

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/07/2024
NAME OF PROVIDER OR SUPPLIER  Bay Ridge Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  208 South Utah LA Porte, TX 77571	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45328</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident has the right to be free from abuse for 1 (Resident #1) of 5 residents reviewed for abuse.</p> <p>-The facility failed to ensure Resident #1 was free from abuse when CNA A allowed her significant other to verbally abuse Resident #1, allowed the significant other entry into the facility, and took him to Resident #1's room. The Significant other then threatened Resident #1 by pointing a gun at him.</p> <p>On 03/05/24 an Immediate Jeopardy (IJ) was identified. While the IJ template was removed on 03/07/24, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.</p> <p>This failure placed residents at risk of physical harm, mental anguish or emotional distress, pain and/or death.</p> <p>The findings included:</p> <p>Record review of Resident #1's Admission Record, dated 03/05/24, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. The resident's diagnoses included pressure ulcer of sacral region (the portion of your spine between your lower back and tailbone), paraplegia (condition that affects the lower half of the body, making it hard or impossible to walk, stand, or control the pelvic muscles), acute transverse myelitis demyelinating disease of central nervous system (neurological condition wherein the spinal cord is inflamed), and acquired absence (medical condition that indicates the loss or amputation) of right leg below knee.</p> <p>Record review of Resident #1's Quarterly MDS assessment, dated 02/05/24, revealed a BIMS score of 15, indicating intact cognitive skills. Further review revealed he required substantial/maximal assistance with toileting, bathing, and dressing.</p> <p>Record review of Resident #1's undated care plan revealed he required staff assistance for meeting emotional, intellectual, physical, and social needs related to physical limitations. The resident required extensive assistance with bed mobility and total assistance with transfers.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 03/04/24 at 12:15 p.m., revealed Resident #1 was lying in bed watching television. He said on 03/03/24 (he could not recall the time) Nurse B was in his room performing wound care on him while CNA A assisted. He said CNA A's phone kept going off and Nurse B told her not to answer. He said when they were done with his wound care, CNA A finally answered her phone, and it was her significant other. He said he could hear CNA A's significant other yelling at her and saying bitch, why didn't you answer this motherfucking phone. It does not take two hours to do wound care. He said he told Nurse B maybe CNA A's significant other needed to get his RN license or CNA so he could see that it took that long to do wound care. He said CNA A's significant other told her to tell him to shut the fuck up and CNA A told him. He said CNA A put her significant other on speaker phone and Resident #1 said he told him [NAME], you shut the fuck up. He said CNA A's significant other and him continued to curse at one another. He said CNA A left his room and came back approximately two minutes later and told him he needed to apologize to her significant other who was on speaker phone. He said her significant other also told him that he needed to apologize to him. He said he told them he was not going to apologize, and CNA A left his room again. He said it felt like CNA A was gone for approximately four to five minutes after she left his room the second time. He said Resident #2 was in his room when CNA A and her significant other entered his room. He said CNA A's significant other told her to get her bitch ass out and she left the room. He said he told Resident #2 to leave the room and he left. He said CNA A's significant other pulled out a gun and pointed it at him. He said soon after, Nurse B entered his room and pushed the significant other out. He said Nurse B told CNA A and her significant other that CNA A should have never let him in the building. He said he told police he did not want to press charges but did press charges against CNA A's significant other. He said he was not traumatized from having a gun pointed at him but was worried about the other residents. He said he was alright and felt safe at the facility.</p> <p>In an interview on 03/04/24 at 12:55 p.m., the Administrator said she had been working at the facility since August 2022. She said she received a call from the DON on Sunday, 03/03/24, between 2:30 p.m. and 2:50 p.m. She said she was told CNA A was doing wound care with Nurse B on Resident #1. She said she was told that while they were doing wound care, CNA A's significant other called her to go to lunch/go outside but she was saying to him she could not because she was in the middle of helping Nurse B. She said she guessed the significant other said some curse words to CNA A to relay to Resident #1 and from her understanding CNA A relayed what her significant other said to Resident #1. She said she was told Resident #1 said some curse words for CNA A to tell her significant other in return and then it sounded like it escalated to where her significant other wanted to come to the building so he could tell Resident #1 in person what he wanted to tell him. She said to her knowledge CNA A's significant other told her to go to the door and open it. She said CNA A opened the facility's door for her significant other and they went to Resident #1's room. She said she believed there was a yelling match and staff (unknown) called 911. She said the police came to the facility and escorted CNA A and her significant other off the property. She said she told the ADON to start in-servicing on violence in the workplace, abuse, neglect, and exploitation, to conduct safe surveys to check on the residents, gather witness statements, and told the DON to refer the resident to psych services to make sure he was okay and did not suffer any trauma. She said CNA A was suspended until further investigation was completed. She said the police were called and was told they would be patrolling the area a little more frequently for the next two weeks. She said all the keycode pads were recoded. She said they were planning on starting HIPPA staff in-service training violation because CNA A should not have been saying what care she was providing to Resident #1 and/or if the Resident #1's name was mentioned. She said staff were told that there were to be no more cell phones when providing care because it could have prevented the incident from occurring. She said the incident may have happened around 12:30ish p.m.