Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	74908	A. BUILDING: _____ B. WING _____	C 02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE AT ST CLOUD	4641 OLD CANOE CREEK ROAD SAINT CLOUD, FL 34769

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	INITIAL COMMENTS Complaint survey #2025001902 was conducted from to . The complaint was substantiated. Aspire at St. Cloud had deficiencies found at the time of the visit.	N 000		
N 042 SS=D	400.1183 FS Resident Grievances and Complaints (1) Every nursing home must have a grievance procedure available to its residents and their families. The grievance procedure must include: (a) An explanation of how to pursue redress of a grievance. (b) The names, job titles, and telephone numbers of the employees responsible for implementing the facility's grievance procedure. The list must include the address and the toll-free telephone numbers of the ombudsman and the agency. (c) A simple description of the process through which a resident may, at any time, contact the toll-free telephone hotline of the ombudsman or the agency to report the unresolved grievance. (d) A procedure for providing assistance to residents who cannot prepare a written grievance without help. (2) Each nursing home facility shall maintain records of all grievances and a report, subject to agency inspection, of the total number of grievances handled, a categorization of the cases underlying the grievances, and the final disposition of the grievances. (3) Each facility must respond to the grievance within a reasonable time after its submission. (4) The agency may investigate any grievance at any time. This Statute or Rule is not met as evidenced by: Based on interview, and record review, the facility	N 042	1) On , Resident #7 reported	

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N 042	Continued From page 1 failed to ensure staff were knowledgeable of and followed their grievance process for 1 of 2 residents reviewed for grievances, of a total sample of 8 residents, (#7). Findings: Review of resident #7's medical record revealed she was admitted to the facility on with diagnoses including , , , (that affects the), , , , type 2 , , and . Review of the Minimum Data Set (MDS) quarterly assessment with Assessment Reference Date of revealed resident #7 had a score of 7 out of 15 which indicated she was , , , . The MDS assessment indicated she had no hearing or vision , . She was usually understood by other and she usually understood others. The MDS assessment noted no behaviors and no rejection of care necessary to obtain goals for her health and well-being. She was dependent on staff for toileting hygiene and needed substantial/maximal assistance for personal hygiene. She was always of and . Review of the Resident Grievance Log revealed resident #7 filed a concern on . The Complaint/Grievance Report read, resident #7, "had to be changed for the second time and the CNA (Certified Nursing Assistant) yelled at her saying "I just changed you." [Resident #7] says this is not the first time and does not like being yelled at. Incident occurred at night." The Documentation of Investigation section showed the	N 042	grievance was submitted to AIRS system by NHA (2) A comprehensive review of all grievances for the months of , and , was conducted by Regional Vice President of Operations, Executive Director and Social Services Director to ensure adherence to facility policy. No new issues found. (3) 1. Education provided by RVPO to SSD and ED on grievance and reporting process 2. Education provided to all staff on the grievance and reporting process, postings and placement of grievance forms. 3. All grievances are reviewed by ED, SSD and DON daily, supervisor calls and reviews grievances with ED, SSD, DON or designee on weekends. 4. Grievance policy reviewed by Executive Director in resident council meeting on . 5. A quality review is conducted weekly by ED/DON or SSD on grievances and reportable incidents. (4) A quality review will be completed by the Executive Director/designee of grievances and reportable incidents, to ensure the policy/ process is adhered to, 5 times a week for 4 weeks, and then weekly for 2 months. The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee	

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N 042	Continued From page 2 grievance was assigned to Nursing on . The "Findings of investigation" section was left blank. The "Plan to resolve complaint/grievance," read, "corrective action taken w/ (with) management re: (regarding) behavior." The "Expected results of actions taken," read, "To improve customer service." The NO box was checked for, "Reportable to stage agency." The "Post-Investigation Follow Up" section was left blank. Review of the Reportable Event Log in did not include resident #7. There was no report submitted to the State agency. On at 10:07 AM, the Social Services Director (SSD) explained she was the Grievance Officer and responsible for overseeing the grievances. She stated grievances could be written by anyone and the facility determined if it was, "truly a grievance." She indicated the facility had 10 days to resolve the grievance. The Social Services Director said, "Depending on the situation, it may become a reportable." She stated grievances were discussed every day during morning meetings. She noted the Administrator (NHA) was the Coordinator, but anyone of them were mandatory reporters and anyone could report allegations of and neglect. She shared the facility had two hours to report and neglect. On at 10:22 AM, the Administrator (NHA) stated grievances were discussed in morning meetings but were not read verbatim just discussed as a general concern. She mentioned whoever received a grievance needed to inform her if a reportable was questionable.	N 042	determines substantial compliance has been met.	

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N 042	Continued From page 3 On at 3:42 PM, the NHA and SSD reviewed resident #7's grievance form dated . The SSD stated she gave a copy to the Unit Manager (UM) to follow up and she was waiting for disciplinary action and education for the resolution. The NHA stated she had not seen the grievance and "was not aware of it." The NHA read the concerns of resident #7 and stated the grievance, "sounded as [like] ." The NHA confirmed the grievance was not followed up with resident #7 or reported to the State agency. On at 3:55 PM, the NHA stated the SSD told her she had not seen this grievance, it "may have through the cracks," or was probably given to the Unit Manager (UM) directly by the Direct Patient Experience Coordinator. The NHA stated when the form was handed to the SSD by the UM, she did not read it and just filed it. The NHA confirmed this was not investigated as required. Review of the facility's Complaint/Grievance policy revised on revealed the intent to support each resident's right to voice a complaint/grievance and to make prompt efforts to resolve the complaint/grievance and inform the resident of the progress towards resolution. The document read, "Grievances discovered to meet the definition of , Neglect, , or Misappropriation will be handled per the facility's Policy." Class III	N 042		

