DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road Ste 200, Cambridge Bldg.
Newark, DE 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Kutz Rehabilitation And Nursing

DATE SURVEY COMPLETED: February 16, 2024

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 02/12/24 to 02/16/24 Survey Census: 82 Sample Size: 25 Supplemental Residents: 4	Cross Reference to CMS-2567	
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0			
3201.1.2	**Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.**		

Provider's Signature Tiffiska E. Hall Title NHA, CEO Date 3/17/2024

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	This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed February 16, 2024: F565, F580, F585, F600, F609, F610, F623, F625, F657, F686, F688, F689, F690, and F812.		

Provider's Signature Tricia E. Hall Title NHA, CEO Date 3/17/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

(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) COMPLETION DATE
E 000	Initial Comments A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality on 02/12/24 through 02/16/24. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
F 000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the Delaware Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 02/12/24 to 02/16/24 Survey Census: 82 Sample Size: 25 Supplemental Residents: 4	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written	F 565		4/15/24

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

Electronically Signed | 03/17/2024

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.

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F 565	Continued From page 1 requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interviews and review of the Resident Council Meeting Minutes, the facility failed to provide feedback and/or resolutions to resident complaints and/or grievances discussed in the monthly resident council meetings in 12 of 13 resident council meetings. Findings include: Review of the "Resident Council" meeting minutes for 01/18/23 revealed ". . .Residents report CNAs [certified nursing assistants] are still on their phones while providing care . . . Residents report call lights are not being left within reach . . ." There were no documented actions taken by staff to resolve these issues in the resident council minutes and there was not a	F 565	1. All concerns from the January 2023 to January 2024 Resident Council meeting minutes with unsatisfactory feedback, noted in the Statement of Deficiencies were related to the nursing department. The Director of Nursing (or designee) will investigate and take actions to resolve the issues and the resolutions will be reported to the Life Enrichment (LE) Director by 3/27/24. The LE Director will report at the April Resident Council meeting on 4/17/24 and document in the minutes for that meeting. 2. All concerns from the February 2024 Resident Council meeting have potential to be affected. All concerns from that	

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F 565	Continued From page 2 documented thorough investigation or resolution provided to the group. Review of the "Resident Council" minutes for 02/28/23 revealed ". . . CNAs are still using phones during care - Residents report CNAs are stopping care to answer their phones - Residents report CNAs take 25-30 minutes to answer call lights . . ." The meeting was led by the Social Services Director (SSD) and the residents were asked if staff using cell phones had improved because the Administrator texted the policy to ALL staff regarding cell phone use - the residents in the groups stated it was not effective and the problem persisted. Review of the "Resident Council" minutes for 03/15/23, revealed the February minutes were reviewed and the residents reported staff were constantly on phones or wearing ear buds and the residents cannot tell if staff is speaking to them or on their phones. The new business included multiple complaints that residents were being rushed in the shower and the agency aides were rude to them. There was a notation indicating the SSD educated residents about resident rights but no formal investigation into or resolution for their complaints was provided. Review of the "Resident Council" minutes for 04/19/23, revealed ". . .2. Old business - March minutes reviewed - still no progress with staff not using their phones during care . . . staff do this in the resident's rooms . . ." It was noted that the SSD explained a new grievance/complaint process she and the Assistant Director of Nursing (ADON) would be implementing. The review of minutes for 05/17/23, revealed "2.	F 565	meeting were resolved by 3/1/24 and were reported by the LE Director at the March Resident Council meeting on 3/20/24, and were documented in the minutes for that meeting. 3. RCA: No process existed to ensure the management team responded to the LE Director, or designee, regarding resident concerns monthly. Also, the Resident Council policy did not outline a process. The issues with the call lights, and loudness were investigated (not documented) by the previous ADON, and agency staff was reduced to zero in August of 2023. These issues have not re-occurred. The Staff member too damn busy was already terminated for similar complaints when identified. The educations regarding the reoccurring issues related to cellphone and earbud use during 2023 were ineffective related to a lack of immediate disciplinary action being taken. The Resident Council policy was updated, to include a process for receiving timely responses from the IDT so they could be reported timely to the residents at the next council meeting. The Grievance official is the Social Services Director, and the person responsible to act on the grievances is the department head for that area (DON for nursing, Kitchen Director for Kitchen, etc.). Human Resource Director will educate IDT and Nurse Managers regarding disciplinary procedure and the expectation	

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F 565	Continued From page 3 Old business . . . B. Residents continue to feel the nursing dept [department] is not taking care of the staff cellphone and/or earbud use . . . New Concerns . . . F.) Nurses and CNAs continue on cell phones. G.) Nurses and CNAs talk/argue loudly all the time. . ." There were no documented actions taken by staff to resolve these issues in the resident council minutes and there was not a documented thorough investigation or resolution provided to the group. Review of the "Resident Council" minutes for 06/21/23, revealed, ". . . 2. Old business . . . 6. Most CNAs and some nurses are still on their phones . . . problem is getting worse . . ." There were no documented actions taken by staff to resolve these issues in the resident council minutes and there was not a documented thorough investigation or resolution provided to the group. Review of the "Resident Council Meeting" minutes for 07/19/23, revealed ". . . 2. Old Business . . . B. Overview and follow up . . . 1. Almost ALL CNAs and some nurses are still on their phones . . . problem getting worse. 2. No change in noise problems CNAs talking to loud, everywhere, all the time. The other noise problem is staff slamming doors and laundry carts/bins ..." There were no documented actions taken by staff to resolve these issues in the resident council minutes and there was not a documented thorough investigation or resolution provided to the group. Review of the Resident Council minutes for 08/16/23, revealed ". . . Overview and Follow up - Nurses and CNAs continue to be on their phones	F 565	that immediate disciplinary action occur with any instances of cellphone and earbud use. The LE Director (or Designee) will educate the IDT on the new Resident Council policy. The Staff Developer (or Designee) will educate the nursing staff regarding the new disciplinary process. 4. LE Director, or designee, will conduct audits of monthly Resident Council Minutes to ensure that all concerns from the previous month have documented responses, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. 5. The corrective action will be completed by April 15, 2024.	