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 03/04/24 at 1:47 p.m., the ADON said she had been working at the facility since 10/28/23. She said Nurse B called her on 03/03/24 and reported that CNA A and she were doing wound care on Resident #1. She said Nurse B told her CNA A was on the phone with her significant other who told CNA A that it was taking too long to do wound care. She said she was not sure if CNA A had her phone on speaker or at some point the significant other told CNA A to put the phone on speaker. She said Nurse B told her when CNA A had her phone on speaker, Resident #1 and the significant other started saying f-U's to each other and CNA A's significant other threatened to come to the facility with a handgun to handle Resident #1. She said she went to the facility and the cops were on the scene. She said she found out that CNA A entered the keycode in to the south hall's door, let her significant other inside the facility, and escorted him to Resident #1's room. She said she was present when Nurse B was talking to the cops and Nurse B told them the significant other had a handgun in his waistband. She said she walked away and went to speak with the resident. She said Resident #1 told her CNA A's significant other had a handgun, that it was visible, was in his hand, and went inside his room. She said she asked Resident #1 if the significant other pointed the handgun at him and he told her no. She said she asked him if he felt safe and he told her yes. She said Resident #1 told her he did not feel traumatized and did not need psych services. She said he told her the significant other said he would be back.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In a telephone interview on 03/04/24 at 4:14 p.m., Nurse B said CNA A was helping her with Resident #1's wound care and had no clue that she was on the phone because she had her air pods/headphones in her ear. She said she was in the middle of taking off Resident #1's dressings and putting on new ones, and CNA was making and getting the bedding ready. She said CNA A said a few things (did not know what she said) and Resident #1 asked CNA A if she was talking to the air because they did not know she was on the phone. She said out of nowhere, CNA A blurted out it does take me two hours to do wound care. She said CNA A's significant other was upset because it was taking two hours. She said she asked CNA A what she was talking about, and CNA A told her she was talking to her significant other. She said she asked her what she meant, and she said CNA A told her that she answered her phone on her air pods/headphones. She said she asked CNA A to please not do that, especially at bedside. She said CNA A ignored her and continued talking on the phone. She said Resident #1 told CNA A to tell her significant other to go get his RN license and become a nurse and when he got his RN license and had to do wound care, he would see how extensive his wounds were and that it took two hours. She said after Resident #1 said that she carried on with what she was doing and thought CNA A got off the phone but then out of nowhere CNA A told Resident #1 that her significant other said, shut the fuck up. She said she was shocked that CNA A repeated those words, was still on her phone, and said that to the resident. She said she asked CNA A to exit the room, that it was very inappropriate, and why would she tell that to a resident. She said CNA A got an attitude and exited the room. She said CNA A went back to the hall and was walking around talking to her significant other. She said when she was done helping another resident, she went back down to Resident #1's room. She said Resident #1 told her CNA A had come in his room after she left, was on speaker phone with her significant other and cussed him out at bedside. She said that was when she found out CNA A was not down the hall. She said she was super busy because she was at the nurse's station charting, but from the corner of her eye she saw people walk past her but did not see who it was. She said she then heard really, really, really, loud screaming and was like what in the heck and triggered that oh my god it was probably CNA A's significant other going after Resident #1. She said she had a bad feeling about it because of the way they had talked and threatened each other over the phone. She said she jumped up, ran to the room, and heard the significant other tell Resident #1 I'm not a fucking boy, I'm a fucking man, and I am about to show you. She said when she got to the resident's room, CNA A's significant other looked at CNA A and told her to step out the room and shut the door behind her. She said she told CNA A's significant other, oh no, we are not doing this. She said he was at Resident #1's bedside hovering over him. She said CNA A's significant other was wearing baggy pants and a real big baggy jacket, so she did not see the pistol at first. She said he had one arm around his waist, and had his other arm bunched up like he was nudging at Resident #1 trying to intimidate him while he was also screaming at him. She said she told CNA A's significant other we are not doing this; you need to get out of the room right now. She said Resident #1 told her that it was okay and to let him stay but she said no we are not doing this. She said she told Resident #1 they were not going to have him in there threatening him and that it was not happening. She said she was literally screaming at the top of her lungs. She said Resident #1 looked at her again and said that it was okay and to let him stay and she said she told the resident no. She said at that point she was confused and did not understand why the resident was telling her to let him stay. She said she had no