

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/08/2024
NAME OF PROVIDER OR SUPPLIER Focused Care at Beechnut		STREET ADDRESS, CITY, STATE, ZIP CODE 12777 Beechnut St Houston, TX 77072	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26454</p> <p>Based on record review and interview, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 of 10 residents (CR #1) reviewed for Quality of Care.</p> <p>1.The facility failed to immediately transfer CR #1, who was cognitively impaired and received Eliquis (an anticoagulant/blood thinner) when CR #1 went to the hospital after an unwitnessed fall on 09/22/2023 at 4:55 a.m. and sustaining a head injury. CR #1 was transferred to the hospital via non-emergency transportation service as a replacement for 911 emergency services.</p> <p>An Immediate Jeopardy (IJ) was identified on 01/18/2024 at 10:49 a.m. The IJ template was provided to the facility on [DATE] at 10:49 a.m. While the IJ was removed on 01/19/2024, the facility remained out of compliance at a scope of isolated with the potential for more than minimal harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>2.The facility failed to assess CR #1 in her primary language of Spanish when she sustained a head injury on 09/22/2023.</p> <p>These failures placed residents on anticoagulant therapy who experience falls with injuries at risk of progression of the injury, prolonged pain, excessive bleeding, intracranial hemorrhage, and possible death.</p> <p>Findings included:</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of CR #1's face sheet dated 01/17/2024 revealed she was an [AGE] year-old female who was admitted to the facility on [DATE]. CR #1's diagnoses included: Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), unspecified dementia (dementia without a specific diagnosis), epilepsy (brain condition that causes recurring seizures) and epileptic syndromes (a type of epilepsy identified by a specific seizure type), abnormality of gait (unusual walking pattern), heart failure (a chronic condition in which the heart does not pump blood as well as it should), dysphagia-oropharyngeal phase (reduced ability to feel food, liquid, or saliva that remains in the mouth or throat after swallowing), cognitive communication deficit (deficits which result in difficulty with thinking and how someone uses language), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), vascular dementia (brain damage caused by multiple strokes that causes memory loss in older adults), essential hypertension (abnormally high blood pressure that is not the result of a medical condition), and joint pain (physical discomfort where two or more bones meet to form a joint). CR #1 was discharged from the facility on 09/28/2023.</p> <p>Record review of CR #1's quarterly MDS assessment dated [DATE] revealed she was Hispanic or Latino; her preferred language was Spanish and she needed/wanted an interpreter to communicate with a doctor or health care staff; she had a BIMS score of 00 (severe cognitive impairment); she required extensive physical assistance from at least one staff for bed mobility, locomotion, dressing, eating, toilet use, and personal hygiene and she was totally dependent on staff for transfers and bathing; she was wheelchair bound; she was always incontinent of bowel and bladder; she was prescribed anticoagulant medication; and she received hospice services.</p> <p>Record review of CR #1's care plan updated on 09/25/2023 revealed the following areas of concern:</p> <p>* The resident was at risk for increased falls and fractures as evidence by confusion and incontinence. Goals included: The resident will be free of falls through the review date. Interventions included: Anticipate and meet the resident's needs. Be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs.</p> <p>* The resident had a communication problem related to dementia and language barrier; speaks Spanish. Spanish speaking however nonsensical due to dementia majority of the time. Communication effective with simple basic terms. Goals included: The resident will maintain current level of communication function by next review. Interventions included: Anticipate and meet needs. Monitor/document/report PRN any changes in: ability to communicate, potential contributing factors for communication problems, potential for improvement. Speak on an adult level, speaking clearly and slower than normal. The resident is able to communicate by: gestures, translator (Spanish).</p> <p>* Resident at Risk for Falls as evidenced by: Cognitive Impairment. Goals included: Dignity will be maintained. Resident will not experience falls or injuries from falls throughout the review date. Interventions included: Assure lighting is adequate and areas are free of clutter. Encourage resident to ask for assistance of staff. Ensure call light is in reach and answer promptly. Therapy to evaluate and treat per orders.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>* 9/22/23 I have had an actual fall with minor laceration to forehead related to poor balance, unsteady gait. Goals included: The resident's (Specify: injured areas [no injuries were noted]) will resolve without complication by review date. Interventions included: 9/22/23 Clean the forehead laceration with wound cleanser, pat dry and apply dry dressing. 9/22/23 Continue interventions on the at-risk plan. 9/22/23 Give PRN Tylenol per physician order for pain. 9/22/23 Neuro-checks x 72 hours per facility protocol. 9/25/23 Neuro-checks x 72 hours per facility protocol. 9/22/23 PT consult for strength and mobility. 9/22/23 Send resident to ER for CT scan without contrast. 9/25/23 Check range of motion every shift daily. 9/25/23 For no apparent acute injury, determine and address causative factors of the fall. 9/25/23 Monitor/document/report PRN x 72h to MD for signs and symptoms: pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation.</p> <p>Further review of CR #1's care plan revealed no documentation of a care area, goal, or interventions related to CR #1's anticoagulant therapy.</p> <p>Record review of CR #1's Nursing Progress Notes for March 2023 revealed the following:</p> <p>On 03/07/2023, the SW (no longer employed at the facility) wrote, SW met with resident in the common area of Station C to complete a quarterly social service assessment . SW utilized an interpreter to assist with the assessments, as resident is Spanish speaking .</p> <p>Record review of CR #1's physician's orders for September 2023 revealed the following orders:</p> <p>* Admit to hospice with diagnosis: Alzheimer's Disease. Order date - 05/28/2023.</p> <p>* Eliquis Oral Tablet 5 MG. Give 1 tablet by mouth two times a day for DVT (blood clot) until 10/17/2023. Order date - 04/17/2023. End date - 10/17/2023.</p> <p>* Acetaminophen Oral Tablet. Give 2 tablets by mouth every 4 hours as needed for pain. Order date - 04/18/2023.</p> <p>Record review of CR #1's MAR for September 2023 revealed:</p> <p>* Acetaminophen Oral Tablet. Give 2 tablets by mouth every 4 hours as needed for pain. There was no documentation to show this medication was administered in September 2023.