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F 565	Continued From page 4	F 565		

and using ear buds during care - Still no change in the noise problem . . . There's no nursing staff available to help after dinner . . ." There was no documented solution or resolution to the residents' ongoing complaints about cell phone use. The New Business included R48 stating a CNA on day shift told him "Im too damn busy to put you on the toilet," he reported it to his nurse, but nothing ever happened. R48 said the "CNA is mean ..." There were no documented actions taken by staff to resolve these issues in the resident council minutes and there was not a documented thorough investigation or resolution provided to the group.

Review of the Resident Council minutes for 09/20/23, revealed, ". . . 7-3 aid who said too damn busy still not identified. Activity Director will check schedule. . ." There was no appropriate response by the facility to elevate this grievance and conduct a thorough investigation. There was no documented resolution provided to R48 about this alleged verbal abuse.

Review of the Resident Council minutes for 10/18/23, revealed ". . . 7-3 aid who said too busy to put you on the toilet was resolved. . . Call bell wait times extremely long and unresolved . . . Aides talk on phones and watch tv [television] ..." These complaints were not addressed in the "New Business" and no resolution was offered to the residents. There were no documented actions taken by staff to resolve these issues in the resident council minutes and there was not a documented thorough investigation or resolution provided to the group.

Review of the Resident Council minutes for 11/15/23, revealed no mention of the previous

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complaints in "Old Business." The "New business" section included complaints by R48 that ". . . the aids talk on the phones about personal things, paychecks, other residents, etc . . . he didn't want to complain because his care might get worse . . ." Another resident confirmed she has the same problem with CNAs "speaking out of turn." The Activities Director (AD) told them it was their right to speak up but there was no further investigation or resolution provided.

Review of the Resident Council minutes for 12/13/23, revealed vague comments about staffing but nothing as specific as in the previous months. A couple of residents complimented one of the CNAs. There were no documented actions taken by staff to resolve these issues in the resident council minutes and there was not a documented thorough investigation or resolution provided to the group.

Review of the Resident Council Minutes for 01/17/24, revealed in "Old Business" that there was a slight improvement for R48 regarding getting up earlier as desired. In the "New Business" it was noted that the Resident Council President commented there was no communication at all between the residents and the Director of Nursing (DON). There was no reply to this concern.

The AD was interviewed on 02/14/24 at 3:10 PM in the conference room. The AD stated she attended the meetings when invited to take notes for the resident council president (RCP) and the RCP wanted old business included each month. The AD stated she typed up the meeting minutes and sends to the Administrator and the DON, as well as the RCP. The AD stated she was not

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F 565	Continued From page 6 responsible for elevating the resident concerns to a reportable incident/investigation. During an interview on 02/15/24 at 9:00 AM, the Social Services Director (SSD), the facility's Grievance Official revealed she investigated and interviewed staff present during any specific incidents reported. The SSD stated she did not attend all of the resident meetings but did go when there was an issue she could address or new staff or any big changes the residents would want to know about. The SSD stated in the meetings the residents did not always have specific complaints that can be tracked down to one thing, or one incident. The SSD stated she was new to the role and has recently added a Grievance Resolution Form so she can provide residents with written responses and for her own investigations. During an interview with R9 and R77 on 02/16/24 at 9:15 AM, the alert and oriented residents were asked about the potential grievances and whether or not the concerns raised in the resident council meetings were addressed by the facility and resolved to the resident's satisfaction. Both residents agreed they were only resolved by the facility 60 to70 percent of the time. R9 stated, "we can speak for ourselves, and we do - but others aren't so lucky so we try to look out for them too!" R77 agreed.	F 565		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident	F 580		4/15/24

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F 580	Continued From page 7	F 580		

representative(s) when there is-
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement

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F 580	Continued From page 8 its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the facility failed to ensure one of 25 sampled residents' (Resident (R)11) physicians was notified of a change in condition. R11 was documented as refusing to wear her left resting hand splint most of the time over the past two weeks. R11's Physician had not been notified creating the potential that the need for treatment to be modified would not occur. Findings include: Review of the undated "Admission Record" in the electronic medical record (EMR) under the "Profile" tab revealed R11 was admitted to the facility on 05/03/19. Diagnoses included hemiplegia (severe or complete loss of strength or paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side. Review of the quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 12/18/23, located in the EMR under the "MDS" tab, revealed R11 was unimpaired in cognition with a Brief Interview for Mental Status (BIMS) score of 15 out of 15 (score of 13 - 15 indicates intact cognition). R11 was impaired to her upper extremity (shoulder, elbow, wrist, hand) on one side.	F 580	1. Dr. Dattani was notified on 3/7/24 by DON that R11 was documented as refusing to wear her left resting hand splint most of the time during the two-week period stated in the 2567. 2. All residents documented as refusing treatments have the potential to be affected by failing to notify the physician. Director of Nursing (or designee) will audit progress notes since 2/16/2024 to identify residents refusing treatments and notify the physician by 3/27/24. 3. RCA: Nurse offered splint daily and resident refused daily. After one re-attempt, resident consistently complained about being awoken and refused treatment. Nurse recognized resident□s right to refuse treatment. The nurse documented refusals in the electronic treatment administration record (eTAR). Knowledge deficit of nurse of when to notify physician of refusal of order for splint. The Notification of Changes policy was reviewed and updated to allow for differing levels of notification of resident□s refusal of physician orders, depending on the risk of the refusal.	