clue what was going on and all she knew was CNA A let her significant other in the building and he was screaming at Resident #1 and had a pistol. She said at the time when she got in front of CNA A's significant other, she did not see the pistol. She said when he turned around, she was in between him and Resident #1, and told him to exit the room. She said he was trying to push up against her, nudging her, like a chest pump. She said she would not move so he did not get to Resident #1, but he was trying to stay there. She said she told him no, forced him backwards out of the room, and when he turned around to get in the hallway that was when she saw the pistol. She said when she noticed the pistol, she was like oh my god, just play it off, pretend you did not see it and she continued to escort CNA A and her significant other out of the building. She said she told them there was the exit and kept being forceful with them and said, exit the building, both of y'all. She said when she finally got CNA A and her significant other out the door area, she told both of them, do not come back on the premises, do not come back in this door. She said he did not care when he got out to the door. She said he was flaunting the pistol everywhere. She said he had it in his hand and was nonchalantly talking. She said she shut the door</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 03/04/24 at 5:33 p.m., CNA B said she had been working at the facility for [AGE] years and worked the 6:00 a.m. to 6:00 p.m. shift. She said she would tell the Administrator if there was someone in the building with a weapon but said she did not know what she would do if the administrator was not at the facility. She said she did not know what the facility's Emergency Procedure - Workplace Aggression/Violence procedure was.</p> <p>In an interview on 03/05/24 at 8:02 a.m., CNA C said she had been working at the facility for approximately 4 months. She said she received ANE, HIPPA, and cell phone use training yesterday, 03/04/24. She said the Administrator went over some other information during the in-service trainings, but she could not remember what it was about. She said she was not feeling well, and her brain was kind of foggy.</p> <p>In an interview on 03/05/24 at 10:08 a.m., CNA D said she had been working at the facility for approximately 2 1/2 years. She said she did not receive Emergency Procedure - Aggression/Violence training. She said it was her signature on the in-service sign in sheet, but said she thought she was just signing off on getting the abuse policy. She said the sign-in sheet did not have the topics listed when she signed.</p> <p>In a follow-up interview on 03/05/24 at 10:32 a.m., CNA B said it was her signature on the in-service sign in sheet. She said they (could not recall who gave out the policies) gave out copy of the policies, reviewed the information, but said she just could not recall what was covered during the in-service trainings.</p> <p>In an interview on 03/05/24 at 12:35 p.m., Resident #2 said he was in Resident #1's room when a man came in and started arguing with Resident #1. He said he did not see a gun and did not know who the man was. He said Resident #1 told him to leave the room and he said he left right away. He said he did not remember what time it happened.</p> <p>In a telephone interview on 03/05/24 at 2:03 p.m., CNA A said she was in Resident #1's room doing care on him. She said her significant other called when she was doing wound care and she answered. She said when she answered the call, Resident #1 said something smart (could not recall what was said) to her significant other. She said Resident #1 then called her significant other a bitch, said he was a stay-at-home dad, and called him a MF word. She said Resident #1 was being vulgar and saying the B word and she told Resident #1 to respect her significant other and he said no. She said she told Resident #1 then to respect her by respecting her significant other. She said she was talking to her significant other on her headphones. She said her significant other did not say anything, but Resident #1 was still talking vulgarly. She said her significant other went to the facility to get her. She said she let her significant other in the building through the side door. She said she took her significant other to Resident #1's room, and he told Resident #1 to respect him as a man three times and then they left. She said her significant other did not have a gun. She said they were in Resident #1's room for about a minute. She said she was not on the phone when she was doing patient care but was on the phone while getting the bed linen up off the floor.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 03/07/24 at 8:22 a.m., the DON said the ADON notified her on 03/03/24 and she notified the Administrator. She said the ADON told her that CNA A may have to be sent home. She said the ADON told her that CNA A let her significant other in the building and in Resident #1's room. She said when the ADON made it to the building the police were already on the scene, and she said she told the ADON to go ahead and figure out what was going on and to call her back. She said she called the Administrator and told her what the ADON said happened. She said they got on the phone with regional support and the Regional Director of Operations, and the Administrator called in the report to the State. She said the ADON called her back, told her something about CNA A was on her phone, there was something about air pods, and that her significant other could hear conversations. She said she was told there was something about Resident #1 getting smart, phone being put on speaker, and an exchange of words between CNA A's significant other and Resident #1. She said she was told that CNA A's significant other went to the facility, and CNA A let him in Resident #1's room. She said the ADON said Nurse B and Resident #1 saw a pistol.</p> <p>Record review of the facility's policy titled Abuse Prohibition Policy, revised date 11/07/23, read in part .each resident has the right to be free from abuse .Policy: 1. The facility will prohibit neglect, mental or physical abuse .Definitions: Abuse means the willful infliction of injury .intimidation .