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N 917	Continued From page 4	N 917		
N 917 SS=D	400.147(8), FS Report , Neglect, & , (8) , neglect, or , must be reported to the agency as required by 42 C.F.R. s. 483.13(c) and to the department as required by chapters 39 and 415. This Statute or Rule is not met as evidenced by: Based on interview, and record review, the facility failed to prevent further , and timely and accurately report an allegation of to the State Agency for 2 of 4 residents reviewed for , of a total sample of 8 residents, (#1 and #7). Findings: 1. Review of resident #7's medical record revealed she was readmitted to the facility on with diagnoses including , , , (that affects the), , , , type 2 , , and . Review of the Minimum Data Set (MDS) quarterly assessment with Assessment Reference Date (ARD) of revealed resident #7 was usually understood by other and she usually understood others. Resident #7 had a ( ) score of 7 out of 15 which indicated she was , , , . The MDS assessment noted no behaviors and no rejection of care necessary to obtain goals for her health and well-being. She was dependent on staff for toileting hygiene and needed substantial/maximal assistance for personal hygiene. She was always of and .	N 917	1) On , Resident #7 reported grievance was submitted to AIRS system by NHA (2) A comprehensive review of all grievances for the months of , and , was conducted by Regional Vice President of Operations, Executive Director and Social Services Director to ensure adherence to facility policy. No new issues found. (3) 1. Education provided by RVPO to SSD and ED on grievance and reporting process 2. Education provided to all staff on the grievance and reporting process, postings and placement of grievance forms. 3. All grievances are reviewed by ED, SSD and DON daily, supervisor calls and reviews grievances with ED, SSD, DON or designee on weekends. 4. Grievance policy reviewed by Executive Director in resident council meeting on . 5. A quality review is conducted weekly by ED/DON or SSD on grievances and reportable incidents.	

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N 917	Continued From page 5 Review of the Resident Grievance Log revealed resident #7 filed a concern on . The Complaint/Grievance Report read, resident #7 "had to be changed for the second time and the CNA (Certified Nursing Assistant) yelled at her saying, "I just changed you." [Resident #7] says this is not the first time and does not like being yelled at. Incident occurred at night." Review of the Reportable Event Log in , did not include resident #7. There was no report submitted to the State Agency. On at 3:42 PM, the Administrator (NHA) stated she had not seen the grievance from resident #7 and "was not aware of it." The NHA read the concerns in the grievance form from resident #7 and stated it "sounded as " and confirmed it was not followed up or reported. Later at 3:55 PM, the NHA stated the Social Service Director told her she had not seen this this grievance, that it "may have through the cracks," or was probably given to the Unit Manager (UM) directly by Direct Patient Experience Coordinator. The NHA confirmed this was not investigated as required. 2. Review of resident #1's medical record revealed he was admitted to the facility on with diagnoses including , , , of right lower , difficulty walking, orthopedic aftercare, , and repeated . Review of the MDS quarterly assessment with ARD of revealed resident #1 had a score of 14 out of 15 which indicated he was , . The MDS assessment noted no	N 917	(4) A quality review will be completed by the Executive Director/designee of grievances and reportable incidents, to ensure the policy/ process is adhered to, 5 times a week for 4 weeks, and then weekly for 2 months. The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been met.	

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N 917	Continued From page 6 behaviors and no rejection of care necessary to obtain goals for his health and well-being. Resident #1 needed substantial assistance from staff for toileting hygiene and personal hygiene. He was always of and occasionally of . Review of a State Agency report for , , submitted by the facility on revealed the NHA learned of resident #1's allegation of at 2:15 PM on . The report included the following description of the allegation/incident: Resident #1 wanted to be changed, CNA C asked him to give her a moment, but he wanted to be changed immediately. CNA C walked up to resident #1 to advise him that she would get to him when she finished the other resident. Resident #1 stated he felt uncomfortable with how close she got to him when she approached him. On at 8:50 AM, resident #1 stated prior to admission to the facility, he had right , surgery, after surgery at the hospital, and had not been able to walk again or work with , , . Resident #1 shared he experienced an " incident" early one morning. He explained a CNA raised her to hit him, and he reacted by using foul language towards her. He mentioned that was the first time the CNA had worked with him. He stated the police came to talk to him and he was told she would not care for him again. He explained his nurse told the CNA to change him, but the CNA left him naked then left the room. He mentioned when she returned, she made a gesture to hit him, and he closed his fists and raised his arms to protect himself because he felt like she would hit him. He stated he could not get up to defend himself. He said, "She must have been drugged or	N 917		

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N 917	Continued From page 7	N 917		

something because someone who does that to a patient lying in bed cannot be right." He recalled someone else came to get him dressed. He stated a manager later spoke with him about the incident.

On at 5:44 AM, Registered Nurse (RN) A recalled early one Saturday morning resident #1 reported CNA C raised her and he perceived it as she was going to hit him. She explained that morning, CNA C called RN A into resident #1's room and the resident told her he was wet and needed to be changed. RN A stated CNA C responded she would return to change him. RN A indicated CNA C stepped out of the room and sat by the nurses' station to document and did not change resident #1 at that time. RN A mentioned she later returned to give resident #1 his medications and he told her CNA C returned to his room later and he had to hold her to not get hit. She indicated she reported the incident to the Weekend Supervisor and completed a witness statement. She stated she and the Weekend Supervisor called the Director of Nursing (DON) that same morning and reported the allegation. She stated she did not know what happened after that because she did not work the rest of the weekend. She indicated she did not perform a -to- assessment for resident #1. She stated he was not crying, agitated or upset when he told her about the incident and he did not request a change of assignment. She recalled the oncoming shift CNA B reported what resident #1 told her and she told CNA B she had already reported the incident to the DON. She explained after that day, no one in the facility asked her any questions about that incident.

On at 8:09 AM, the Weekend Supervisor

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N 917	Continued From page 8	N 917		

stated the Coordinator was the NHA. She shared allegations of or neglect were reported immediately because the facility had 2 hours to file a report. When asked about the incident for resident #1, she recalled CNA B told her resident #1 reported a CNA had, "smacked him or put her towards him." She indicated she was unable to interview resident #1 because he spoke Spanish. She shared she and CNA B went to resident #1's room to interview him. The Weekend Supervisor stated resident #1 said the CNA who had him last night put her toward him. She indicated she later asked RN A and she confirmed she was aware of the incident. The Weekend Supervisor shared she then called the DON and reported it. She explained "typically we would have the nurse do a skin check" but she did not do it. She said, "My time in his room was limited" because resident #1's roommate did not like anyone in the room who did not speak Spanish. She indicated CNA C was assigned to that room from 11 PM to 7 AM and did not speak Spanish. She said, "We do not always have Spanish speaking CNAs at night," but there was a staff member working who could translate if or when needed. She stated she did not recall if she wrote a statement or not that morning but remembered reporting it to Administration. She shared she worked on nursing carts in the South Wing both Saturday and Sunday and did not know what happened after she reported the incident.