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F 580	Continued From page 9 Review of the "Order Summary Report," dated 05/03/23 and located in the EMR under the "Orders" tab, revealed the Physician ordered, "Don [put on] left hand resting splint in AM, doff [remove] left hand resting splint at PM before bedtime." Review of the "Treatment Administration Record (TAR)" for January 2024 in the EMR under the "Orders" tab revealed R11's left resting hand splint was donned at 6:00 AM 26 days; was refused twice; and there was no documentation one day. Review of the "TAR" for February 2024 (up through 02/15/24) in the EMR under the "Orders" tab revealed R11's left resting hand splint was donned at 6:00 AM four days (02/03/24 - 02/05/24 and 02/13/24); was refused 10 days, and there was no documentation one day. Review of the "Occupational Therapy (OT) Evaluation and Plan of Care" for the certification period from 03/30/23 through 06/25/23 and provided by the facility revealed R11 had a contracture to her left hand. The reason for the referral was the new onset of decrease in range of motion (ROM) and joint instability. One of the long-term goals was for R11 to wear the resting hand splint on the left hand for up to eight hours a day. During an interview on 02/13/24 at 2:44 PM, R11 stated she used to wear a left-hand splint but the staff had not brought it and applied to her left hand for over a week. During an interview on 02/15/24 at 8:31 AM, R11 again stated the left-hand splint had not been applied by staff this week.	F 580	Staff Developer, or designee, will educate licensed nurses on Notification of Changes policy and process. 4. Director of Nursing (or designee) will conduct audits of Progress Notes daily x 3 to ensure that residents refusing treatments have physician notification until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. 5. April 15, 2024	

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F 580	Continued From page 10 During an interview on 02/13/24 at 2:59 PM, Certified Nursing Assistant (CNA) 12 stated R11 had a left-hand splint but she had not seen R11 wearing it in a while. During an interview on 02/15/24 at 9:42 AM, the Director of Rehabilitation (DOR) stated R11 had a left resting hand splint that should be applied in the morning and removed before bedtime. During an interview on 02/15/24 at 12:51 PM, the Administrator stated that according to the February 2024 TAR, R11 had been refusing the splint or removing it most of the time and would need to be evaluated for another one. During an interview on 02/15/24 at 5:40 PM, the Director of Nursing (DON) stated if R11 was refusing to wear the splint, the nurses who cared for R11 should document this in nursing notes and let the Physician or therapist know. This would be necessary so a reassessment could be completed. During an interview on 02/16/24 at 10:53 AM, Physician1 stated she had not been notified of the splint not being worn by R11. Physician1 stated, "I would want to know." Physician1 stated there was a physician notification book in which staff could document residents that needed to be seen by the physician. Physician1 gave the surveyor the book and there was no documentation from 02/01/24 - 02/16/24 of R11 not wearing the splint or any notation regarding R11. Physician 1 stated she and another Physician were in the building every day. During an interview on 02/16/24 at 4:52 PM, the	F 580		

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F 580	Continued From page 11 Administrator and Former DON were interviewed and indicated the staff should notify the Physician if R11 was not wearing the splint. A request was made for evidence the physician had been notified and no evidence was provided as of the survey exit. Review of the "Physician Notification Policy & Procedure" dated December 2023 and provided by the facility revealed, "Policy: To strive to notify the physician, via phone, e-mail, or other electronic means, when the resident's clinical condition changes and/or when the resident requires physician intervention ... The licensed nurse is responsible for notifying the resident's physician at a minimum when there is: ... A need to significantly alter treatment (i.e., need to discontinue an existing form of treatment ...)"	F 580		
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.	F 585		4/15/24

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F 585	Continued From page 12 §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: (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	F 585		

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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;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the 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, record review, and policy review, the facility failed to make prompt efforts to resolve grievances and report the findings in

1. Resident #8 and Family # 88 will be provided the Resolution to Grievances #1-9 in writing by the Social Services

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F 585	Continued From page 14 writing to the resident/family for one of 25 sampled residents (Resident (R) 8). Findings include: Review of the undated "Admission Record" in the electronic medical record (EMR) under the "Profile" tab revealed R8 was admitted to the facility on 04/03/17 with diagnoses including anxiety disorder, weakness, and chronic kidney disease. Review of the quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 12/20/23, located in the EMR under the "MDS" tab, revealed R8's cognition was intact with a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15. R8 required substantial/maximal assistance with toileting hygiene and she was always incontinent of bowel and bladder. During an interview on 02/12/24 at 1:11 PM, R8 stated she and two of her family members ((F)8 and F88) had reported numerous instances when staff did not answer her call light timely, toilet her or change her soiled incontinence brief timely. R8 stated the concern continued and verified several incidents occurred within the last month or so. During an interview on 02/13/24 12:54 PM, F8 stated she and F88, in addition to R8, had reported numerous incidents of a lack of toileting, R8 "sitting in feces for hours" and call light concerns to the Social Service Director (SSD). F8 stated the incidents were dismissed, came back inconclusive and they (R8, F8, and F88) were told, "That person could not have done it." F8 stated for every incident reported nothing was	F 585	Director by 3/27/24. 2.¿ All residents who have had Grievances have the potential to be affected. All residents with Grievances since 2/16/2024 will be audited by the Social Services Director. Those lacking written resolution will be completed, utilizing the new grievance policy and forms, by 3/27/24 and written resolution will be provided. 3. RCA: Grievance investigations were not thorough due to a lack of knowledge about the grievance policy and grievance requirements. A clear-cut procedure was not implemented for staff to conduct thorough investigations of grievances. The Kutz Rehabilitation and Nursing Grievance Policy was not being followed. The procedure for grievance resolution was not being followed. Administrator updated the grievance policy, as well as the grievance forms, and grievance outcome forms. A check list was created to ensure all portions of the Grievance process is completed. Administrator reviewed with social services director the items that need to be included in a grievance, as well as a grievance resolution. Licensed staff to receive an in-service from Staff Developer (or designee) on the updated grievance forms, and policy & procedure when reporting a grievance. The IDT and Nursing Management to receive education on new Grievance process checklist.	