</p> <p>Record review of the facility's policy titled Emergency Procedure - Workplace Aggression/Violence, dated 06/07/2023, read in part . The following procedure is utilized in the event of a Workplace Aggression/Violence incident in or near our facility. 1. If an incident or verbal aggression escalates or appears to be escalating to physical aggression, announce CODE GRAY: AGGRESSIVE (or any other code as adopted by the facility) with the location of the incident. 2. Call 911 if there is threat-based screaming, fighting, weapons involved, or any threat of danger. IF IN DOUBT, CALL 911. Provide the 911 dispatcher with as much relevant information as possible. 3. Instruct staff to move the residents and themselves immediately to safe, secure refuge and remain there until ALL CLEAR .</p> <p>This was determined to be an Immediate Jeopardy (IJ) and the Administrator was notified on 03/05/24 at 5:03 p.m. The IJ template was presented to the facility and the POR was requested at this time.</p> <p>The following Plan of Removal submitted by the facility was accepted on 03/06/24 at 12:08 p.m. and included:</p> <p>Plan of Removal</p> <p>Immediate Jeopardy</p> <p>On 03/03/2024, an abbreviated survey was initiated at [the facility]. On 03/05/2024 the surveyor provided an Immediate Jeopardy (IJ)Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to resident health and safety.</p> <p>The notification of Immediate Jeopardy states as follows:</p> <p>F689: Quality of Care, Accidents/Hazards the facility failed to provide a safe environment on 3/3/2024 when CNA allowed her significant other, who was armed with a pistol, to enter the facility through south hall's locked and coded door and access to Resident #1 Room.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Administrator/Designee conducted life safety satisfaction assessment for all residents to ensure that no other resident affected completed by 3/5/2024. The facility also conducted In-Services on Workplace aggression/violence and ANE. Documents are in POR binder and uploaded to charts. The facility will follow policy and procedure regarding Workplace Aggression/Violence and ANE. Administrator/Designee will conduct in-services and they will be completed by 3/5/2024.</p> <p>Action on CNA A - suspended pending investigation on 3/3/2024.</p> <p>Psychosocial assessment completed on Resident #1 by social worker and resident no trauma/not affected by incident. Psychologists also saw Resident #1 and agreed to meet therapist on the next visit. Stated he was not affected by the incident.</p> <p>Nurse A was referred to our free services for Psych Services</p> <p>Action:</p> <p>Immediately, on March 5, 2024, Clinical Specialist in serviced DON and ADM to include Quality of care and treatment provided to facility residents. Training and competencies for DON, and ADM were completed on March 5, 2024: workplace violence, facility security, and ANE.</p> <p>On March 5, 2024, ADM/DON initiated in-services with all staff. In-services to include Workplace Aggression/violence and ANE, and life satisfaction surveys and any abnormalities will be given to family, physician, and ADM/DON. Completion date for staff in-services to be completed March 5, 2024. All Nursing staff will not be allowed to work until in servicing has been completed. Any contract staff or PRN staff will be in-service prior to working the floor.</p> <p>HIPAA and no use of cell phone while providing care in services was initiated on March 5, 2024, by ADM. Training will be documented and completed on March 5, 2024. Staff will not be allowed to work until in servicing has been completed. Any contract staff or PRN staff will be in-service prior to working the floor.</p> <p>The above training material (Workplace Aggression/violence and ANE) will be incorporated into the new hire orientation by ADM effective March 5, 2024, and ongoing.</p> <p>On March 5, 2024 an audit was conducted by ADM/Designee to identify other residents with potential trauma of from violence in the work place. Via direct observation, staff interviews, and record review, no other residents were identified as having an issue.</p> <p>In order to monitor current residents for potential risk, ADM/Designee will monitor residents with change in condition daily beginning March 5, 2024, for 30 days on all residents via Life Satisfaction/Trauma. The purpose of this log is to monitor residents with change in conditions. DON compliance will be monitored weekly by ADM/Designee for 90 days. Thereafter, QA will monitor quarterly up to a year for compliance of change of condition. If any issues are identified, the physician will be contacted (by ADM/Designee) immediately for further medical management and family/POA of the same. The facility QA Committee will meet weekly for the next eight weeks to review compliance with the plan of action. If no further concerns noted, will continue to monitor as per routine facility QA Committee.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Start Date: 3/5/2024</p> <p>Completion Date: 3/5/2024</p> <p>Responsible: ADM and DON.</p> <p>Monitoring of the POR included:</p> <p>During interviews on 03/06/24 and 03/07/24, with staff from all shifts, revealed the following staff members were able to verbalize an understanding of the steps to take if an incident of workplace aggression/violence occurred: Administrator, DON, ADON, Rehab Director, Housekeeping/Laundry Manager, Nurses D, E and F, Medication Aide A, and CNAs A, B, E, and F.</p> <p>Record review of in-service sign in sheets for Workplace Aggression/Violence, ANE, HIPPA and cell phones revealed 44 staff signatures.</p> <p>Record review of Resident Life Satisfaction Round surveys, dated 03/05/24, revealed all 42 resident surveys were completed.</p> <p>Record review of CNA A's personnel file revealed the employee was suspended on 03/03/24 pending the facility's investigation.</p> <p>Record review of Resident #1's progress notes revealed the Social Worker completed a psychosocial assessment and resident reported no trauma from the incident.</p> <p>An Immediate Jeopardy was identified on 03/05/24 at 5:03 p.m. While the IJ was removed on 03/07/24, the facility remained out of compliance at a scope of isolated and severity of no actual harm with potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems/plan of correction.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/07/2024