On at 9:25 AM, CNA B stated on Saturday , she started her shift at 6:30 AM, and did her rounds as always. She mentioned resident #1 liked his privacy curtain closed and the light off at night. She recalled when she went to resident #1's room, he was crying. She stated she asked him

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N 917	Continued From page 9	N 917		

what happened, and he shared an incident that occurred earlier during the night. She stated resident #1 told her he had in his brief and was ˵ so he pressed his call light and the CNA responded she did not have time to change him, turned the call light off and told him to go to sleep. CNA B indicated he said he turned on the call light for a second time, the same CNA returned and she started yelling at him. He told her the CNA raised her like she was going to hit him on his so he put his up and he asked her, "Are you going to hit me on my ?" then the CNA left the room. She explained he shared the nurse came in and he explained what happened to the nurse but still he was not changed. CNA B indicated she changed resident #1 at that time, and he was "soaking wet" so she took him to the shower room and gave him a shower. She shared she noticed he had "a lot of , ˵ on." She explained, "only a little" of that should be used in red areas but not the "private areas" because it could cause ˵ sensation. She indicated before she gave resident #1 a shower she spoke with the Weekend Supervisor. She recalled the Weekend Supervisor came to resident #1's room, he was upset and talking in Spanish, so she tried to translate. She mentioned she was present when the Weekend Supervisor and the nurse called the DON. She stated resident #1 was very upset the rest of the day, he called his son, and his son tried to calm him down. CNA B mentioned whenever he remembered the incident, "he cried, he was very upset." She stated she, "wrote a statement right away." She shared CNA E who was also a witness when resident #1 told her about the incident also wrote a statement. She stated she worked on , and and no one from

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N 917	Continued From page 10 Administration spoke with her or asked her questions about the incident. On at 10:26 AM, the DON recalled resident #1's incident started on when he turned his call light on because he needed to be changed. He indicated resident #1 did not speak much English, so CNA C called the nurse, and the nurse explained to the CNA he needed to be changed. He stated CNA C left resident #1's room and returned to change him. The DON said, "According to the resident, he saw the CNA was agitated with him, the CNA went to provide the care, the resident told the CNA hey do you want to hit me, hit me." The DON stated he asked resident #1 if CNA C hit him and the answer was no and the CNA provided care, and "that was the end." The DON recalled the Weekend Supervisor called him after Licensed Practical Nurse (LPN) D told her about the incident. He indicated he spoke with resident #1 via video call with LPN F who was working in that unit but was not assigned to resident #1. The DON stated he called LPN F because she spoke Spanish. The DON stated he asked resident #1 if he felt intimidated or unsafe and the resident responded he was okay, but he did not want CNA C caring for him. The DON said, "On that day there is nothing to report because it was a customer service issue." On at 10:50 AM, the DON and NHA presented their report to the State Agency dated . The NHA stated the Direct Patient Experience staff was informed by resident #1's CNA about an incident with CNA C. The DON stated on , CNA B mentioned resident #1 was crying about something that happened that morning, and his night shift CNA did not	N 917		

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understand him. The DON and NHA did not answer why they did not have witness statements from the staff assigned to resident #1 the day of the allegation. The DON stated the staff did not mention resident #1 thought CNA C was going to hit him. The DON did not answer whether he read the progress note from LPN D in resident #1's medical record. The NHA stated they did not have RN A's or CNA B's statements in their investigation folder.

On at 11:47 AM, the DON and CNA B stated they wanted to clarify that resident #1 did not say he was hit by CNA C. The DON and CNA B validated CNA B's statement was correct. The DON verified he instructed the Weekend Supervisor to collect witness statements, but he did not follow up with her.

On at 11:59 AM, LPN D stated during morning medication pass on , resident #1 told her he did not want the he was on because it made him "pee too much" and turned his orange. She shared she could tell he was upset, and he shared, "They do not want to take him to the bathroom." She explained he had a , ( ), and he needed to take his . She recalled he shared "I go to the bathroom too much and someone tried to hit me." She indicated his main language was Spanish, but he spoke some English. She mentioned she spoke with CNA B and they told the Weekend Supervisor about what resident #1 shared. She recalled the Weekend Supervisor informed the DON who got on the phone with resident #1 but they were talking in Spanish, so she did not understand their conversation. She stated CNA B, the DON and herself were in the

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N 917	Continued From page 12 room when the DON spoke with resident #1. She recalled when resident #1 told her someone tried to hit him, he was not crying but he was agitated, and "I could tell he was upset." She stated she entered a progress note in his medical record but was not asked to write a witness statement. LPN D said, "There was no other conversation about this incident until today." Review of resident #1's medical record revealed a Progress Note entered on at 9:04 AM, by LPN D. The note read, "During a.m. (morning) med (medication) pass , (patient) seem upset, , didn't want to take ABT for , , was stating it turns his orange and stated that it , , was educated on the importance of taking meds, and that his turning orange is a harmless side effect that goes away after completion of taking med, and the medication will help the , , took meds and stated he didn't have a good night because CNA tried to hit him because he turns on light to be changed, stating he urinates too much. Supervisor was notified." On at 12:17 PM, CNA E shared before 7:00 AM on CNA B called her to come into resident #1's room. She indicated CNA B told her she wanted a witness to ensure she understood correctly what resident #1 was saying. CNA E stated resident #1 was crying and she asked what happened. She mentioned he stated he was "very, very upset" because he got into an argument with the night shift CNA because he wanted his brief to be changed and felt a sensation, and they were "like fighting verbally." CNA E stated resident #1 raised his showing them what he did when he thought the CNA was going to slap him. She explained she and CNA B asked resident #1 if	N 917		