</p> <p>* Eliquis Oral Tablet 5 MG. Give 1 tablet by mouth two times a day for DVT until 10/17/2023. This medication was administered daily as prescribed (except for the 8:00 a.m. dose on 09/22/2023) for the month of September 2023 until she was discharged on [DATE].</p> <p>Record review of drugwatch.com's article, Eliquis revised 10/15/2023 and written by a board-certified patient advocate revealed Eliquis was a powerful blood thinner prescribed to prevent strokes and potentially fatal clots. The article stated doctors prescribed Eliquis to people after knee or hip replacement surgery to prevent deep vein thrombosis (DVT) which was when blood clots formed in veins deep in the body. The article stated Eliquis' effects lasted for at least 24 hours after the last dose, according to the drugs label. The label stated serious and potentially life-threatening bleeding was the most severe side effect.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview with CR #1's family member on 01/17/2024 at 8:15 a.m., she stated CR #1 passed away in November 2023. She stated she missed three calls from the facility on 09/22/2023, so she called the hospice nurse. The family member said the facility failed to assess the seriousness of CR #1's injury and did not send her out for two hours. She stated CR #1 was transferred to another facility after the incident. She said CR #1 did not speak English, but she could understand it. She stated CR #1's dementia had progressed, so she really could not voice her needs.</p> <p>In an interview with the DON on 01/17/2024 at 11:23 a.m., she stated she thought CR #1 had a fall and went out to the hospital but returned the same day. She said after the fall, CR #1's RP requested her to transfer to a sister facility. She said CR #1 was on hospice. The DON stated if a resident experienced a fall and hit their head with swelling or anything, the staff automatically sent them out for a CT scan just to be on the safe side. She said the staff would call hospice because some hospice residents were still full code (no DNR). The DON said if the fall incident occurred at 4:55 a.m., the nurse would start neurological assessments immediately but whether or not 911 was called to transport the resident depended on the nurse's assessment. The DON said if a resident had a bleeding laceration, they should be sent out 911, but it depended on what the nurse assessed. She said the risk of failing to immediately transport someone on a blood thinner who experienced a fall with head injury would have been possible internal bleeding, which may not have been assessed. She said there was no active bleeding, but since CR #1 was on Eliquis, there may have been internal bleeding that the nurse was not able to see. She stated the facility did not have a policy on quality of care or any policy specific to CR #1's incident.</p> <p>In an interview with the Administrator on 01/17/2024 at 12:15 p.m., he stated he thought the 6:41 a.m. transfer time documented on CR #1's transfer form dated 09/22/2023 was a documentation error. He said he thought CR #1 was sent out to the hospital before that time. He said the facility's nurses would not send a resident out right away unless they were profusely bleeding. He said there were no changes to CR #1's level of consciousness and she was not actively bleeding, so there could have been some delay in transferring her to the ER. He said he thought the nurse applied pressure to CR #1's wound and it was stable.</p> <p>In a telephone interview with Hospice RN on 01/17/2024 at 1:20 p.m., she stated she could not recall what time the facility called her, but if the fall happened at 4 a.m., she must have been the on-call nurse. She said she could not recall if the facility nurse called her before or after they sent CR #1 out to the ER after she fell and hit her head. She stated the details of the incident would be in her notes.</p> <p>In a follow-up telephone interview with Hospice RN on 01/17/2024 at 1:40 p.m., she stated RN A called her at 5:00 a.m. on 9/22/23 and said CR #1 struck her head on the bed, but she initially denied there was a fall. Hospice RN said RN A eventually said an aide told her CR #1 did fall and hit her head on the dresser. Hospice RN said RN A told her CR #1 sustained a laceration to her head and was bleeding. She said CR #1 was sent out for evaluation and CT for a subdural hematoma (a pool of blood between the brain and its outermost covering). She said RN A told her she had already called EMS.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In a telephone interview with RN A on 01/17/2024 at 2:26 p.m., she stated she recalled CR #1, who was on hospice. She stated CR #1 was alert, but only spoke Spanish, so she could not understand her. RN A said on the night CR #1 fell, she was asleep until she (RN A) made her final rounds for the night. RN A said she worked from 6:00 p.m. - 6:00 a.m. She said when she walked into CR #1's room, she was on the floor mat. RN A said CR #1's bed was very low to the ground, so it appeared she rolled out of bed or something. She said she saw that CR #1's face had blood and the bottom drawer of the dresser had a blood stain on it. RN A said CR #1's face was positioned near the dresser area. She said the laceration was like a line that resembled the dresser drawer handle. RN A said she cleaned CR #1's wound and she was still alert and talking (in Spanish). She said she rounded every two hours and the laceration appeared to be fresh like the fall had just happened. RN A said CR #1 could not really communicate with her, but she cleaned the wound and saw the line from the laceration. She said she called hospice and spoke with the nurse. RN A said she told Hospice RN that CR #1 needed to go to the hospital, so she gave the order to send CR #1 to the ER. She said the incident happened at the end of her shift. She said as soon as she wiped the blood from CR #1's laceration, the bleeding stopped so she covered it with a dry dressing. RN A said she knew CR #1 had to go to hospital because it was their policy. She said she called their non-emergency transportation company, and they came almost immediately. She said CR #1 left the building while she (RN A) was still in the building. RN A said she knew CR #1 was on Eliquis. She said she knew CR #1 had to go to the hospital but spoke to the hospice nurse before she called the transportation company. She stated the hospice nurse never mentioned calling 911. RN A said the ETA for the transportation company was soon because they were in the area.</p> <p>In a follow up telephone interview with RN A on 01/23/2024 at 12:52 p.m., she stated CR #1 could speak some English, but mostly Spanish. She said CR #1 could say, Yes in English and could say, Poquito ('a little' in Spanish) when she was in pain. RN A said when she conducted a ROM assessment on CR #1, there was no sign of pain, but when she felt around the laceration area, CR #1 jerked a little and said, Poquito. RN A said CR #1 was speaking in Spanish the morning she fell, and none of the staff could speak Spanish to her. She said she gave CR #1 Tylenol, if she was not mistaken. She said the Tylenol administration was probably not on CR #1's MAR, but she thought she gave it to her.