NAME OF PROVIDER OR SUPPLIER  Bay Ridge Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  208 South Utah LA Porte, TX 77571	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45328</p> <p>Based on observation, interview, and record review, the facility failed to ensure that the resident environment remains as free of accident hazards for 1 (Resident #1) of 5 residents reviewed for quality of care.</p> <p>-The facility failed to provide a safe environment when CNA A allowed her significant other, who was armed with a pistol, entry into the facility's locked building, and access to Resident #1.</p> <p>-The facility failed to provide the Emergency Procedure - Workplace Aggression/Violence training.</p> <p>On 03/05/24 an Immediate Jeopardy (IJ) was identified. While the IJ template was removed on 03/07/24, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.</p> <p>This failure placed residents at risk of physical harm, mental anguish or emotional distress, pain and/or death.</p> <p>The findings included:</p> <p>Record review of Resident #1's Admission Record, dated 03/05/24, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. The resident's diagnoses included pressure ulcer of sacral region (the portion of your spine between your lower back and tailbone), paraplegia (condition that affects the lower half of the body, making it hard or impossible to walk, stand, or control the pelvic muscles), acute transverse myelitis demyelinating disease of central nervous system (neurological condition wherein the spinal cord is inflamed), and acquired absence (medical condition that indicates the loss or amputation) of right leg below knee.</p> <p>Record review of Resident #1's Quarterly MDS assessment, dated 02/05/24, revealed a BIMS score of 15, indicating intact cognitive skills. Further review revealed he required substantial/maximal assistance with toileting, bathing, and dressing.</p> <p>Record review of Resident #1's undated care plan revealed he required staff assistance for meeting emotional, intellectual, physical, and social needs related to physical limitations. The resident required extensive assistance with bed mobility and total assistance with 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>Observation and interview on 03/04/24 at 12:15 p.m., revealed Resident #1 was lying in bed watching television. He said on 03/03/24 (he could not recall the time) Nurse B was in his room performing wound care on him while CNA A assisted. He said CNA A's phone kept going off and Nurse B told her not to answer. He said when they were done with his wound care, CNA A finally answered her phone, and it was her significant other. He said he could hear CNA A's significant other yelling at her and saying bitch, why didn't you answer this motherfucking phone. It does not take two hours to do wound care. He said he told Nurse B maybe CNA A's significant other needed to get his RN license or CNA so he could see that it took that long to do wound care. He said CNA A's significant other told her to tell him to shut the fuck up and CNA A told him. He said CNA A put her significant other on speaker phone and Resident #1 said he told him [NAME], you shut the fuck up. He said CNA A's significant other and him continued to curse at one another. He said CNA A left his room and came back approximately two minutes later and told him he needed to apologize to her significant other who was on speaker phone. He said her significant other also told him that he needed to apologize to him. He said he told them he was not going to apologize, and CNA A left his room again. He said it felt like CNA A was gone for approximately four to five minutes after she left his room the second time. He said Resident #2 was in his room when CNA A and her significant other entered his room. He said CNA A's significant other told her to get her bitch ass out and she left the room. He said he told Resident #2 to leave the room and he left. He said CNA A's significant other pulled out a gun and pointed it at him. He said soon after, Nurse B entered his room and pushed the significant other out. He said Nurse B told CNA A and her significant other that CNA A should have never let him in the building. He said he told police he did not want to press charges but did press charges against CNA A's significant other. He said he was not traumatized from having a gun pointed at him but was worried about the other residents. He said he was alright and felt safe at the facility.</p> <p>In an interview on 03/04/24 at 12:55 p.m., the Administrator said she had been working at the facility since August 2022. She said she received a call from the DON on Sunday, 03/03/24, between 2:30 p.m. and 2:50 p.m. She said she was told CNA A was doing wound care with Nurse B on Resident #1. She said she was told that while they were doing wound care, CNA A's significant other called her to go to lunch/go outside but she was saying to him she could not because she was in the middle of helping Nurse B. She said she guessed the significant other said some curse words to CNA A to relay to Resident #1 and from her understanding CNA A relayed what her significant other said to Resident #1. She said she was told Resident #1 said some curse words for CNA A to tell her significant other in return and then it sounded like it escalated to where her significant other wanted to come to the building so he could tell Resident #1 in person what he wanted to tell him. She said to her knowledge CNA A's significant other told her to go to the door and open it. She said CNA A opened the facility's door for her significant other and they went to Resident #1's room. She said she believed there was a yelling match and staff (unknown) called 911. She said the police came to the facility and escorted CNA A and her significant other off the property. She said she told the ADON to start in-servicing on violence in the workplace, abuse, neglect, and exploitation, to conduct safe surveys to check on the residents, gather witness statements, and told the DON to refer the resident to psych services to make sure he was okay and did not suffer any trauma. She said CNA A was suspended until further investigation was completed. She said the police were called and was told they would be patrolling the area a little more frequently for the next two weeks. She said all the keycode pads were recoded. She said they were planning on starting HIPPA staff in-service training violation because CNA A should not have been saying what care she was providing to Resident #1 and/or if the Resident #1's name was mentioned. She said staff were told that there were to be no more cell phones when providing care because it could have prevented the incident from occurring. She said the incident may have happened around 12:30ish p.m.