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	74908	A. BUILDING: _____ B. WING _____	C 02/18/2025

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N 917	Continued From page 13 the CNA hit him and he responded no, but he raised his because he thought she was going to hit him. She stated she reported the incident to the night nurse who told her she had spoken with the resident. She mentioned no one asked her for her witness statement until today. On at 9:02 AM, CNA C stated resident #1 communicated with her in English. She recalled performing her rounds as usual on that , night. She mentioned at around 3:00 AM she was collecting cups to get new ones with fresh water for all her assigned residents. She stated she answered a call light in resident #1's room and he said he needed his cup of water and began speaking to her in Spanish. She indicated she asked him what he was saying, but he continued speaking in Spanish, so she left the room to get the nurse because she did not understand Spanish. She stated she returned with RN A and the nurse told her resident #1 said he was wet and needed to be changed. She indicated she changed his brief and accidentally bumped into his bedside table causing some things to to the floor. CNA C stated she pulled his pants up, got all the things from the floor and told him to pull his sheet over his the way he liked and always did. She indicated she made the gesture for him to pull the sheet over his . She stated she left the blanket over his , instructed him to pull it over and he told her not to talk to him like that and made a gesture with his pointing at her. She indicated she left his room after that, and returned to check on him around 5:00 AM and he was sleeping. She mentioned she did not talk to him again. She recalled she finished her shift and left for the day. No one mentioned anything or asked any questions. She explained when she returned	N 917		

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N 917	Continued From page 14 to work on Monday , she noticed her assignment was changed so she wondered why. She shared she spoke to the other CNA who had her assignment, and they discussed changing their assignments. She stated a CNA working on the unit asked her if she had received a call from Human Resources (HR). She shared she was told by that CNA resident #1 made an allegation, "apparently on Friday you threw your up" and that was the rumor she heard. CNA E stated she did not receive a call that weekend from the facility and was "shocked" about the allegation. She stated she was told by that CNA if I were you, I would leave the assignment the way it was. She indicated she tried to speak with RN A who working that night, but she did not speak much English. She mentioned RN A confirmed she had to stay over on Saturday to write a statement about what happened that morning. CNA E stated she did not go into resident #1's room on to . She stated she attended a town hall meeting the morning of and left the facility at approximately 9:00 AM. She indicated she received a call from HR later that day, between 4:00 and 5:00 PM and was informed she was suspended and had to come in to write a statement. She shared she came to the facility on Wednesday , wrote her statement and learned the facility's protocol was to suspend her for three days until they completed an investigation. She stated HR called her yesterday and told her she needed to come in for a class today. On at 11:54 AM, the Direct Patient Experience explained she visited all residents daily to ensure "everything is up to par" with them. She explained on , a CNA shared resident	N 917		

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N	Continued From page 15 #1 had a concern. The Direct Patient Experience staff stated she and the NHA spoke with resident #1. She shared resident #1 explained he had a verbal altercation with CNA C one night, and he felt safe in the facility, but did not want that CNA to care for him any longer. On at 1:30 PM, the NHA explained HR spoke with CNA C to inform her of the suspension. The NHA stated she felt CNA C's statement was clear and she did not have any follow up questions for her. She shared when the DON called her on , he explained resident #1 was upset at a CNA but the resident was the one yelling to the CNA and it escalated. The NHA indicated she ran it by the Regional Nurse Consultant and was told it "sounded more like a grievance." She shared all grievances were discussed during morning meetings but she "did not realize the whole situation, and the DON made it seem like the Weekend Supervisor was not making it a severe incident." The NHA stated when she was called, a physical or allegation was not mentioned. She indicated she assumed the DON took it as not an allegation or undermined it. The NHA stated LPN F said she did not get a statement from CNA B, but CNA B confirmed she wrote a statement. The NHA stated she did not review and was not aware of LPN D's progress note in resident #1's medical record and did not think management looked at the note. She confirmed the facility did not interview other residents assigned to CNA C. Review of the facility's , Neglect, , & Misappropriation policy revised on included the steps for investigating allegations of . The form read, "Immediately	N 917		

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N 917	Continued From page 16 upon an allegation of or neglect, the suspect(s) shall be segregated from residents pending the investigation of the resident allegation. The nurse or Director of Nursing/designee shall perform and document a thorough nursing evaluation and notify the attending physician. An incident report shall be filed by the individual in charge who received the report in conjunction with the person who reported the . This report shall be filed as soon as possible in order to provide the most accurate information in a timely fashion, and submitted to the Coordinator." The Investigation section included, 'The Coordinator and/or Director of Nursing shall take statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged . Any suspect who is an employee will be suspended when identified. Increased supervision of alleged victim and residents . . ." The Protection section read, "Provide the resident with emotional support and counseling during and after the investigation, if needed." The Reporting/Response section revealed reporting should be immediately, but no later than 2 hours after the allegation was made if the events that caused the allegation involved to the Administrator and other officials in accordance with State law. The policy included the DON was the designated coordinator in the absence of the Executive Director. Class III	N 917		

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F 000	INITIAL COMMENTS Complaint survey #2025001902 was conducted from to . The complaint was substantiated. Aspire at St. Cloud was not in compliance with 42 CFR Part 483 and 488, requirements for Long Term Care Facilities.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:	F 585		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed /2025

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F 585	Continued From page 1	F 585		

(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
( ) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, , including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the

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F 585	Continued From page 2	F 585		

provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based on interview, and record review, the facility failed to ensure staff were knowledgeable of and followed their grievance process for 1 of 2 residents reviewed for grievances, of a total sample of 8 residents, (#7).