</p> <p>In an interview with CR #1's NP on 01/17/2024 at 3:45 p.m., she stated she did not recall CR #1's fall in September 2023. She stated if a resident was cognitively impaired, confused, and had a communication barrier experienced a fall with a head injury and was on Eliquis, it did not necessarily mean the nurse should have called 911. She stated CR #1 was on hospice and usually, hospice patients did not go to the hospital unless the hospice agency said to send them out. She said if a resident hit their head and was bleeding, they would send the resident out for a CT to ensure there were no injuries. CR #1's NP said if CR #1 had a head injury that was bleeding and there was a two-hour delay in getting her to the hospital, you would have to be very careful, but if she was not actively bleeding and there was just a skin laceration, the situation was not urgent to her. She said if a resident had a brain bleed for two hours, that would be an emergency. She said CR #1 was in a low bed, so she could not say for sure if there was a possibility for her to have sustained a brain bleed as a result of the fall. The NP said it depended on how hard CR #1 hit her head. She said a normal person would have had altered mental status if they had a brain bleed, but CR #1 was already confused.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In another telephone interview with Hospice RN on 01/18/2024, at 9:40 a.m., she stated she ordered RN A to send CR #1 out after the fall to evaluate for subdural hematoma because she could have had a brain bleed. She stated going out to the hospital was not usually recommended for residents on hospice unless their family wanted it. Hospice RN said, CR #1 could have had a brain bleed and being on a blood thinner would have exacerbated that condition. She said typically, a family would not treat a brain bleed if the resident was on hospice. She said if a resident was not on hospice, a two-hour delay would not be appropriate for this situation. She said CR #1 could not speak any English at all. She said she took over as CR #1's primary hospice nurse after she experienced the fall in September 2023 and followed her to the other facility (after she was discharged from the facility). She said CR #1 had dementia, so even when she spoke Spanish, she could not communicate her needs.</p> <p>In an interview with the Administrator, VP of Operations and Regional Nurse on 01/18/2024 at 10:50 a.m., the VP of Operations stated she was previously the administrator at the facility, and she recalled that CR #1 could speak some English. The Regional Nurse stated she was previously the DON at the facility and CR #1 did speak some English and was able to communicate some although she was selective who she spoke English to. The Administrator, who was also an RN stated Eliquis acted different from blood thinners like Coumadin. The Administrator said doctors prescribed Eliquis because it controlled the blood/bleeding better. The Administrator said CR #1 could speak some English and they sent her to the hospital for evaluation. The Administrator said it was not an emergency because staff were monitoring CR #1 during the time she was in the facility, and she was stable.</p> <p>In an interview with CNA C on 01/22/2024, at 1:40 p.m., she stated she cared for CR #1 a few times and she only spoke Spanish.</p> <p>In an interview with LVN E on 01/23/2024 at 12:30 p.m., she stated she cared for CR #1 while she was there and every one-in-a while, CR #1 would say thank you in English. LVN E said CR #1 spoke some English before she declined a few months before she left the facility, but after the decline, she only spoke Spanish.</p> <p>In an interview with MA F on 01/23/2024 at 12:30 p.m., she stated she administered CR #1's medications when she was at the facility. She stated she recalled that CR #1 required total care and did not speak any English. She said CR #1 only spoke Spanish.</p> <p>Record review of the facility's Change in Condition policy dated 11/01/2019 revealed, Communities will use the facility's definition for a Change in Condition. It will be the policy that once the nurse has notified the physician for a change in condition the resident/patient will be monitored for 1 hour until the physician has responded. The monitoring will include vital signs, pulse ox, and finger stick blood sugar if a diabetic (one time only). A physical assessment should be completed relative to the symptoms present and a pain assessment. If the resident/patient condition appears emergent, Transfer to local ER may occur without physician order.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Focused Care at Beechnut		STREET ADDRESS, CITY, STATE, ZIP CODE 12777 Beechnut St Houston, TX 77072	
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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's Incident and Accident policy dated 03/01/2017 revealed, 3. Licensed nurse will complete a fall investigation report after every fall to include vital signs, pain assessment, and environmental assessment . A head-to-toe assessment must be completed at the time of the incident . 10. All residents are at risk for falls. A risk assessment will be conducted on admission and the findings of that assessment will be included in the plan of care . 12. A fall is defined as unintentionally coming to rest on the floor, ground or lower level . b. a resident found on the floor is considered to have fallen . 13. A neurological check form is to be completed for any fall involving the head or any unwitnessed fall .</p> <p>This was determined to be an Immediate Jeopardy (IJ) on 01/18/2024 at 10:49 a.m. The Administrator, VP of Operations, and the Regional Nurse were notified. The Administrator, VP of Operations, and Regional Nurse were provided with the IJ template on 01/18/2024 at 10:49 a.m. A Plan of Removal was requested at that time.</p> <p>The following Plan of Removal submitted by the facility was accepted on 01/18/2024 at 3:09 p.m.:</p> <p>1. Immediate Action Taken</p> <p>* Resident was discharged to another facility.</p> <p>* On 1/18/2024 the Director of Nurses (DON) or designee, started education with all license nurse on the guidelines for sending out residents via 911 emergency services that are on anticoagulant therapy. This will guide the clinical team on ensuring that each resident receives emergency care immediately, and services in the event of a unwitnessed fall when a resident is on anticoagulant therapy. This education will be completed at 3:00 pm on 1/19/2024, and no license nurse will be allowed to work until this education has been completed.</p> <p>* An In-service by the Social Worker was started on 1/18/2024 on the use of the language line and the communication charts. This education will be completed on 1/19/2024.</p> <p>* An in-service initiated on 1/18/2024 by the DON for licensed nurses on proper assessment of a resident with fall with injury to include language barriers. To be completed by 1/19/2024</p> <p>* The below policies were reviewed on 1/18/2024 and there are no changes to current policy.