</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 on 03/04/24 at 1:47 p.m., the ADON said she had been working at the facility since 10/28/23. She said Nurse B called her on 03/03/24 and reported that CNA A and she were doing wound care on Resident #1. She said Nurse B told her CNA A was on the phone with her significant other who told CNA A that it was taking too long to do wound care. She said she was not sure if CNA A had her phone on speaker or at some point the significant other told CNA A to put the phone on speaker. She said Nurse B told her when CNA A had her phone on speaker, Resident #1 and the significant other started saying f-U's to each other and CNA A's significant other threatened to come to the facility with a handgun to handle Resident #1. She said she went to the facility and the cops were on the scene. She said she found out that CNA A entered the keycode in to the south hall's door, let her significant other inside the facility, and escorted him to Resident #1's room. She said she was present when Nurse B was talking to the cops and Nurse B told them the significant other had a handgun in his waistband. She said she walked away and went to speak with the resident. She said Resident #1 told her CNA A's significant other had a handgun, that it was visible, was in his hand, and went inside his room. She said she asked Resident #1 if the significant other pointed the handgun at him and he told her no. She said she asked him if he felt safe and he told her yes. She said Resident #1 told her he did not feel traumatized and did not need psych services. She said he told her the significant other said he would be back.</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 on 03/04/24 at 4:14 p.m., Nurse B said CNA A was helping her with Resident #1's wound care and had no clue that she was on the phone because she had her air pods/headphones in her ear. She said she was in the middle of taking off Resident #1's dressings and putting on new ones, and CNA was making and getting the bedding ready. She said CNA A said a few things (did not know what she said) and Resident #1 asked CNA A if she was talking to the air because they did not know she was on the phone. She said out of nowhere, CNA A blurted out it does take me two hours to do wound care. She said CNA A's significant other was upset because it was taking two hours. She said she asked CNA A what she was talking about, and CNA A told her she was talking to her significant other. She said she asked her what she meant, and she said CNA A told her that she answered her phone on her air pods/headphones. She said she asked CNA A to please not do that, especially at bedside. She said CNA A ignored her and continued talking on the phone. She said Resident #1 told CNA A to tell her significant other to go get his RN license and become a nurse and when he got his RN license and had to do wound care, he would see how extensive his wounds were and that it took two hours. She said after Resident #1 said that she carried on with what she was doing and thought CNA A got off the phone but then out of nowhere CNA A told Resident #1 that her significant other said, shut the fuck up. She said she was shocked that CNA A repeated those words, was still on her phone, and said that to the resident. She said she asked CNA A to exit the room, that it was very inappropriate, and why would she tell that to a resident. She said CNA A got an attitude and exited the room. She said CNA A went back to the hall and was walking around talking to her significant other. She said when she was done helping another resident, she went back down to Resident #1's room. She said Resident #1 told her CNA A had come in his room after she left, was on speaker phone with her significant other and cussed him out at bedside. She said that was when she found out CNA A was not down the hall. She said she was super busy because she was at the nurse's station charting, but from the corner of her eye she saw people walk past her but did not see who it was. She said she then heard really, really, really, loud screaming and was like what in the heck and triggered that oh my god it was probably CNA A's significant other going after Resident #1. She said she had a bad feeling about it because of the way they had talked and threatened each other over the phone. She said she jumped up, ran to the room, and heard the significant other tell Resident #1 I'm not a fucking boy, I'm a fucking man, and I am about to show you. She said when she got to the resident's room, CNA A's significant other looked at CNA A and told her to step out the room and shut the door behind her. She said she told CNA A's significant other, oh no, we are not doing this. She said he was at Resident #1's bedside hovering over him. She said CNA A's significant other was wearing baggy pants and a real big baggy jacket, so she did not see the pistol at first. She said he had one arm around his waist, and had his other arm bunched up like he was nudging at Resident #1 trying to intimidate him while he was also screaming at him. She said she told CNA A's significant other we are not doing this; you need to get out of the room right now. She said Resident #1 told her that it was okay and to let him stay but she said no we are not doing this. She said she told Resident #1 they were not going to have him in there threatening him and that it was not happening. She said she was literally screaming at the top of her lungs. She said Resident #1 looked at her again and said that it was okay and to let him stay and she said she told the resident no. She