Findings:

Review of resident #7's medical record revealed she was admitted to the facility on with diagnoses including , , , (that affects the), , , , type 2 , , and

This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of these deficiencies cited are correctly

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F 585	Continued From page 3 . Review of the Minimum Data Set (MDS) quarterly assessment with Assessment Reference Date of revealed resident #7 had a score of 7 out of 15 which indicated she was . The MDS assessment indicated she had no hearing or vision . She was usually understood by other and she usually understood others. The MDS assessment noted no behaviors and no rejection of care necessary to obtain goals for her health and well-being. She was dependent on staff for toileting hygiene and needed substantial/maximal assistance for personal hygiene. She was always of and . Review of the Resident Grievance Log revealed resident #7 filed a concern on . The Complaint/Grievance Report read, resident #7, "had to be changed for the second time and the CNA (Certified Nursing Assistant) yelled at her saying "I just changed you." [Resident #7] says this is not the first time and does not like being yelled at. Incident occurred at night." The Documentation of Investigation section showed the grievance was assigned to Nursing on . The "Findings of investigation" section was left blank. The "Plan to resolve complaint/grievance," read, "corrective action taken w/ (with) management re: (regarding) behavior." The "Expected results of actions taken," read, "To improve customer service." The NO box was checked for, "Reportable to stage agency." The "Post-Investigation Follow Up" section was left blank.	F 585	applied. 1) On , Resident #7 reported grievance was submitted to AIRS system by NHA (2) A comprehensive review of all grievances for the months of , and , was conducted by Regional Vice President of Operations, Executive Director and Social Services Director to ensure adherence to facility policy. No new issues found. (3) 1. Education provided by RVPO to SSD and ED on grievance and reporting process 2. Education provided to all staff on the grievance and reporting process, postings and placement of grievance forms. 3. All grievances are reviewed by ED, SSD and DON daily, supervisor calls and reviews grievances with ED, SSD, DON or designee on weekends. 4. Grievance policy reviewed by Executive Director in resident council meeting on . 5. A quality review is conducted weekly by ED/DON or SSD on grievances and reportable incidents. (4) A quality review will be completed by the Executive Director/designee of grievances and reportable incidents, to ensure the policy/ process is adhered to, 5 times a week for 4 weeks, and then weekly for 2 months. The findings of these quality	

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F 585	Continued From page 4 Review of the Reportable Event Log in did not include resident #7. There was no report submitted to the State agency. On at 10:07 AM, the Social Services Director (SSD) explained she was the Grievance Officer and responsible for overseeing the grievances. She stated grievances could be written by anyone and the facility determined if it was, "truly a grievance." She indicated the facility had 10 days to resolve the grievance. The Social Services Director said, "Depending on the situation, it may become a reportable." She stated grievances were discussed every day during morning meetings. She noted the Administrator (NHA) was the Coordinator, but anyone of them were mandatory reporters and anyone could report allegations of and neglect. She shared the facility had two hours to report and neglect. On at 10:22 AM, the Administrator (NHA) stated grievances were discussed in morning meetings but were not read verbatim just discussed as a general concern. She mentioned whoever received a grievance needed to inform her if a reportable was questionable. On at 3:42 PM, the NHA and SSD reviewed resident #7's grievance form dated . The SSD stated she gave a copy to the Unit Manager (UM) to follow up and she was waiting for disciplinary action and education for the resolution. The NHA stated she had not seen the grievance and "was not aware of it." The NHA read the concerns of resident #7 and stated the grievance, "sounded as [like] ." The	F 585	reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been met.	

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F 585	Continued From page 5 NHA confirmed the grievance was not followed up with resident #7 or reported to the State agency. On at 3:55 PM, the NHA stated the SSD told her she had not seen this grievance, it "may have through the cracks," or was probably given to the Unit Manager (UM) directly by the Direct Patient Experience Coordinator. The NHA stated when the form was handed to the SSD by the UM, she did not read it and just filed it. The NHA confirmed this was not investigated as required. Review of the facility's Complaint/Grievance policy revised on revealed the intent to support each resident's right to voice a complaint/grievance and to make prompt efforts to resolve the complaint/grievance and inform the resident of the progress towards resolution. The document read, "Grievances discovered to meet the definition of , Neglect, , or Misappropriation will be handled per the facility's Policy."	F 585		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of , neglect, , or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving , neglect, , or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve or result in serious bodily injury, or not later than 24 hours if	F 609		

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F 609	Continued From page 6 the events that cause the allegation do not involve and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to prevent further , and timely and accurately report an allegation of to the State Agency for 2 of 4 residents reviewed for , of a total sample of 8 residents, (#1 and #7). Findings: 1. Review of resident #7's medical record revealed she was readmitted to the facility on with diagnoses including , , , (that affects the), , , , type 2 , , and . Review of the Minimum Data Set (MDS) quarterly assessment with Assessment Reference Date (ARD) of revealed resident #7 was usually understood by other and she usually understood	F 609	1) On , Resident #7 reported grievance was submitted to AIRS system by Executive Director (ED). On , Resident #1 reported was submitted to AIRS system by the Executive Director (ED). (2) A comprehensive review of all grievances for the months of , and , was conducted by Regional Vice President of Operations, Executive Director and Social Services Director to ensure adherence to facility policy. An audit was conducted on all residents with a of 11 or higher for potential reportable events No new issues found.	

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F 609	Continued From page 7 others. Resident #7 had a ( ) score of 7 out of 15 which indicated she was . The MDS assessment noted no behaviors and no rejection of care necessary to obtain goals for her health and well-being. She was dependent on staff for toileting hygiene and needed substantial/maximal assistance for personal hygiene. She was always of and . Review of the Resident Grievance Log revealed resident #7 filed a concern on . The Complaint/Grievance Report read, resident #7 "had to be changed for the second time and the CNA (Certified Nursing Assistant) yelled at her saying, "I just changed you." [Resident #7] says this is not the first time and does not like being yelled at. Incident occurred at night." Review of the Reportable Event Log in did not include resident #7. There was no report submitted to the State Agency. On at 3:42 PM, the Administrator (NHA) stated she had not seen the grievance from resident #7 and "was not aware of it." The NHA read the concerns in the grievance form from resident #7 and stated it "sounded as " and confirmed it was not followed up or reported. Later at 3:55 PM, the NHA stated the Social Service Director told her she had not seen this this grievance, that it "may have through the cracks," or was probably given to the Unit Manager (UM) directly by Direct Patient Experience Coordinator. The NHA confirmed this was not investigated as required.	F 609	(3) 1. Education provided by RVPO to SSD and ED on grievance and reporting process 2. Education provided to all staff in regards to the grievance and reporting process, postings and placement of grievance forms, reporting events timely to meet 2 hour post allegation window, and 24 hours for events that do not involve or serious bodily injury. 3. All grievances are reviewed by ED, SSD and DON daily, supervisor calls and reviews grievances with ED, SSD, DON or designee on weekends. 4. All investigations will be reviewed by RVPO and RDCS for thoroughness, accuracy and timeliness. 5. A quality review is conducted weekly by ED, DON and SSD on grievances and reportable incidents. (4) A quality review will be completed by the Executive Director or designee of grievances and reportable incidents to ensure a thorough investigation was completed and to ensure the policy and process is adhered to, 5 times a week for 4 weeks, and then weekly for 2 months. The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been met.	