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F 585	Continued From page 15 done. F8 stated there was a recent incident in which the certified nursing assistant (CNA) would not change R8's brief when R8 reported she was wet. The CNA stated the brief was not wet and argued with the resident about it. F8 stated the CNA was wearing gloves and could not tell the brief was wet; however, it was verified the brief was wet. F8 stated she was on the phone with R8 when this incident occurred and heard everything. During an interview on 02/13/24 at 12:19 PM, F88 stated if R8 did not receive timely assistance to get a soiled brief changed she called F8 or F88 and then she or F8 called the front desk. F88 stated there was an instance when she stayed on the phone with R8 while R8 was waiting to be changed. A nurse reported to the family that R8 had been changed; however, F88 stated she had been on the phone with R8 the whole time and no one had come and changed R8. F88 stated the staff denied everything and continued to do what they wanted to do. A review of grievances filed by R8, F8 or F88 04/03/23 through 08/23/23 were reviewed. There was a total of nine grievances during this period that did not include sufficient findings, and/or did not include written documentation at the conclusion of the grievance to the complainant as follows: 1. Review of the "Record of Concern/Complaint," dated 04/03/23 and provided by the facility, revealed R8 reported CNA7 often made her wait on the toilet 30 minutes or more and gave her grief when she asked for assistance. There was no documentation in the grievance file of any staff statements and no evidence of a written response being provided to the resident at the conclusion of	F 585	4. Social Services Director (or designee) will conduct audits of Grievances daily x 3 to ensure that they are resolved promptly with findings reported to the resident/family until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. 5. Corrective action will be completed on April 15, 2024.	

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the investigation.

During an interview on 02/13/24 at 4:16 PM, the Social Service Director (SSD) stated she was the Grievance Official. The SSD verified there were no staff statements, no written documentation following the grievance provided to R8 or R8's family, and no decision whether it was validated. The SSD stated CNA7 was eventually terminated (09/28/23) due to complaints from other residents.

2. Review of the "Record of Concern/Complaint," dated 06/12/23 and provided by the facility, revealed R8 reported on 06/11/23 she pushed her call light at 10:00 PM and her assigned CNA never came to the room. R8 reported she asked her nurse for Imodium (medication for loose stools); however, did not receive it and reported her commode was broken. There was no documentation in the grievance file of any investigation into the allegation of R8's CNA never coming to her room. There were no staff statements and no evidence of a written response being provided to the resident at the conclusion of the investigation, and no grievance decision of whether it was validated.

During an interview on 02/13/24 at 4:16 PM, the SSD verified there were no staff statements and no written documentation following the grievance provided to R8 or R8's family.

3. Review of the "Record of Concern/Complaint," dated 07/01/23 and provided by the facility, revealed R8 reported CNA9 was mean and did not clean her adequately and that the 3:00 PM - 11:00 PM CNA found stool in her clothes. There was a statement from CNA9 who stated there

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was no stool when she and a second unknown CNA went back in to check R8 after the allegation was made. There were no additional statements.

During an interview on 02/13/24 at 4:16 PM, the SSD stated one of the CNAs went to change R8 (after CNA9) and said she should be wiped more appropriately, and she cleaned her up; there was no documentation of this in the grievance/grievance file. The SSD verified there was no written documentation following the grievance provided to R8 or R8's family, and no grievance decision of whether it was validated.

4. Review of the "Kutz Senior Living Grievance Form," dated 08/07/23 and provided by the facility, revealed R8 reported CNA5 refused to walk her and put her clothes out for the next day. R8 stated Licensed Practical Nurse (LPN) 1 said she rang the call bell too much. The file included statements from CNA5 who denied refusing to care for R8. There was a statement from LPN1 who verified she told the resident her excessive call bell used resulted in delayed care to other residents.

During an interview on 02/13/24 at 4:16 PM, the SSD verified there was no written documentation following the grievance provided to R8 or R8's family, and no grievance decision of whether it was validated.

5. Review of the "Kutz Senior Living Grievance Form," dated 08/23/23 and provided by the facility, revealed R8 reported she began ringing her call light at 10:00 AM and at 11:07 AM she had not received assistance to use the toilet. There were no staff statements and no written documentation of whether it was validated.

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F 585	Continued From page 18 During an interview on 02/13/24 at 4:16 PM, the SSD indicated CNA10 was assigned to the resident and was terminated on 08/30/23, but not related to this complaint. The SSD verified there was no written documentation following the grievance provided to R8 or R8's family, and no grievance decision of whether it was validated. 6. Review of the "Kutz Senior Living Grievance Form," dated 12/26/23 and provided by the facility, revealed F8 and F88 made the complaint that R8 pressed her call bell at 11:30 AM to be changed and she was not changed until after 2:50 PM. Under "Summary of Pertinent Findings or Conclusions" the following was documented, "From 11:20 AM - 3:00 PM resident's assigned CNA was in and out of resident's room 6 x [times]. - Additional staff in the room throughout that time were the OT [occupational therapist] and the Kutz physician. - Resident was changed prior to 2:50 PM per camera footage . . . Grievance was unsubstantiated." There were no staff statements including from CNA9, who R8 was assigned to, or from the other individuals who were named going in and out of the room, or from the nurse on duty that shift. It was unclear how long the call light was on before it was answered. During an interview on 02/13/24 at 4:16 PM, the SSD stated garbage (incontinence brief) was removed from R8's room at 2:09 PM per review of the hallway camera; therefore, the incontinence brief was changed before 2:50 PM. The SSD stated she did not know when the light was activated as the camera did not show that. The SSD verified she did not know how long the call light had been on.	F 585		

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7. Review of the "Kutz Senior Living Grievance Form," dated 12/28/23 and provided by the facility, revealed F8 and F88 made the complaint that R8 "waited a significant amount of time to be changed by her aide. When asked if they could specify the shift or time period [F8 and F88] said that they were unable to do so." Under "Summary of Pertinent Findings or Conclusions" the following was documented, "LSW [licensed social worker, the SSD] viewed the camera footage from 7:24 AM - 10:30 AM. -In that time 10 nursing staff members entered and exited the resident's room to attend to resident. -Additional staff that entered resident's room were restorative staff and the hairdresser. - At 10 AM CNA got resident up and in her wheelchair and took resident to the hair salon ... Grievance was unsubstantiated." There were no staff statements for this complaint.

During an interview on 02/13/24 at 4:16 PM, the SSD stated she did not know which shift the incident had occurred on because the time when it occurred was not identified in the complaint. The SSD stated she view camera footage from 7:24 AM - 10:30 AM. The SSD stated one bag of garbage with soiled briefs came out of the room for the time period from 7:24 AM - 10:30 AM.