said at that point she was confused and did not understand why the resident was telling her to let him stay. She said she had no clue what was going on and all she knew was CNA A let her significant other in the building and he was screaming at Resident #1 and had a pistol. She said at the time when she got in front of CNA A's significant other, she did not see the pistol. She said when he turned around, she was in between him and Resident #1, and told him to exit the room. She said he was trying to push up against her, nudging her, like a chest pump. She said she would not move so he did not get to Resident #1, but he was trying to stay there. She said she told him no, forced him backwards out of the room, and when he turned around to get in the hallway that was when she saw the pistol. She said when she noticed the pistol, she was like oh my god, just play it off, pretend you did not see it and she continued to escort CNA A and her significant other out of the building. She said she told them there was the exit and kept being forceful with them and said, exit the building, both of y'all. She said when she finally got CNA A and her significant other out the door area, she told both of them, do not come back on the premises, do not come back in this door. She said he did not care when he got out to the door. She said he was flaunting the pistol everywhere. She said he had it in his hand and was nonchalantly talking. She said she shut the door</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 on 03/04/24 at 5:33 p.m., CNA B said she had been working at the facility for [AGE] years and worked the 6:00 a.m. to 6:00 p.m. shift. She said she would tell the Administrator if there was someone in the building with a weapon but said she did not know what she would do if the administrator was not at the facility. She said she did not know what the facility's Emergency Procedure - Workplace Aggression/Violence procedure was.</p> <p>In an interview on 03/05/24 at 8:02 a.m., CNA C said she had been working at the facility for approximately 4 months. She said she received ANE, HIPPA, and cell phone use training yesterday, 03/04/24. She said the Administrator went over some other information during the in-service trainings, but she could not remember what it was about. She said she was not feeling well, and her brain was kind of foggy.</p> <p>In an interview on 03/05/24 at 10:08 a.m., CNA D said she had been working at the facility for approximately 2 1/2 years. She said she did not receive Emergency Procedure - Aggression/Violence training. She said it was her signature on the in-service sign in sheet, but said she thought she was just signing off on getting the abuse policy. She said the sign-in sheet did not have the topics listed when she signed.</p> <p>In a follow-up interview on 03/05/24 at 10:32 a.m., CNA B said it was her signature on the in-service sign in sheet. She said they (could not recall who gave out the policies) gave out copy of the policies, reviewed the information, but said she just could not recall what was covered during the in-service trainings.</p> <p>In an interview on 03/05/24 at 12:35 p.m., Resident #2 said he was in Resident #1's room when a man came in and started arguing with Resident #1. He said he did not see a gun and did not know who the man was. He said Resident #1 told him to leave the room and he said he left right away. He said he did not remember what time it happened.</p> <p>In a telephone interview on 03/05/24 at 2:03 p.m., CNA A said she was in Resident #1's room doing care on him. She said her significant other called when she was doing wound care and she answered. She said when she answered the call, Resident #1 said something smart (could not recall what was said) to her significant other. She said Resident #1 then called her significant other a bitch, said he was a stay-at-home dad, and called him a MF word. She said Resident #1 was being vulgar and saying the B word and she told Resident #1 to respect her significant other and he said no. She said she told Resident #1 then to respect her by respecting her significant other. She said she was talking to her significant other on her headphones. She said her significant other did not say anything, but Resident #1 was still talking vulgarly. She said her significant other went to the facility to get her. She said she let her significant other in the building through the side door. She said she took her significant other to Resident #1's room, and he told Resident #1 to respect him as a man three times and then they left. She said her significant other did not have a gun. She said they were in Resident #1's room for about a minute. She said she was not on the phone when she was doing patient care but was on the phone while getting the bed linen up off the floor.</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 on 03/07/24 at 8:22 a.m., the DON said the ADON notified her on 03/03/24 and she notified the Administrator. She said the ADON told her that CNA A may have to be sent home. She said the ADON told her that CNA A let her significant other in the building and in Resident #1's room. She said when the ADON made it to the building the police were already on the scene, and she said she told the ADON to go ahead and figure out what was going on and to call her back. She said she called the Administrator and told her what the ADON said happened. She said they got on the phone with regional support and the Regional Director of Operations, and the Administrator called in the report to the State. She said the ADON called her back, told her something about CNA A was on her phone, there was something about air pods, and that her significant other could hear conversations. She said she was told there was something about Resident #1 getting smart, phone being put on speaker, and an exchange of words between CNA A's significant other and Resident #1. She said she was told that CNA A's significant other went to the facility, and CNA A let him in Resident #1's room. She said the ADON said Nurse B and Resident #1 saw a pistol.</p> <p>Record review of the facility's policy titled 'Emergency Procedure - Workplace Aggression/Violence, dated 06/07/2023, read in part . The following procedure is utilized in the event of a Workplace Aggression/Violence incident in or near our facility. 