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2. Review of resident #1's medical record revealed he was admitted to the facility on with diagnoses including , , , of right lower , difficulty walking, orthopedic aftercare, , and repeated .

Review of the MDS quarterly assessment with ARD of revealed resident #1 had a score of 14 out of 15 which indicated he was . The MDS assessment noted no behaviors and no rejection of care necessary to obtain goals for his health and well-being. Resident #1 needed substantial assistance from staff for toileting hygiene and personal hygiene. He was always of and occasionally of .

Review of a State Agency report for , submitted by the facility on revealed the NHA learned of resident #1's allegation of at 2:15 PM on . The report included the following description of the allegation/incident: Resident #1 wanted to be changed, CNA C asked him to give her a moment, but he wanted to be changed immediately. CNA C walked up to resident #1 to advise him that she would get to him when she finished the other resident. Resident #1 stated he felt uncomfortable with how close she got to him when she approached him.

On at 8:50 AM, resident #1 stated prior to admission to the facility, he had right , surgery, after surgery at the hospital, and had not been able to walk again or work with . Resident #1 shared he experienced an " incident" early one morning. He explained a CNA raised her to hit him, and he reacted by using foul

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language towards her. He mentioned that was the first time the CNA had worked with him. He stated the police came to talk to him and he was told she would not care for him again. He explained his nurse told the CNA to change him, but the CNA left him naked then left the room. He mentioned when she returned, she made a gesture to hit him, and he closed his fists and raised his arms to protect himself because he felt like she would hit him. He stated he could not get up to defend himself. He said, "She must have been drugged or something because someone who does that to a patient lying in bed cannot be right." He recalled someone else came to get him dressed. He stated a manager later spoke with him about the incident.

On at 5:44 AM, Registered Nurse (RN) A recalled early one Saturday morning resident #1 reported CNA C raised her and he perceived it as she was going to hit him. She explained that morning, CNA C called RN A into resident #1's room and the resident told her he was wet and needed to be changed. RN A stated CNA C responded she would return to change him. RN A indicated CNA C stepped out of the room and sat by the nurses' station to document and did not change resident #1 at that time. RN A mentioned she later returned to give resident #1 his medications and he told her CNA C returned to his room later and he had to hold her to not get hit. She indicated she reported the incident to the Weekend Supervisor and completed a witness statement. She stated she and the Weekend Supervisor called the Director of Nursing (DON) that same morning and reported the allegation. She stated she did not know what happened after that because she did not work the rest of the

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weekend. She indicated she did not perform a -to- assessment for resident #1. She stated he was not crying, agitated or upset when he told her about the incident and he did not request a change of assignment. She recalled the oncoming shift CNA B reported what resident #1 told her and she told CNA B she had already reported the incident to the DON. She explained after that day, no one in the facility asked her any questions about that incident.

On at 8:09 AM, the Weekend Supervisor stated the Coordinator was the NHA. She shared allegations of or neglect were reported immediately because the facility had 2 hours to file a report. When asked about the incident for resident #1, she recalled CNA B told her resident #1 reported a CNA had, "smacked him or put her towards him." She indicated she was unable to interview resident #1 because he spoke Spanish. She shared she and CNA B went to resident #1's room to interview him. The Weekend Supervisor stated resident #1 said the CNA who had him last night put her toward him. She indicated she later asked RN A and she confirmed she was aware of the incident. The Weekend Supervisor shared she then called the DON and reported it. She explained "typically we would have the nurse do a skin check" but she did not do it. She said, "My time in his room was limited" because resident #1's roommate did not like anyone in the room who did not speak Spanish. She indicated CNA C was assigned to that room from 11 PM to 7 AM and did not speak Spanish. She said, "We do not always have Spanish speaking CNAs at night," but there was a staff member working who could translate if or

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when needed. She stated she did not recall if she wrote a statement or not that morning but remembered reporting it to Administration. She shared she worked on nursing carts in the South Wing both Saturday and Sunday and did not know what happened after she reported the incident.

On at 9:25 AM, CNA B stated on Saturday , she started her shift at 6:30 AM, and did her rounds as always. She mentioned resident #1 liked his privacy curtain closed and the light off at night. She recalled when she went to resident #1's room, he was crying. She stated she asked him what happened, and he shared an incident that occurred earlier during the night. She stated resident #1 told her he had in his brief and was ˳ so he pressed his call light and the CNA responded she did not have time to change him, turned the call light off and told him to go to sleep. CNA B indicated he said he turned on the call light for a second time, the same CNA returned and she started yelling at him. He told her the CNA raised her like she was going to hit him on his so he put his up and he asked her, "Are you going to hit me on my ?" then the CNA left the room. She explained he shared the nurse came in and he explained what happened to the nurse but still he was not changed. CNA B indicated she changed resident #1 at that time, and he was "soaking wet" so she took him to the shower room and gave him a shower. She shared she noticed he had "a lot of , ˳ on." She explained, "only a little" of that should be used in red areas but not the "private areas" because it could cause ˳ sensation. She indicated before she gave resident #1 a shower she spoke with the

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Weekend Supervisor. She recalled the Weekend Supervisor came to resident #1's room, he was upset and talking in Spanish, so she tried to translate. She mentioned she was present when the Weekend Supervisor and the nurse called the DON. She stated resident #1 was very upset the rest of the day, he called his son, and his son tried to calm him down. CNA B mentioned whenever he remembered the incident, "he cried, he was very upset." She stated she, "wrote a statement right away." She shared CNA E who was also a witness when resident #1 told her about the incident also wrote a statement. She stated she worked on , and and no one from Administration spoke with her or asked her questions about the incident.