</p> <p>o Falls (Incident and Accident) to include witnessed and unwitnessed falls</p> <p>* Anticoagulation therapy information pamphlets</p> <p>o Communication</p> <p>* Using Language Line for Non-English-Speaking Residents.</p> <p>2. Identification of Residents Affected or Likely to be Affected:</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>* On 1/18/2024 the DON completed the audit for any resident who was on anticoagulant therapy. We identified 8 residents on anticoagulant. An audit was completed on 1/18/2024 by the DON and Assistant Director of Nurses (ADON) on resident with falls within the past 72 hours to validate that no other residents failed to receive emergency care, that were on anticoagulant therapy. This is to be completed by 1/18/2024.</p> <p>* Licensed nurses will use the resident clinical records (Medical Administration Records), to identify residents on anticoagulants. If resident is on anticoagulant, they will immediately be transferred to Higher Level of Care (Hospital) via 911 emergency.</p> <p>3.Actions to Prevent Occurrence/Recurrence:</p> <p>* The DON/Designee will validate daily x 30 days, that the Incident and Accidents are reviewed daily during morning meeting to ensure no delays in services.</p> <p>* Any new licensed nurse hired by the facility will receive education upon hire on:</p> <ul style="list-style-type: none"> o Education on the guidelines for sending out residents that are on anticoagulant therapy. o The use of the language line and the communication charts. o Proper assessments with a resident with a fall with injury to include language barriers. <p>On 1/18/2024 the facility's Administrator notified the Medical Director regarding the Immediate Jeopardy the facility received related to failure to provide treatment and care in accordance with professional standards of practice and reviewed plan to sustain compliance.</p> <p>Monitoring of the plan of removal included the following:</p> <p>Record review of In-Service Training Report dated 01/18/2024 revealed all facility staff were educated on Falls and on Anticoagulant or Blood Thinner by the DON. The document read in part, If a resident has a fall and is on anticoagulants or blood thinners, then send out 911 for evaluation.</p> <p>Record review of undated facility document, Are Coumadin and Eliquis the Same Thing? revealed the document was included in the in-service dated 01/18/2024 regarding falls and residents on blood thinners. The document explained the difference between Coumadin and Eliquis, including their indications, side effects, drug interactions, and how they should be taken.</p> <p>Record review of In-Service Training Report dated 01/18/2024 revealed all licensed nurses were educated by the DON regarding proper assessment of residents with language barriers who experience falls with injuries and how to identify residents on anticoagulant therapy.</p> <p>Record review of In-Service Training Report dated 01/18/2024 revealed all facility staff were educated on Residents with Language Barriers [TRUNCATED]</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26454</p> <p>Based on observation, interview, and record review, the facility failed to ensure that the resident environment remained as free of accidents and hazards as is possible for 22 of 22 residents reviewed for accidents and hazards.</p> <ol style="list-style-type: none"> 1. CNA B and CNA C engaged in a verbal and physical altercation in the presence of at least two residents, Resident #2, and Resident #3 on 1/18/24 at approximately 6:00 a.m. 2. CNA C left a loaded firearm unattended inside her personal bag in an unsecured cabinet under the nurse's station desk located directly across from a resident TV area for an undetermined amount of days/time. 3. CNA C pointed a loaded firearm at CNA B and discharged the gun outside in the air approximately one yard from resident-occupied rooms on 1/18/24. <p>An Immediate Jeopardy (IJ) was identified on 02/07/2024 at 9:40 a.m. The IJ template was provided to the facility on [DATE] at 9:40 a.m. While the IJ was removed on 02/08/2024, the facility remained out of compliance at a scope of isolated with the potential for more than minimal harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>These failures placed all residents at risk possibly being seriously harmed/injured or killed by an unsecured firearm or stray bullet.</p> <p>Findings included:</p> <p>Observation of the nurse's station on the 100 Hall on 01/22/2024 at 11:00 a.m. revealed the entrance to the nurse's station was directly across from a resident television area. There were open areas underneath the desk with shelves. There were bags, purses, and jackets on the shelves. No staff were observed at the nurse's station at that time. There were three residents in wheelchairs sitting in the television area.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview with the DON on 01/22/2024 at 9:30 a.m., she stated on 01/18/2024, LVN V called her and said two staff members (CNA B and CNA C) were having an altercation. She could not recall what time LVN V called her, but it was at the start of the 6:00 a.m. - 2:00 p.m. shift. The DON said she told LVN V to get replacement staff and send CNA B and CNA C home. The DON said LVN called her again that morning and said there were gun shots fired outside. The DON said the MDS Nurse called the police after she heard gunshots. The DON said there had not been any prior altercations between the two staff that she knew of. She said CNA C was just hired in December 2023. She said CNA C had not complained about any prior incidents with any other staff. She said their corporate staff were involved in the investigation. She said CNA D tried to separate the two staff when they were fighting. She said all three staff were suspended pending the investigation, but CNA D returned to work on Sunday, 01/21/2024. She said the MDS Nurse was currently in the hospital having emergency surgery. She said the nurses did 12-hour shifts from 6:00 a.m. - 6:00 p.m. and 6:00 p.m. - 6:00 a.m. She said RN A was the night shift nurse and she also witnessed the altercation.