8. Review of the "Kutz Senior Living Grievance Form," dated 01/08/23 and provided by the facility, revealed F8 and F88 made the complaint that R8 called them at approximately 6:45 PM and stated she had been pressing her call bell as her pants were wet. The CNA told the resident that her pants were not wet. Resident's daughter reported that the CNA was very rude to the resident and the conversation was overheard on the phone. Under "Summary of Pertinent

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Findings" the following was documented, "LSW observed camera footage from 5:20 PM until 7:40 PM. During that time resident had 11 staff members in and out of her room. LSW observed that resident changed at 6:20 PM . . ." Two CNAs had provided care; however, there was no statement from the CNAs. The statement from the nurse on duty read, "resident's daughter [name] was on phone c/o [complained of] that CNA would not change her mother's wet pajama bottom. This writer went into Room [number] and touched resident's pajama bottom, they were damp in groin area but it is difficult to feel dampness with gloves on . . . CNA entered room and stated, 'I told you they were not wet.' This writer told CNA that they were damp in groin area . . . Asked CNA to put clean pajama bottoms on resident which CNA did . . ." The grievance was unsubstantiated.

During an interview on 02/13/24 at 4:16 PM, the SSD stated she tried but was unable to get a statement from CNA6 who was alleged as being rude to R8. The SSD stated the grievance was unsubstantiated due to not having all the facts (not having all the witness statements).

9. Review of the "Grievance Form," dated 01/12/24 and provided by the facility revealed, "Resident reports that on 01/12/24 she pressed her call bell at 12:00 pm as she had a bowel movement and wanted to be changed. Resident reports that her aide did not come to change her until 2:23 pm. Resident reports that when her aide arrived and changed her, he then unplugged her call bell to keep her from being able to call for assistance." Cross reference to F609 and F610.

The "Grievance Decision Report," dated 01/17/24

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and provided by the facility, revealed steps taken to investigate the incident were "LSW looked at the assignment sheet for 7 - 3 shift. LSW spoke with the Director of Nursing . . . Summary of Pertinent Findings or Conclusions: Determined that resident's assigned CNA had to leave their shift early due to an emergency. A new CNA was assigned to the resident but was feeding other residents at the time that they were reassigned. Resident's call bell was not unplugged by the aide that resident named, as he had already clocked out at 12 pm." The grievance was unsubstantiated.

The grievance file was reviewed; there was no evidence CNA11 was interviewed about the incident. There was no written or signed statement by the R8 beyond the allegation noted in the grievance form. There was no statement by the nurse who was working when the incident occurred or one from the CNA who assumed CNA11's assignment. There was no statement from the staff member who changed R8's brief, allegedly at 2:23 PM. In addition, there was no documentation of staff checking R8's call light to determine if it had been pulled out of the wall.

During an interview on 02/13/24 at 5:17 PM, the SSD stated her investigation revealed CNA11, who was R8's CNA for day shift, left early at noon and told the DON he was leaving early. The SSD stated the DON assumed CNA11 had notified the RN Supervisor; however, he had not and there was no coverage for his assignment (including R8). The SSD verified R8 waited to have her incontinence brief changed due to CNA11 leaving early, a lack of a CNA assuming the assignment, and the replacement CNA (once notified) being busy with lunch. The SSD stated the allegation

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was unsubstantiated because CNA11 was not in the facility at 2:23 PM when R8 alleged her call light was unplugged. The SSD verified there was no statement from CNA11 or any other staff who were working on R8's unit that day. The SSD verified no one checked the call light to see if it had been disconnected.

During an interview on 02/16/24 at 4:15 PM, the Administrator stated the SSD had been working with a consultant and made some changes to the grievance process such as the form which now indicated if the grievance was substantiated or not. In addition, starting around the beginning of 2024, a form was being filled out and provided to the resident/family at the conclusion of the grievance with information about the results of the grievance and the measures that were taken. The Administrator stated she expected there to be statements from staff in the grievance files. The Administrator stated she was surprised the more recent grievances did not have witness statements.

Review of the "Resident and Family Grievances - Kutz Rehabilitation & Nursing" policy, dated 09/01/23 and provided by the facility, revealed, "It is the policy of Kutz Rehabilitation & Nursing to support each resident's and family member's right to voice grievances without discrimination, reprisal, or fear of discrimination or reprisal. Definitions: "Prompt efforts to resolve" include "facility acknowledgment of a complaint/grievance and actively working toward resolution of that complaint/grievance . . . In accordance with the resident's right to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decision on the grievance to the resident or representative at the

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F 585	Continued From page 23 conclusion of the investigation. The written decision will include at a minimum: . . . The steps taken to investigate the grievance . . . A summary of the pertinent findings or conclusions regarding the resident's concern(s) . . . A statement as to whether the grievance was confirmed or not confirmed . . ."	F 585		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and policy review, the facility failed to protect the resident's right to be free from neglect when eight residents (Resident (R) 65, R12, R26, R30, R38, R68, R70, and R233) were not provided care on the 100 B Unit out of 73 residents that resided in the facility on 02/01/23. Certified Nursing Assistant (CNA) 1 left the facility without informing staff he was refusing to care for the residents. During this time, R65 sustained a fall in her room and was found by restorative certified nursing assistants.	F 600	1. As this occured in the past, unable to correct. 2. No other CNA has refused a re-assignment and left the facility without notifying the supervisor since 2/1/2023. 3. RCA: Staff member refused re-assignment and left without notifying supervisor. Whenever there is a mid-shift	4/15/24

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F 600	Continued From page 24 Findings include: Review of R65's undated "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab, revealed the resident was admitted to the facility on 04/14/22 with diagnosis of other sequelae of cerebral infarction (stroke). Review of R65's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 04/11/23, located in the EMR under "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" score of six out of 15 which indicated she was severely cognitively impaired. The "MDS" revealed R65 required extensive assistance of one person with bed mobility, transfers, dressing, eating and toileting. The "MDS" indicated R65 had one fall since the last "MDS" assessment with no injuries. Review of R65's "Care Plan," revised 02/01/23, located in the EMR under the "Care Plan" tab, revealed an actual fall occurred on 02/01/23 with interventions to have call bell within reach, remind/encourage to use; remind resident to use call for any assistance. Review of R65's "Nursing Progress Notes," dated 02/01/23, located in the EMR under the "Prog Note" tab, revealed "Resident was found with her pelvis on the bed and her head on the floor. She was lowered to the floor by staff. VSS [vital signs stable]. Resident c/o [complained of] headache across forehead and next soreness after fall. She is treated with Eliquis [an anticoagulant]. MD [medical director] did bedside visit - received order to send to ED [emergency department] for further evaluation. Family has been made aware."	F 600	re-assignment, the RN Manager will round on the area of re-assignment within 15 minutes to ensure that the assignment has been assumed. Staff Developer, or designee, will educate all nursing staff that refusing a mid-shift assignment and leaving the facility without verbally notifying the supervisor is job abandonment and will be reported to the State Agency as neglect. The same education will be added to the Agency Nursing staff packets. RN managers will be educated by the Staff Developer, or designee, on the new process. 5. Corrective action will be completed on April 15, 2024.	