On at 10:26 AM, the DON recalled resident #1's incident started on when he turned his call light on because he needed to be changed. He indicated resident #1 did not speak much English, so CNA C called the nurse, and the nurse explained to the CNA he needed to be changed. He stated CNA C left resident #1's room and returned to change him. The DON said, "According to the resident, he saw the CNA was agitated with him, the CNA went to provide the care, the resident told the CNA hey do you want to hit me, hit me." The DON stated he asked resident #1 if CNA C hit him and the answer was no and the CNA provided care, and "that was the end." The DON recalled the Weekend Supervisor called him after Licensed Practical Nurse (LPN) D told her about the incident. He indicated he spoke with resident #1 via video call with LPN F who was working in that unit but was not assigned to resident #1. The DON stated he called LPN F

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because she spoke Spanish. The DON stated he asked resident #1 if he felt intimidated or unsafe and the resident responded he was okay, but he did not want CNA C caring for him. The DON said, "On that day there is nothing to report because it was a customer service issue."

On at 10:50 AM, the DON and NHA presented their report to the State Agency dated . The NHA stated the Direct Patient Experience staff was informed by resident #1's CNA about an incident with CNA C. The DON stated on , CNA B mentioned resident #1 was crying about something that happened that morning, and his night shift CNA did not understand him. The DON and NHA did not answer why they did not have witness statements from the staff assigned to resident #1 the day of the allegation. The DON stated the staff did not mention resident #1 thought CNA C was going to hit him. The DON did not answer whether he read the progress note from LPN D in resident #1's medical record. The NHA stated they did not have RN A's or CNA B's statements in their investigation folder.

On at 11:47 AM, the DON and CNA B stated they wanted to clarify that resident #1 did not say he was hit by CNA C. The DON and CNA B validated CNA B's statement was correct. The DON verified he instructed the Weekend Supervisor to collect witness statements, but he did not follow up with her.

On at 11:59 AM, LPN D stated during morning medication pass on , resident #1 told her he did not want the he was on

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because it made him "pee too much" and turned his orange. She shared she could tell he was upset, and he shared, "They do not want to take him to the bathroom." She explained he had a , ( ), and he needed to take his . She recalled he shared "I go to the bathroom too much and someone tried to hit me." She indicated his main language was Spanish, but he spoke some English. She mentioned she spoke with CNA B and they told the Weekend Supervisor about what resident #1 shared. She recalled the Weekend Supervisor informed the DON who got on the phone with resident #1 but they were talking in Spanish, so she did not understand their conversation. She stated CNA B, the DON and herself were in the room when the DON spoke with resident #1. She recalled when resident #1 told her someone tried to hit him, he was not crying but he was agitated, and "I could tell he was upset." She stated she entered a progress note in his medical record but was not asked to write a witness statement. LPN D said, "There was no other conversation about this incident until today."

Review of resident #1's medical record revealed a Progress Note entered on at 9:04 AM, by LPN D. The note read, "During a.m. (morning) med (medication) pass , (patient) seem upset, , didn't want to take ABT for , , was stating it turns his orange and stated that it , , was educated on the importance of taking meds, and that his turning orange is a harmless side effect that goes away after completion of taking med, and the medication will help the , , took meds and stated he didn't have a good night because CNA tried to hit him because

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he turns on light to be changed, stating he urinates too much. Supervisor was notified."

On at 12:17 PM, CNA E shared before 7:00 AM on CNA B called her to come into resident #1's room. She indicated CNA B told her she wanted a witness to ensure she understood correctly what resident #1 was saying. CNA E stated resident #1 was crying and she asked what happened. She mentioned he stated he was "very, very upset" because he got into an argument with the night shift CNA because he wanted his brief to be changed and felt a sensation, and they were "like fighting verbally." CNA E stated resident #1 raised his showing them what he did when he thought the CNA was going to slap him. She explained she and CNA B asked resident #1 if the CNA hit him and he responded no, but he raised his because he thought she was going to hit him. She stated she reported the incident to the night nurse who told her she had spoken with the resident. She mentioned no one asked her for her witness statement until today.

On at 9:02 AM, CNA C stated resident #1 communicated with her in English. She recalled performing her rounds as usual on that night. She mentioned at around 3:00 AM she was collecting cups to get new ones with fresh water for all her assigned residents. She stated she answered a call light in resident #1's room and he said he needed his cup of water and began speaking to her in Spanish. She indicated she asked him what he was saying, but he continued speaking in Spanish, so she left the room to get the nurse because she did not understand Spanish. She stated she returned with RN A and

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the nurse told her resident #1 said he was wet and needed to be changed. She indicated she changed his brief and accidentally bumped into his bedside table causing some things to to the floor. CNA C stated she pulled his pants up, got all the things from the floor and told him to pull his sheet over his the way he liked and always did. She indicated she made the gesture for him to pull the sheet over his . She stated she left the blanket over his , instructed him to pull it over and he told her not to talk to him like that and made a gesture with his ˻ pointing at her. She indicated she left his room after that, and returned to check on him around 5:00 AM and he was sleeping. She mentioned she did not talk to him again. She recalled she finished her shift and left for the day. No one mentioned anything or asked any questions. She explained when she returned to work on Monday , she noticed her assignment was changed so she wondered why. She shared she spoke to the other CNA who had her assignment, and they discussed changing their assignments. She stated a CNA working on the unit asked her if she had received a call from Human Resources (HR). She shared she was told by that CNA resident #1 made an allegation, "apparently on Friday you threw your up" and that was the rumor she heard. CNA E stated she did not receive a call that weekend from the facility and was "shocked" about the allegation. She stated she was told by that CNA if I were you, I would leave the assignment the way it was. She indicated she tried to speak with RN A who working that night, but she did not speak much English. She mentioned RN A confirmed she had to stay over on Saturday to write a statement about what happened that morning. CNA E stated

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she did not go into resident #1's room on to . She stated she attended a town hall meeting the morning of and left the facility at approximately 9:00 AM. She indicated she received a call from HR later that day, between 4:00 and 5:00 PM and was informed she was suspended and had to come in to write a statement. She shared she came to the facility on Wednesday , wrote her statement and learned the facility's protocol was to suspend her for three days until they completed an investigation. She stated HR called her yesterday and told her she needed to come in for a class today.