</p> <p>In an interview with the Administrator on 01/22/2024 at 10:22 a.m., he stated on 01/18/2024, he received a call from a nurse at about 7:15 a.m. He said he could not recall what nurse called him, but the nurse said the Medical Records Coordinator said CNA C had a gun and fired shots in the air. The Administrator said CNA C texted him at 8:11 a.m. after the incident and said the other staff jumped her. He said he sent her a text saying she brought a weapon into the facility when signs were posted everywhere saying it was a felony and then discharged it unsafely. He said CNA C texted back saying she figured he would say that and that it was not a felony to protect herself. The Administrator said the police came and did an investigation, but as of Friday, 01/19/2024, they had not found CNA C or arrested her. He said CNA C texted that she rode the bus to work, and the gun was in her bag. The Administrator said he did not know where CNA C's bag was stored inside the facility. He said CNA C told him she brought the gun for safety reasons because she rode the bus at night. He said this was the first time he heard about any incident between CNA B and CNA C. The Administrator said CNA C never told him what the argument was about, but he heard during the investigation that the argument was about an unsafe transfer. He said CNA C transferred Resident #2, who was a two-person transfer, alone and CNA B told her how to do it the right way. The Administrator said Resident #2 told him CNA B was very calm when she approached CNA C and told her how to transfer him the right way. The Administrator said that was when things escalated, and CNA D tried to stop CNA C from going outside to mess with CNA B, who was outside smoking. He said RN A, MDS Nurse, and CNA D all tried to stop CNA C from bothering CNA B outside. He said CNA C went outside and that was when everybody heard guns shots. The Administrator said nobody went outside with CNA C. He said from his understanding, there was a short amount of time when CNA C went outside and when gunshots were heard. He said from his understanding, there was not a physical altercation inside the building because some people said it was physical, and some said it was not. He said CNA C told the VP of Operations she was being bullied, but there were no reports of that to him. He said CNA C never reported being bullied before this incident. He said he always did in-services about staff getting along and workplace violence as part of their ongoing training. He said there were no prior issues with staff having altercations that he knew of. He said staff had lockers available to them outside in the courtyard and in the staff breakroom. He said staff could bring their own locks to secure their personal belongings. He said he did not know if CNA C had a locker or not. The Administrator said he implemented a new rule that staff could only bring clear bags into the facility. He said he also contracted to have security in the building 24-hours daily and in-serviced staff. He said there were always signs posted at every entrance and exit about not bringing guns into the building, but he posted more signs.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In a telephone interview with CNA C on 01/22/2024 at 10:45 a.m., she stated she took responsibility for what she did because they (the Administrator and VP of Operations) told her having weapon on the premises was a felony. She said she only had the gun because she rode the bus at night to and from school. She stated she worked the 6:00 a.m. - 2:00 p.m. shift, but on 01/18/2024, she arrived early and clocked in at 5:45 a.m. She said she got Resident #2 up because he wanted to get up. She said she gave him a bed bath and transferred him safely with a Hoyer Lift to his wheelchair. She said RN A went to Resident #2's room because he was rambling and going on (she did not say what Resident #2 was rambling about). She said RN A said, Oh, you got him up, it was not time to get him up and you were not supposed to get him up by yourself. She said she was still in Resident #2's room and was leaving out right at 6:00 a.m. when CNA B approached her and was very aggressive about it. She said CNA B told her, I don't know what you think you are doing, but this is a two-person assist and you are going to get yourself fired. CNA C said she did not know what CNA B's problem was because she came down the hallway with her hands up like she was going to hit her. CNA C said CNA B swung at her and she backed up and asked CNA B not to do that. She said CNA B told her RN A asked her to come talk to her. She said she asked CNA B why she was so mad, and CNA B said she was done talking and was about to burst her upside her head. CNA C said she previously observed CNA B get Resident #2 up unassisted and CNA B said, I don't care what you thought you saw. CNA C said CNA B kept pushing and chest butting her. CNA C said she was walking away when CNA D grabbed her hand and said, Don't run up behind CNA B like that. CNA C said she told the rest of the staff she was leaving and showed them her bus pass. She said while CNA D held her, CNA B punched her on left side of her face. She said nobody let her leave. She said CNA B said, You about to go outside and get your ass whooped. CNA C said there were 3 - 4 people standing outside with CNA B and they were bullying her, so she pulled her gun out and shot into the air. She said she did not know the names of the other staff who were outside with CNA B. She said she called the Administrator and the VP of Operations after the incident. She said her car was broken, so she had to ride the bus. She said she went to class from 5:00 p.m. - 9:00 p.m. and she stored her bag behind the nurse's station, under the cabinet where there was an open area. She said that was where all the staff kept their things. She said she left her bag with the gun inside on the bottom shelf, next to the computer and chair on hall 100. She said her weapon was not exposed. She said RN A was there when CNA B hit her in the face. She said CNA B and another staff were already outside when she tried to leave the building and CNA D held her back and would not let her leave. She said she did not know if CNA D made it outside before her, but she saw some people at the door yapping their mouth (yelling at her and bullying her). She said she went out the side door of the building and was in the middle of the parking lot when she fired the shot in the air. She said she did not aim the gun at anybody, and she did not try to hurt anybody. She said the other staff were nowhere near her when she fired the shot. She said the other staff were more than 200 - 300 ft. away from her. She said the Medical Records Coordinator heard her telling the other staff to get off her. She said she told the Medical Records Coordinator and another CNA that she was being bullied by CNA B. She said during the week prior to the incident, she was mistreated by some African staff and CNA B defended her, so she did not understand why CNA B hit her in the face. She said she never reported to the Administrator or other management staff that she was being bullied. She said 01/18/2024 was the first day she brought her gun inside the building. She said she had never gone inside the building with a bag before because she previously had her car. She said her car broke down a couple of weeks before the incident. She said she never noticed or paid attention to the posted signs that said she could not bring a gun inside the building. She said she did not know she could not have the gun to protect herself. She said none of the residents had access to it because it was behind nurse station under the open cabinet.