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Review of R65's "Nursing Progress Note," dated 02/01/23, located in the EMR under the "Prog Note" tab, revealed ". . . Resident was sent out to [hospital] for further evaluation, CT [computed tomography] of head and neck negative. Resident is currently now back in facility."

Review of the facility "Nursing Schedule," dated 02/01/23, provided by the facility, revealed CNA1 was the assigned aide to eight residents on the 100 B Unit (R12, R26, R30, R38, R65, R68, R70, and R233).

Review of the facility's "Initial Report," dated 02/01/23, provided by the facility, revealed "CNA reported the resident [R65] was found partially off the bed with her head on the floor and her hips on the bed. Nurse was summoned and found the resident fully laying on her left side on the floor next to her bed. She had under her head. Resident complained of headache across her forehead and a sore neck. No open skin areas, wearing non-skid socks, able to MAE [move all extremities], no pain in legs or hips. Resident treated with Eliquis [a blood thinner]. Resident stated that she was laying too close to the edge of the bed and leaned over and fell over head first onto the floor. She was unable to say if she was reaching for an item. 911 was called and resident take to [hospital]. Family made aware."

Review of the facility's "5-day Follow-up Report," dated 02/06/23, provided by the facility, revealed "[R65] was initially reported as her head with a pillow were on the floor and her hips and legs were still on the bed. Resident unable to report events leading up to the fall. MD [physician] assessed but with complaints of neck discomfort

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F 600	Continued From page 26 and headache, resident sent for further evaluation and testing. Resident in quarantine in room, with limited supervision and remains high risk for falls. Resident wearing non-skid socks. Care planned interventions in place are call bell on the bed, bed in lowest position, and staff heightened awareness with purposeful rounds. No previous falls in the facility. All falls are evaluated by physical therapy." During an interview on 02/13/24 at 12:56 PM, the Administrator stated CNA1 came to work on 02/01/23 for a special assignment but was given an assignment on the floor by Registered Nurse (RN) 1 due to a CNA testing positive for COVID-19. The Administrator stated RN1 called the Director of Nursing (DON) and asked permission to give CNA1 an assignment on the floor and the DON said yes. The Administrator indicated RN1 notified CNA1 that his assignment changed to patient care on 100 B unit. The Administrator indicated CNA1 clocked out of the building at 8:58 AM without notifying any staff that he was leaving the building. The Administrator revealed CNA1 told the Scheduler he had completed his special assignment but did not tell her that he was leaving for the day. The Administrator revealed CNA2 and CNA3 found R65's head on the floor and body still on the bed at 10:00 AM and RN1 notified her that CNA1 had not gone to his assigned unit that day and RN1 reported it to the State Agency (SA). The Administrator acknowledged CNA1 was suspended without pay for neglect and job abandonment to his residents on 02/01/23 then was terminated for leaving the facility after he was given his assignment and cursing (misconduct) at RN1 on 02/07/23.	F 600		

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During an interview on 02/13/24 at 1:43 PM, CNA3 confirmed while rounding on the residents with CNA2 (restorative aides) on the 100 Unit she heard R65 calling for someone to help her, so she entered her room and found her hanging off the edge of the bed, her head and upper body was on the floor and her lower body was on the bed around 10:00 AM on 02/01/23.

During an interview on 02/13/24 at 1:53 PM, RN1 indicated she called the former DON to get permission to give CNA1 an assignment on the 100 B Unit which included eight residents and she approved the request on 02/01/23. RN1 stated she informed CNA1 of the change in assignment at 8:50 AM and he did not inform her he did not want to take the assignment or that he left the building at 8:58 AM. RN1 indicated she did not know CNA1 left the building until CNA2 and CNA3 notified her that R65 fell in her room around 10:00 AM. RN1 stated she did not verify that CNA1 had shown up for his assignment because that was the unit nurses' responsibility.

During an interview on 02/13/24 at 2:16 PM, CNA2 verified she along with CNA3 heard R65 saying she needed help and when they opened the door the resident's upper body and head was laying on the floor mat and her legs were still on the bed while rounding on the 100 B Unit after breakfast around 10:00 AM on 02/01/23. CNA2 stated R65 had no injuries, but when she asked what she was trying to do before she fell, she stated she did not remember.

During an interview on 02/13/24 at 2:54 PM, CNA1 stated he came in on 02/01/23 at 7:00 AM to complete a special assignment and was told he needed to work on the 100 B Unit. CNA1 stated

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he did not take the assignment because they gave it to him two hours later that day and another CNA was available that they could have assigned to the unit; however, he did not tell anyone that he did not take the assignment. CNA1 confirmed he left the building at 9:00 AM because he was finished with the special assignment and did not tell anyone he was left for the day.

During an interview on 02/13/24 at 4:34 PM, the Human Resources Director revealed that CNA1 was suspended on 02/01/23 for abandonment and neglect of residents and on 02/07/23 at 7:50 AM terminated him for telling RN1 "I'm not f***ing doing this. I don't care" after not wanting to take care of the residents he was assigned.

Review of the facility's policy titled "Resident Abuse Prevention, Protection, Identification; Suspected Crime, Incident Reporting and Investigation," revised December 2023, revealed "the facility will prohibit, prevent, and not tolerate residents to be subject to abuse, violence, neglect, mistreatment, or misappropriation of property by anyone, including: staff members, other residents, family members, resident representatives . . . Any allegation of abuse, neglect, mistreatment, injury of unknown origin, suspected commission of a crime, misappropriation of resident property or financial exploitation will be thoroughly investigated and reported ... Prevention Upon admission residents and resident representatives receive a handbook and a copy of the resident rights. These documents contain abuse information, which is posted at each nurse's station and the information board near the main dining room . . ."