On at 11:54 AM, the Direct Patient Experience explained she visited all residents daily to ensure "everything is up to par" with them. She explained on , a CNA shared resident #1 had a concern. The Direct Patient Experience staff stated she and the NHA spoke with resident #1. She shared resident #1 explained he had a verbal altercation with CNA C one night, and he felt safe in the facility, but did not want that CNA to care for him any longer.

On at 1:30 PM, the NHA explained HR spoke with CNA C to inform her of the suspension. The NHA stated she felt CNA C's statement was clear and she did not have any follow up questions for her. She shared when the DON called her on , he explained resident #1 was upset at a CNA but the resident was the one yelling to the CNA and it escalated. The NHA indicated she ran it by the Regional Nurse Consultant and was told it "sounded more like a grievance." She shared all grievances were discussed during morning

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meetings but she "did not realize the whole situation, and the DON made it seem like the Weekend Supervisor was not making it a severe incident." The NHA stated when she was called, a physical or allegation was not mentioned. She indicated she assumed the DON took it as not an allegation or undermined it. The NHA stated LPN F said she did not get a statement from CNA B, but CNA B confirmed she wrote a statement. The NHA stated she did not review and was not aware of LPN D's progress note in resident #1's medical record and did not think management looked at the note. She confirmed the facility did not interview other residents assigned to CNA C.

Review of the facility's , Neglect, , & Misappropriation policy revised on included the steps for investigating allegations of . The form read, "Immediately upon an allegation of or neglect, the suspect(s) shall be segregated from residents pending the investigation of the resident allegation. The nurse or Director of Nursing/designee shall perform and document a thorough nursing evaluation and notify the attending physician. An incident report shall be filed by the individual in charge who received the report in conjunction with the person who reported the . This report shall be filed as soon as possible in order to provide the most accurate information in a timely fashion, and submitted to the Coordinator." The Investigation section included, 'The Coordinator and/or Director of Nursing shall take statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged . Any suspect

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F 609	Continued From page 19 who is an employee will be suspended when identified. Increased supervision of alleged victim and residents . . ." The Protection section read, "Provide the resident with emotional support and counseling during and after the investigation, if needed." The Reporting/Response section revealed reporting should be immediately, but no later than 2 hours after the allegation was made if the events that caused the allegation involved to the Administrator and other officials in accordance with State law. The policy included the DON was the designated coordinator in the absence of the Executive Director.	F 609		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at	F 867		

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F 867	Continued From page 20 §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the ␣ and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies ␣: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure	F 867		

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F 867	Continued From page 21	F 867		

that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and , , of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its

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F 867	Continued From page 22 activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to ensure implementation of policies to the extent of including thorough monitoring of previously identified areas of concern and adequately tracking performance to ensure prior improvement measures were realized and sustained. Findings: Review of the complaint survey conducted on at the facility revealed citations including F609 for concerns related to reporting of allegations. During the course of the current survey, F609 was again identified for concerns of investigating and reporting allegations of and/or neglect. As a result of the repeat citation, it was identified there was insufficient auditing and oversight of the previous mentioned citation. On at 3:55 PM, the Administrator explained she did not look at the actual grievance forms, just the grievance log brought in monthly to the Quality Assurance and Performance	F 867	1) On , QAPI was reviewed by Regional Vice President of Operations and Regional Director of Clinical Services for the months of , and , audits were reviewed and updated. (2) A comprehensive review of QAPI plans were conducted by the RVPO and RDCS to ensure all actions and supporting audits were completed and ongoing audits up to date. Any areas of concern were corrected at this time. (3) 1. Education provided by RDCS to the Interdisciplinary team on the importance of QAPI and how to ensure efficient outcomes through, monitoring and evaluation according to facility QAPI policy; as well as a comprehensive review of the facility's Quality Assurance Performance Improvement program policy. 2. Education provided by the Executive Director to the IDT on how the facility will	

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F 867	Continued From page 23 Improvement (QAPI) meeting. She stated the facility's last QAPI meeting was held on and the focus was the facility's new QAPI plan. The Administrator stated she was not the Administrator during the survey in when the facility was previously cited for failure to report allegations of and neglect, and could not say what was done after those concerns were found to prevent repeat deficiencies from occurring. Review of the facility's Complaint/Grievance policy revised on revealed grievances would be review by the Quality Assurance Performance Improvement Program Committee. Review of the facility's , Neglect, , & Misappropriation policy revised on read, "The center will review allegations of , Neglect, misappropriation of resident property and , during QAPI meetings. QAPI committee will review info including but not limited to: The thoroughness of the investigation, Protection of the resident(s), Risk factors identified, Root-cause analysis of the investigation, Systemic changes that may be required." Review of the facility's Quality Assurance Performance Improvement Program policy revised on revealed the objective was to focus on indicators of the outcomes of care and quality of life. The document mentioned the review of activities such as resident/family complaints/satisfaction. The policy read, "The center will collect and monitor data from different departments reflecting its performance. The center will identify data sources and timeframes for collection. Data sources may include but are not	F 867	monitor the effectiveness of the performance improvement plan related to quality assurance and process improvement 3. All grievances (grievance forms and log) will be reviewed by ED, SSD and DON daily 5 days a week. 4. Quality reviews will be conducted weekly for performance improvement adherence, if indicated an Adhoc QAPI will be completed and submitted to monthly QAPI with any findings. (4) A quality review will be completed by the Executive Director or designee of grievances to ensure the policy and process is adhered to, along with a quality review of performance improvement audits each 5 times a week for 4 weeks, and then weekly for 2 months. The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been met.	

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F 867	Continued From page 24 limited to . . . Grievance logs . . . Medical record reviews . . ."	F 867		