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview with the Medical Records Coordinator on 01/22/2024 at 11:15 a.m., she stated days before the incident on 01/1/2024, CNA C told her some other staff were messing with her and the nurses were always hostile to her. She said she told CNA C file a grievance because the Administrator had an open-door policy. She said CNA C told her that on Saturday, 01/13/2024, some nurses got her into the medication room and got in her face. She said CNA C told her that on the day of the incidents, CNA C came and told her she could not get Resident #2 up or change him by herself even though she previously observed CNA C transfer him alone. The Medical Records Coordinator said RN A told CNA B to go and tell CNA C she could not transfer Resident #2 alone. She said the two staff had a verbal and physical altercation in the residents' room. She said Resident #2 told her CNA C hit CNA B first. She said CNA C told her CNA B hit her first. She said CNA C and CNA B never had any disagreements. She said CNA D told her (Medical Records Coordinator) that CNA C said she had a gun and she had 'something for them' if this (when the nurses cornered her in the medication room and got into her face) happened again. She said CNA C told CNA D she had a gun possibly days before the shooting incident. She said CNA B was a smoker and usually went out to the patio in the courtyard to smoke, but on 01/18/2024, CNA B called CNA out and said, Come outside if you got something for me. The Medical Records Coordinator said she was at the table in the front of the building and saw people running. She said she heard staff saying, No! Let my purse go, let me go! and She got a gun! She said by the time she got to the side of the building: CNA C was already gone. She said she did not hear the gun shot. She said the incident occurred around 6:00 a.m., so of course residents were up at that time and roaming around the building. She said none of the residents were outside. She said CNA D was outside when CNA C shot the gun. She said CNA D tried to keep CNA C from leaving with her purse because she knew the gun was in there. She said CNA C's bag was probably behind the nurse station, but staff were supposed to keep their belongings in the lockers.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In a telephone interview with CNA B on 01/22/2024 at 11:35 a.m., she stated she worked the 6:00 a.m. - 2:00 p.m. shift and there had not been any other incidents or animosity between her and CNA C. She said the two of them usually got along. She said on 01/18/2024, she had just gotten to work when RN A asked her to talk to CNA C because she got Resident #2 up way too early and she transferred him alone. She said RN A told her CNA C would not listen to her. She said she and CNA D went to the room and saw CNA C in there. She said she asked CNA C to come to the door and then told her RN A asked her to go and talk to her because Resident #2 was a two-person transfer. She said CNA C got mad and clapped her hands saying she was tired of people telling her what to do. CNA B said she told CNA C she was just trying to keep her from getting in trouble. CNA B said she walked away and told RN A it was too early for this. CNA B said the altercation was only verbal and never got physical. CNA B said they went to the nurse's station and continued arguing back and forth. She said RN A and CNA D were there trying to separate them. She said she tried to go outside and smoke to diffuse the situation, but it was brought up that CNA C had a gun. CNA B said CNA D knew CNA C had a gun. She said CNA D said, Don't let her get her purse! CNA B said at that time, CNA C was going for her purse behind the nurse's station desk. She said CNA D said, Don't let her get it because she got a gun! and CNA C said, And Do (meaning she did have a gun). CNA B said she was getting her stuff to go smoke and CNA B walked up on her back (walked closely behind her). She said as she walked down the hall to go smoke, the other staff were still in the building. She said once she got outside, she could see CNA C walking towards her thru the glass door. She said she saw CNA C's bag under left arm and her right hand was inside the bag. She said when CNA C walked outside, she was talking and pointed the gun at her as soon as she got outside. She said she heard CNA C ranting and raving that she was tired of people telling her what to do. She said when CNA C pointed the gun at her, she (CNA C) was about one or two feet away from the building and about three feet away from her. She said CNA C stood right by residents' windows. She said the police found the bullet shell next to building where she shot the gun. She said after CNA C pointed the gun at her, she backed up and pointed it in the air and fired. She said she did not know CNA C had a gun in building before the incident. She said she previously heard CNA C say they would not catch her like that again. She said CNA C was referring to an incident with some other nurses who attacked her. She said CNA C never reported that incident, but other staff knew because she was upset about it. She said CNA C told her the nurses were in her face and talking loudly because she gave a resident the wrong food tray.</p> <p>In an interview with LVN V on 01/22/2024 at 12:20 p.m., she stated on 01/18/2024, she had the on-call phone and RN A called her to say there were two staff at the nurse's station fighting. She said she asked RN A what the situation was, and RN A said she and other staff pulled them apart and they walked out of the building. She said she called the DON, and the DON said the staff had to write a statement and leave the building. She said when she called CNA B and told her she needed to leave, CNA B went off on her (got very angry). She said CNA B told her she would not give her a statement.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In a telephone interview with the VP of Operations on 01/22/2024 at 12:40 p.m., she stated she was first notified of the incident the morning of 01/18/2024, when the Administrator called her. She said she told the Administrator to interview staff who witnessed the incident and call the police. She said when she arrived at the facility on 01/18/2024, they started safe survey interviews with all residents on the 100 hall, where the staff fought and on the 200 hall, where the staff was when she shot the gun. She said they talked to all staff who worked that day and sent a mass email to each resident's RP and family about the incident. She said they held a resident council meeting and staff meeting where they offered counseling to anybody who needed it. She said they contracted to have security in building because they were not aware if the shooter was arrested. She said CNA C called her when she was on her way to the building and she and CNA B did not have any incidents before that morning. She said CNA C told her that she and CNA B were cool because there was a previous incident where some nurses were trying to discipline her, and CNA B took up for her. CNA C said the incident started when she transferred a resident. She said CNA C told her CNA B said she did it incorrectly, but she previously observed CNA B transfer the resident that same way. She said CNA C told her CNA B said she never saw her do it that way, then they got into it (had a verbal altercation). She said CNA C told her CNA D was in between them and pulled her back while CNA B landed a lick (hit her) and RN A jumped in to get them apart. She said CNA C told her CNA B left, saying she did not have time