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F 609	Continued From page 29	F 609		
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 abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation 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 abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse 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, record review, and review of facility policy, the facility failed to implement policies and procedures for ensuring the reporting of potential neglect and abuse within two hours for two allegations of neglect/abuse involving nine of twenty-five sampled and four supplemental	F 609	1. State Incident Reports were entered on 3/20/2024 for the staff abandonment on 2/1/2023 by CNA1 and the call bell incident on 1/12/2024 for R8. They will be investigated utilizing the new Grievance/Abuse Packet by 3/25/24.	4/15/24

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F 609	Continued From page 30 residents (Resident (R) 8, R65, R12, R26, R30, R38, R68, R70, and R233). The facility failed to report to the State Survey Agency (SSA) an allegation made by R8 that her certified nursing assistant (CNA) unplugged her call light and failed to report when a CNA did not provide care for eight assigned residents for on hour on 02/01/23. Findings include: 1. Review of the undated "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, revealed R8 was admitted to the facility on 04/03/17 with diagnoses including anxiety disorder, weakness, and chronic kidney disease. Review of the quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 12/20/23, located in the EMR under the "MDS" tab, revealed R8's cognition was intact with a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15. R8 required substantial/maximal assistance with toileting hygiene, and she was always incontinent of bowel and bladder. Review of the "Grievance Form," dated 01/12/24 and provided by the facility revealed, "Resident reports that on 01/12/24 she pressed her call bell at 12:00 pm as she had a bowel movement and wanted to be changed. Resident reports that her aide did not come to change her until 2:23 pm. Resident reports that when her aide arrived and changed her, he then unplugged her call bell to keep her from being able to call for assistance." During an interview on 02/12/24 at 1:11 PM, R8	F 609	2. SSD will review other grievances since 2/16/2024 to ensure no other potential alleged violations went unreported to the State Agency by 3/27/2024. 3. RCA: Nurse Supervisor unaware CNA1 left building and was not returning. Upon learning of CNA1 leaving, the RN Supervisor did not identify the incident as neglect, so did not report alleged neglect violation to the State Agency. In the case of R8, Social Services Director (SSD) immediately determined CNA11 left the building at noon, therefore could not have removed the call bell at 2:23pm, but did not complete a thorough investigation, or identify the allegation as potential abuse. Created Grievance/Abuse Packet and updated Policy and the process to ensure NHA or DON notified of all possible allegations. NHA will serve as the Abuse and Neglect Officer, and will review all allegations of abuse and neglect to ensure timely reporting. The Incident Reporting Policy was reviewed, and revisions were made to include notification of abuse and neglect within 2 hours of notification, and the creation of an Abuse/Neglect Officer. Staff Developer (or designee) to educate RN Managers and IDT on the definition of Abuse and Neglect, the updated Policy, the role of the SSD as the Grievance	

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F 609	Continued From page 31 stated a male staff member disconnected her call light at the wall. R8 stated her call light was on because she had a bowel movement, and she was sitting in feces and had waited over two hours to be changed. R8 stated the incident was upsetting and she had reported it to the nurse on duty. During an interview on 02/13/24 at 12:54 PM, Family Member (F) 8 stated R8 called her when the incident on 01/12/24 occurred. F8 stated R8 told her a male staff member had disconnected the call light because she was using it too much. F8 stated R8 did not know the male staff member's name. F8 stated the incident was reported to the Social Services Director (SSD). During an interview on 02/13/24 at 5:17 PM, the SSD stated she was the grievance coordinator and reviewed grievances to determine if they were reportable to the SSA. The SSD stated the allegation of not changing R8's incontinence brief and unplugging the call light from the wall due to overuse was handled as a grievance. The SSD stated she had not identified the allegation as meeting the criteria for abuse/neglect and indicated she did not think the call light had been unplugged. The SSD stated the incident on 01/12/24 reported by R8 had not been reported to the SSA as a potential allegation of abuse/neglect. During an interview on 02/14/24 at 9:47 AM, the Administrator stated if a staff member pulled resident's call light out of the wall so they would not be able to use it, this could be considered abuse. The Administrator stated the SSD was the abuse coordinator and if an allegation of abuse/neglect were made either the DON or	F 609	Officer, and the NHA□s role as the Abuse/Neglect Officer. 4.Nursing Home Administrator (or designee) will conduct audits of grievances & allegations daily x 3 to ensure that allegations of abuse or neglect are reported timely, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. 5. Corrective action will be completed on April 15, 2024.	

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Assistant DON would enter the state reportable incident into the system.

During an interview on 02/15/24 at 5:18 PM, the DON stated the allegation of failure to change R8's brief and the call light being unplugged so she could not use would be an allegation of neglect, if the staff was able to substantiate it. The DON stated the facility would only report the allegation to the SSA if it was substantiated through investigation.

2. Review of the facility "Nursing Schedule," dated 02/01/23, provided by the facility, revealed CNA1 was assigned to eight residents (R65, R12, R26, R30, R38, R68, R70, and R233) on the 100 B Unit on the day shift with a census of 73.

Review of the facility's "Initial Report," dated 02/01/23, provided by the facility, revealed the facility reported R65 had a fall and was transported to the hospital to the SSA.

During an interview on 02/13/24 at 1:18 PM, former Director of Nursing (DON) revealed the following information was reported to the SSA on 02/13/23: On 02/01/23 at 7:00 AM, CNA1 arrived for a special assignment; at 8:30 AM, Registered Nurse (RN) 1 called her and she gave permission for CNA1 to take the 100 B Unit assignment; at 8:58 AM, CNA1 informed the scheduler he was finished with his special assignment; at 10:03 AM, CNA2 and CNA3 reported to RN1 that R65 was found on the floor in her room and sent to the hospital; at 10:23 AM, RN1 notified her that CNA1 did not take the 100 B Unit assignment and that he left for the day without telling her via text message on her phone; at 11:30 AM, CNA1 contacted her and she notified him that he was

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suspended for two days due to neglect and abandonment of eight residents. The former DON stated she did not report it to the SSA due to being out on leave at this time.

