. 9/25/23<br><br>4. 10/12/23<br><br>5. 2/16/24<br><br>6. 5/25/24<br><br>7. 6/13/24<br><br>Further record review revealed mandatory QA members were not present during the following meetings:<br><br>1. 4/20/23-No Administrator<br><br>2. 7/20/23-No Infection Preventionist<br><br>3. 9/25/23-No Infection Preventionist<br><br>4. 10/12/23- No Infection Preventionist<br><br>5. 2/16/24-No Medical Director<br><br>During an interview 6/27/24 at 8:20 AM, the Administrator acknowledged all the required members were not present at the quarterly Quality Assurance meetings as expected. |

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| F 0926<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have policies on smoking.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48886<br><br>Based on observation, record review, resident interview, staff interview, collateral interview and policy review, the facility failed to establish policies regarding smoking, smoking areas, and smoking safety for 1 of 1 residents reviewed for smoking (Resident #48). The facility reported a census of 80 residents.<br><br>Findings include:<br><br>The Minimum Data Set (MDS) dated [DATE] documented Resident #48 had a Brief Interview for Mental Status score of 11, indicating moderate cognitive impairment. The MDS further documented the resident had diagnoses to include hip and knee replacement, cancer, multiple sclerosis and glaucoma.<br><br>The Care Plan for Resident #48, with a revision date of 5/25/24, documented in the problem area the resident has acute delirium related to declining mental health status and instructed staff in the intervention section to engage resident in simple, structured activities that avoid overly demanding tasks, redirect and provide gentle reality orientation as required, reorient to person, place, time, and situation as required. The Care Plan further documented in the problem area the resident is at risk for falls related to impaired balance, poor safety awareness, and decreased function related to diagnosis of left neck of femur fracture. One of the interventions for this problem area documented resident needs a safe environment. The Care Plan further documented in the problem area the resident has impaired cognitive function and impaired decision making capabilities. Interventions for this problem area included staff to cue, orient and supervise as needed.<br><br>On 6/24/24 at 9:00 AM, a male resident was observed sitting at a table outside the main door on the property grounds. The table was on the pathway leading to the main entrance door. Cigarette butts were observed on the ground on this pathway.<br><br>During an observation 6/24/24 at 1:36 PM, Resident #48 had 3 packs of cigarettes on her night stand by her bed.<br><br>During an interview 6/24/24 at 1:40 PM, Resident #48 stated she is a smoker and has to wait for other people who want to smoke to be able to go outside to smoke at the facility. Resident #48 could not say how often she smokes or where she goes to smoke at the facility.<br><br>On 6/24/24 at 4:10 PM, a male resident was observed sitting in a wheelchair smoking outside the main door on the property grounds.<br><br>(continued on next page) |

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| F 0926<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview 6/25/24 at 1:25 PM, the Administrator stated they do not allow smoking on their grounds, if a resident smokes they have to sign themselves out and leave the property to smoke, and then sign themselves back in. They do not have a smoking schedule and staff do not monitor or observe residents when they smoke. Advised the Administrator residents have been observed smoking at a table or in a wheelchair outside the front door and on the property grounds. The Administrator stated residents are told not to smoke on the property and residents would be redirected if observed by a staff member to be smoking on the property. When asked where smoking supplies are kept, the Administrator stated residents keep their own smoking supplies with them. When asked if an assessment is completed on residents who smoke to ensure they have capacity to smoke safely or keep supplies safely in their rooms, the Administrator stated she did not know for sure. The Administrator stated if a resident has cognitive decline they would keep the cigarettes and smoking paraphernalia in the medication cart locked with the nurse. The Administrator acknowledged Resident #48 has cognitive decline. The Administrator stated she has a list of residents who smoke and advised Resident #48 is not on this list.<br><br>During an observation and interview 6/25/24 at 1:40 PM, Resident #48 had 3 packs of cigarettes on the night stand next to the bed in her room. Inquired from the resident if she also keeps a lighter in her room, resident was wearing a fanny pack and reached into a pocket in her fanny pack and pulled out a lighter. Resident #48 stated she always has the lighter in her room, she said she used to have two lighters in her room, but one went missing. Resident #48 advised she has to have someone take her outside to smoke, she cannot go outside alone to smoke. Usually her daughter or family friend will take her outside to smoke. Resident #48 demonstrated that she could use the lighter and knowledge on how to use the lighter.