1. If an incident or verbal aggression escalates or appears to be escalating to physical aggression, announce CODE GRAY: AGGRESSIVE (or any other code as adopted by the facility) with the location of the incident. 2. Call 911 if there is threat-based screaming, fighting, weapons involved, or any threat of danger. IF IN DOUBT, CALL 911. Provide the 911 dispatcher with as much relevant information as possible. 3. Instruct staff to move the residents and themselves immediately to safe, secure refuge and remain there until ALL CLEAR .</p> <p>This was determined to be an Immediate Jeopardy (IJ) and the Administrator was notified on 03/05/24 at 5:03 p.m. The IJ template was presented to the facility and the POR was requested at this time .</p> <p>The following Plan of Removal submitted by the facility was accepted on 03/06/24 at 12:08 p.m. and included:</p> <p>Plan of Removal</p> <p>Immediate Jeopardy</p> <p>On 03/03/2024, an abbreviated survey was initiated at [the facility]. On 03/05/2024 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to resident health and safety.</p> <p>The notification of Immediate Jeopardy states as follows:</p> <p>F689: Quality of Care, Accidents/Hazards the facility failed to provide a safe environment on 3/3/2024 when CNA allowed her significant other, who was armed with a pistol, to enter the facility through south hall's locked and coded door and access to Resident #1 Room.</p> <p>Administrator/Designee conducted life safety satisfaction assessment for all residents to ensure that no other resident affected completed by 3/5/2024. The facility also conducted In-Services on Workplace aggression/violence and ANE. Documents are in POR binder and uploaded to charts. The facility will follow policy and procedure regarding Workplace Aggression/Violence and ANE. Administrator/Designee will conduct in-services and they will be completed by 3/5/2024.</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>Action on CNA A - suspended pending investigation on 3/3/2024.</p> <p>Psychosocial assessment completed on Resident #1 by social worker and resident no trauma/not affected by incident. Psychologists also saw Resident #1 and agreed to meet therapist on the next visit. Stated he was not affected by the incident.</p> <p>Nurse A was referred to our free services for Psych Services</p> <p>Action:</p> <p>Immediately, on March 5, 2024, Clinical Specialist in serviced DON and ADM to include Quality of care and treatment provided to facility residents. Training and competencies for DON, and ADM were completed on March 5, 2024: workplace violence, facility security, and ANE.</p> <p>On March 5, 2024, ADM/DON initiated in-services with all staff. In-services to include Workplace Aggression/violence and ANE, and life satisfaction surveys and any abnormalities will be given to family, physician, and ADM/DON. Completion date for staff in-services to be completed March 5, 2024. All Nursing staff will not be allowed to work until in servicing has been completed. Any contract staff or PRN staff will be in-service prior to working the floor.</p> <p>HIPAA and no use of cell phone while providing care in services was initiated on March 5, 2024, by ADM. Training will be documented and completed on March 5, 2024. Staff will not be allowed to work until in servicing has been completed. Any contract staff or PRN staff will be in-service prior to working the floor.</p> <p>The above training material (Workplace Aggression/violence and ANE) will be incorporated into the new hire orientation by ADM effective March 5, 2024, and ongoing.</p> <p>On March 5, 2024 an audit was conducted by ADM/Designee to identify other residents with potential trauma of from violence in the work place. Via direct observation, staff interviews, and record review, no other residents were identified as having an issue.</p> <p>In order to monitor current residents for potential risk, ADM/Designee will monitor residents with change in condition daily beginning March 5, 2024, for 30 days on all residents via Life Satisfaction/Trauma. The purpose of this log is to monitor residents with change in conditions. DON compliance will be monitored weekly by ADM/Designee for 90 days. Thereafter, QA will monitor quarterly up to a year for compliance of change of condition. If any issues are identified, the physician will be contacted (by ADM/Designee) immediately for further medical management and family/POA of the same. The facility QA Committee will meet weekly for the next eight weeks to review compliance with the plan of action. If no further concerns noted, will continue to monitor as per routine facility QA Committee.</p> <p>Start Date: 3/5/2024</p> <p>Completion Date: 3/5/2024</p> <p>Responsible: ADM and DON.</p> <p>(continued on next page)</p>		

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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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Monitoring of the POR included:</p> <p>During interviews on 03/06/24 and 03/07/24, with staff from all shifts, revealed the following staff members were able to verbalize an understanding of the steps to take if an incident of workplace aggression/violence occurred: Administrator, DON, ADON, Rehab Director, Housekeeping/Laundry Manager, Nurses D, E and F, Medication Aide A, and CNAs A, B, E, and F.</p> <p>Record review of in-service sign in sheets for Workplace Aggression/Violence, ANE, HIPPA and cell phones revealed 44 staff signatures.</p> <p>Record review of Resident Life Satisfaction Round surveys, dated 03/05/24, revealed all 42 resident surveys were completed.</p> <p>Record review of CNA A's personnel file revealed the employee was suspended on 03/03/24 pending the facility's investigation.</p> <p>Record review of Resident #1's progress notes, revealed the Social Worker completed a psychosocial assessment and resident reported no trauma from the incident.</p> <p>An Immediate Jeopardy was identified on 03/05/24 at 5:03 p.m. While the IJ was removed on 03/07/24, the facility remained out of compliance at a scope of isolated and severity of no actual harm with potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems/plan of correction.</p>