for that while CNA D and RN A held her back. She said CNA C told her she told RN A and CNA D she was getting her bag and bus pass so she could leave for the day, and they eventually let her go. She said CNA C told her she proceeded out of the building thru the same door CNA B left from so she could walk towards the bus stop. She said CNA C told her she had the gun for her protection. She said she told CNA C it was a felony to go into a skilled nursing facility with a gun and the corporate office called the police. She said CNA C told her she had also called the police herself because they were trying to jump her. She said CNA C said there was a lot of staff outside, but after speaking to staff, they found that nobody else said they were outside. She said the other staff were inside trying to keep CNA C from going outside and nobody was outside trying to jump her. She said CNA D went outside after CNA C. She said the police had already gone to building by the time she arrived, and the shell was found in the parking lot. She said they completed staff education and counselors were going to talk to those who expressed uneasiness about the incident. She said none of the residents stated they were disturbed. She said Resident #2 and Resident #3, who were in the room where the incident started, did not have concerns. She said they had psych (psychiatric) services see both residents to make sure. She said they in-serviced all staff that if you see something, say something. She said they also educated staff on anger management, reporting, abuse/neglect, and having a gun in the facility.</p> <p>Observation and interview with Resident #2 on 01/22/2024 beginning at 1:30 p.m., revealed he was a larger male who self-ambulated in an electric wheelchair by using his chin to maneuver the controls. Resident #2 could not move his limbs. He stated CNA C was in his room getting him dressed the day of the incident. He said he usually got up at 7:00 a.m., but it was 6:00 a.m. when CNA C got him up. He said CNA C got frustrated and he got frustrated. He said when CNA B came, she was really calm. He said he heard CNA B say, I don't know how you did things where you came from, but around here, this is how we do it. He said the staff were arguing in the hallway but then things got physical when CNA C hit CNA B first. He said CNA C's arm went from down low and then down on CNA B's shoulder, like a windmill. He said the staff went down to the nurse's station, so he could not see anything after that, and he did not know how it ended. He said CNA D came up and stood beside them and did not get involved at all. Resident #2 said he was already in his chair during the incident, but the chair was not on. He said he was upset because CNA C said she was going to go get other residents up, and he told her she could not abandon him like that. He stated he felt safe at the facility, and he did not have any concerns because it was two girls fighting.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Focused Care at Beechnut		STREET ADDRESS, CITY, STATE, ZIP CODE 12777 Beechnut St Houston, TX 77072	
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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview with CNA D on 01/22/2024 at 1:40 p.m., she stated she worked the 6:00 a.m. - 2:00 p.m. shift. She stated there were no prior incidents between CNA B and CNA C that she knew of. She said CNA C told her she had an issue with some of the nurses because she got into it (had verbal altercations) with them the weekend before the gun incident about a wrong food tray. She said CNA C told her that she and the nurses argued, it got heated, and they went into the MDS office where they yelled in her face. She said CNA C received a verbal warning, but she felt she should not have gotten anything. She said CNA C said they were going to stop playing with her (stop harassing her), but she never said she was bringing a gun to the facility. She said she heard CNA B and CNA C arguing down the hall. She said the argument was about getting a resident up because CNA C said she saw other staff do it that way and she was tired of people telling her how to do her job. She said CNA C said she had gotten Resident #2 up safely so what did it matter. She said she saw both of their hands going up in each other's face and they were fanning each other's hands down. She said she told them to stop because they would lose their jobs. She said CNA C said, You stole me (hit me), oh no bitch, you stole me! She said she and RN A got between them, but they were going around them. She said CNA C said, I got something for you. She said CNA B had already gone outside and invited CNA C to go meet her outside. She said CNA C got her stuff, but they tried to keep her inside. She said CNA C said, I got something for this bitch. She said CNA C's bag was in the open area under the desk at the nurse's station. She said she and the MDS Nurse were standing at the door trying to calm CNA C down. She said the MDS Nurse said she would call the police if they fought. She said they tried to keep CNA C from going outside, but once she went outside, she instantly started digging in her purse and she came out of the purse with something. She said she and the MDS Nurse were right at the door with CNA C. She said she heard CNA B say, Oh you gone point the gun at me! She said CNA C then raised the gun and shot in the air. She said CNA C was on the sidewalk, near resident rooms when she shot the gun. She said CNA C was about a yard from the building and she was about a yard from CNA B. She said CNA C said, Ya'll bitches gone stop playing with me. She said CNA C said she quit and the MDS Nurse said, We already knew that. She said CNA C could have gone out the front door to catch the bus instead of going out the side door. She said the residents were getting up at that time.</p> <p>In an interview with Resident #3 on 01/22/2024 at 2:17 p.m., he stated the incident started in his room and then went to the nurse's station. He said he did not know how it started, but he saw one hit the other. He said one staff swung her hand back, but he did not know if she meant to hit the other staff, or if she just landed one accidentally. He said after that, he went outside and saw two police officers at the facility. Her stated he still felt safe in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In a telephone interview with RN A on 01/23/2024 at 12:52 p.m., she stated she was waiting for her relief on 01/18/2024 when she CNA C went and got her because she was having issues with Resident #2's wheelchair. She said when she went to the room, she told CNA C she was not sure how to work the wheelchair, but she would get someone who knew. She said she noticed Resident #2 was already in his chair, so she asked CNA C how she got him in there. She said CNA C said she transferred him by herself. She said she told CNA C it was not safe for her to do that, but she said she could do it that way. She said she told CNA C she needed to get someone else to help her with Resident #2. She said she went to find someone to help control Resident #2's wheelchair and saw CNA B with CNA D in front of the nurse's station. She said she told CNA B that CNA C had already gotten the resident up by herself and that she needed help with the controller on Resident #2's wheelchair. She said CNA B went to the room and then she heard some sounds coming from down the hall. She said she heard someone say, Stop fighting. She said the staff were very close together and one hit the other, but she did not know who hit who first. She said CNA B left the building because she was upset, and they tried to calm CNA C down and told her she could not go outside because CNA B was still out there. She said CNA C kept yelling that she had to get out. She said CNA C took her backpack and left the building. She said by that time, she went out of the building and heard the gunshot. She said she did not go to the door with the other staff. She said she did not hear anybody say anything about a gun while they were inside the building.