<br><br>Review of the electronic health record for Resident #48 revealed the facility did not conduct a smoking safety assessment or evaluation for the resident.<br><br>On 6/25/24 at 3:40 PM, the Administrator sent an email stating our non-smoking policy is located in our admission packet on page 10 and we have signs posted.<br><br>During an interview 6/25/24 at 4:00 PM, the Administrator and Director of Nursing (DON) stated Resident #48 is not approved to go outside on her own. Both stated an awareness of the resident smoking. The Administrator and DON stated they were not aware of the resident having smoking supplies, to include a lighter, in her room, they thought the family brought her supplies in. The DON stated she would have concern for the resident having the supplies in her room given her cognitive impairment. The DON stated the resident fluctuates in her cognition and comprehension and is cognitively impaired. The DON stated she did not know the resident had the supplies in her room. The Administrator stated they are a non smoking facility and residents have to be able to sign themselves out to smoke. Resident #48 is not able to sign herself out, her family takes her out to smoke, they sign her out. The DON stated therapy does an evaluation upon admission to see if a resident can sign themselves out. The Administrator believed Resident #48 would have an evaluation.<br><br>During an interview 6/25/24 at 4:35 PM, the Administrator stated the therapy evaluation would be paper copy, however there is not an evaluation on Resident #48 as they only do an evaluation if a resident requests to go outside on their own and the resident has not requested to go outside on her own.<br><br>(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) |
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| F 0926<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/25/24 at 4:45 PM, a male resident was observed sitting in a wheelchair smoking outside the main door on the property grounds.<br><br>On 6/25/24 at 5:00 PM, a male resident was observed sitting in a wheelchair smoking outside the main door on the property grounds. Cigarette butts were observed on the ground on the pathway to the main door, on property grounds.<br><br>During an interview 6/26/24 at 3:45 PM, a family member advised Resident #48 has had her cigarettes in her room at the facility since her admission, stating the resident likes to have them by her, they have been out in her room, on the bedside table, since April of this year. The family member advised Resident #48 also has a lighter in her room. The family member stated a concern with the resident having a lighter in her room and has a concern about this because of a worry the resident will smoke in her room and forget what she is doing due to her cognitive impairment and harm herself or start a fire. The family member stated the cigarettes have always been in plain sight in the resident's room, and the resident will keep a lighter in her fanny pack in her room.<br><br>During an interview 6/27/24 at 9:30 AM, Staff C, CNA, advised she has worked on the unit where Resident #48 resides and has observed cigarettes in the resident's room. Staff C stated Resident #48 has always had cigarettes in her room, they have been on her bedside table since the resident was admitted . Staff C advised awareness the resident also had a lighter in her room.<br><br>During an interview 6/27/24 at 11:00 AM, a family friend advised Resident #48 does smoke. A few days after her admission to the facility in April of this year, Resident #48 talked about wanting to smoke at the facility. The family friend stated no smoking signs were observed on the property, however other residents had been observed smoking on the property outside so the family friend asked at the front desk if the resident could smoke and was advised that someone would have to take the resident outside to smoke, off the property grounds. They started taking the resident off the property ground to smoke, but said over time they have moved closer and closer to the building and to the front entrance. They now smoke at a table under the archways on the sidewalk going to the front entrance, on the property grounds. The family friend advised they have observed other residents smoking outside in this same area, at tables closer to the front entrance, on property grounds. They have never been told by staff to move. The family friend advised the resident kept her cigarette supplies in her room up until just a few days ago when the facility asked if they could keep them for her. The resident kept her cigarettes on her bedside table and also had a lighter, she liked to keep her lighter in her fanny pack. The family friend stated they were not thrilled about the resident having a lighter due to her cognition issues at times. The resident would always ask to have her lighter and kept it in her room. The family friend advised having a concern about the resident having a lighter in her room and felt it was a safety issue. The facility never said anything about the resident not being able to have her cigarettes and lighter in her room, and they were in plain sight.<br><br>Review of the facility admission packet, page 10, documents the provider operates a non-smoking facility. Smoking may be permitted outside only in provider designated areas. The facility does not have any other policies with regard to smoking. |