</p> <p>In a follow-up interview with the Medical Records Coordinator on 01/24/2024 at 10:15 a.m., she stated after CNA C got into an altercation with the nurses when they were all in her face, CNA D said she (CNA C) told her, I am not gone worry about it because I got something for them. She said after the shooting incident, CNA C called her and said of course she had a gun because she went to school at night on the bus. She said when she went outside after the shooting incident, she heard CNA B tell CNA D, You been knew she had a gun? Why didn't you tell me? The Medical Records Coordinator said CNA D said she already knew CNA C had a gun in the building.</p> <p>Record review of the facility's 'Workplace Violence policy, revised 01/2022 revealed, The facility seeks to provide a safe workplace for all team members and has Zero Tolerance toward any type of workplace violence committed by or against team members. Team members are prohibited from making threats or engaging in violent activities. This list of behaviors, while not inclusive, provides examples of conduct that is prohibited. Causing physical injury to another person; Making threatening remarks; Aggressive or hostile behavior that creates a reasonable fear of injury to another person or subjects another individual to emotional distress; . Possession of a weapon while on facility property or while on facility business; . Any potentially dangerous situations must be reported immediately to a supervisor . Threats, threatening conduct, or any other acts of aggression or violence in the workplace will not be tolerated. Any team members determined to have committed such acts will be subject to disciplinary action, up to and including termination .</p> <p>Record review of the facility's policy on Firearms and Other Weapons revised 01/2022 revealed, All applicants, associates, contractors, subcontractors, or any other persons are prohibited from using or possessing (whether concealed or not) any weapons while on company premises, engaged in company business, or at company-related activities. The company follows state and federal laws regarding concealed weapons, and to the extent this policy conflicts with any such law, the applicable law governs.</p> <p>Record review of In-Service Training Report dated 01/18/2024 revealed all nursing staff were educated by the DON on safe transfers, including Hoyer Lifts and two-person transfers.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of In-Service Training Report dated 01/18/2024 revealed all nursing staff were educated by RN A on reviewing each resident's Kardex (a quick reference for nurses to write, organize, and easily reference key patient information that shapes their nursing care plan) on the plan of care and requesting assistance before providing care.</p> <p>Record review of In-Service Training Report dated 01/18/2024 revealed all nursing staff were educated by the physical therapy department regarding Resident #2's motorized wheelchair, including operation, drive mode, tilting, chin joystick, and recharging.</p> <p>Record review of In-Service Training Report dated 01/18/2024 revealed all facility staff were educated by the SW regarding workplace violence and reporting incidents of bullying, harassment, and retaliation and possession of a weapon.</p> <p>Record review of In-Service Training Report dated 01/18/2024 revealed all facility staff were educated by the SW regarding Abuse and Neglect.</p> <p>This was determined to be an Immediate Jeopardy (IJ) on 02/07/2024 at 9:40 a.m. The DON was notified. The DON was provided with the IJ template on 02/07/2024 at 9:40 a.m. A Plan of Removal was requested at that time.</p> <p>The following Plan of Removal submitted by the facility was accepted on 02/08/2024 at 11:52 a.m. :</p> <p>The facility failed to ensure that resident environment remained free of accidents and hazards.</p> <p>1. Immediate Action Taken</p> <p>* Identified staff were immediately suspended on 1/18/24 and police notified on 1/18/24. The residents that were located near were assessed by the Social Worker and Licensed Nurse to be offered the opportunity to have grief counseling by Psych Services to monitor for Post Traumatic Stress completed on 1/18/2024.</p> <p>* On 2/7/24 the social worker and Director of Nurses (DON), started education with all staff on the company policy for workplace violence, Use of clear bag policy at the community, and abuse and neglect, completed on 2/7/24. Employees that missed the in-service will not be allowed to work until this education has been completed.</p> <p>* The company will purchase clear bags for all employees to carry personal belongings into the facility in-service initiated on 1/19/24 and completed on 1/22/24. Clear bag policy was posted all over the community on 2/7/24.</p> <p>* The social worker and Director of Nursing initiated in- serviced to all staff on handguns prohibition policy, this will be completed on 2/8/24, all staff not available for the in-service will not be allowed to work until the in-service is completed with them.</p> <p>* An In-service by the Social Worker and corporate HR was started on 1/18/2024 to also provide grief counseling information from the employee through the employee's insurance company. This counseling was an immediate offer and is still available. There is no completion date because it is ongoing. Completed 1/18/2024 and ongoing.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>2. Identification of Residents Affected or Likely to be Affected:</p> <p>* On 1/18/2024 the DON and Social Worker completed the audit for any resident who was near and wanted therapy. We identified no residents that wanted therapy. An audit was completed on 1/18/2024.</p> <p>3. Actions to Prevent Occurrence/Recurrence:</p> <p>* The Social Worker and DON will validate daily x 10 days, that there are no residents that suffered stress due to the incident.</p> <p>* Any new licensed nurse hired by the facility will receive education upon hire on:</p> <ul style="list-style-type: none"> o Education on Workplace Violence will be given to all new employees upon hire. o Staff that missed the initial training will have to be in-serviced on workplace violenc [TRUNCATED]