During an interview on 02/13/24 at 2:54 PM, CNA1 stated he came in on 02/01/23 at 7:00 AM to complete a special assignment and was told he needed to work on the 100 B Unit (eight residents). CNA1 stated he did not take the assignment because they gave it to him two hours later that day and another CNA was available that they could have assigned to the unit. CNA1 confirmed he did not tell anyone that he did not take the assignment and he left the building at 9:00 AM because he was finished with the special assignment.

During an interview on 02/14/24 at 3:02 PM, the Administrator confirmed staff did not follow the abuse reporting policy when RN1 reported R65's fall and did not include CNA1 neglected and abandoned eight residents in the initial report to the SSA on 02/01/23. The Administrator stated RN1 had to report R65's fall to the SSA since she was sent to the hospital per the State requirements. The Administrator stated the allegation of neglect should have been reported by staff, but they were investigating it and did not know it was neglect until after it was reported as a fall. The Administrator stated the facility did not have an abuse coordinator, nursing staff were trained to report care concerns to the SSA, and the SSD submitted non-nursing reportable events. The Administrator verified the SSA emailed the former DON on 02/08/23 requesting additional information about R65's fall and staffing on 02/01/23 and the former DON notified the SSA CNA1 did not take the assignment given

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for eight residents on the 100 B Unit in her response on 02/13/23.

During an interview on 02/15/24 at 9:35 AM, RN1 confirmed she sent the initial report to the SSA regarding R65's fall to meet the State reporting requirements on 02/01/23. RN1 stated she had never reported neglect to the SSA in the past and Administration did not tell her to do so.

Review of the facility's policy titled "Resident Abuse Prevention, Protection, Identification; Suspected Crime, Incident Reporting and Investigation," revised December 2023, revealed "Reporting 483.13(c)(2) "The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the Administrator of the facility and to other officials in accordance with State law through established procedures (including to the State Survey and Certification Agency). 'Immediately' means as soon as possible, but ought not exceed 24 hours after discovery of the incident, in the absence of a shorter State time frame requirement. Any employee or anyone who provides services to a patient or resident of a facility on a regular or intermittent basis who has reasonable cause to believe that an alleged violation as described above has occurred must report this immediately to the Charge Nurse. The charge nurse will . . . contact the resident representative, physician, and Administration (if already not aware) and complete an incident report. The charge nurse is to obtain as many signed statements as possible from residents, resident representative, and staff, and document on the Supervisor's report, and submit the incident report to the Division of Long

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F 609	Continued From page 35 Term Care Residents Protection electronically: (https://ltcreporting.dhss.delaware.gov) within 8 hours . . . if there is suspicion that a crime has been committed, employees are required to report to the Division of Long Term Care Residents Protection electronically . . . and to contact local law enforcement within 2 hours if there is serious bodily injury, or within 24 hours otherwise . . ."	F 609		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 record review, interview, and policy review, the facility failed facility failed to thoroughly investigate and document abuse investigations for three of 25 sampled residents (Resident (R) 8, R27, and R48).	F 610	1. As this occured in the past, unable to correct. 2. Social Services Director (SSD) will review other grievances since 2/16/2024 to ensure proper investigation and	4/15/24

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F 610	Continued From page 36 1. Review of the undated "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, revealed R8 was admitted to the facility on 04/03/17 with diagnoses including anxiety disorder, weakness, and chronic kidney disease. Review of the quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 12/20/23, located in the EMR "MDS" tab, revealed R8's cognition was intact with a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15. R8 required substantial/maximal assistance with toileting hygiene, and she was always incontinent of bowel and bladder. During an interview on 02/12/24 at 1:11 PM, R8 stated a male staff member disconnected her call light at the wall on 01/12/24. R8 stated her call light was on because she had a bowel movement, and she was sitting in feces and had waited over two hours to be changed which was upsetting to her. Review of the "Grievance Form" dated 01/12/24, completed by the Social Service Director (SSD) and provided by the facility revealed, "Resident reports that on 01/12/24 she pressed her call bell at 12:00 pm as she had a bowel movement and wanted to be changed. Resident reports that her aide did not come to change her until 2:23 pm. Resident reports that when her aide arrived and changed her, he then unplugged her call bell to keep her from being able to call for assistance." The outcome of the investigation/follow up was, "LSW [licensed social worker] spoke with DON [Director of Nursing] [name] and was notified that resident's assigned CNA [Certified Nursing Assistant (CNA11)] had clocked out at 12:00 pm	F 610	statements from all parties were obtained, by 3/27/2024. 3. RCA: There was no specific investigation process to thoroughly collect evidence and conduct interviews with all staff present at the time, or other residents. Administrator updated the grievance/abuse policy, the Abuse-Risk Management-Forms-Packet and forms, and the Grievance-Risk Management-Forms-Packet outcome forms. A check list was created to ensure all portions of the Grievance/Abuse process is completed. Staff Developer (or designee) to educate all RN Managers and IDT on the definition of Abuse and Neglect, the updated Policy and new Packet, and the NHA□s role as the Abuse/Neglect Officer 4. Nursing Home Administrator (or designee) will conduct audits of allegations daily x 3 to ensure that they are investigated until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. 5. Corrective action will be completed on April 15, 2024.	

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(please see attached clock-in sheet) as he had a family emergency. Per DON, CNA forgot to notify RN [Registered Nurse] Supervisor that he was leaving early. When DON informed RN supervisor that CNA had left, the RN Supervisor had to find an aide to cover resident's room. As it was lunch time and several CNAs were feeding residents and handing out trays it took some time for a CNA to change [R8]."

The "Grievance Decision Report" dated 01/17/24 and provided by the facility revealed steps taken to investigate the incident were "LSW looked at the assignment sheet for 7 - 3 shift. LSW spoke with the Director of Nursing . . . Summary of Pertinent Findings or Conclusions: Determined that resident's assigned CNA had to leave their shift early due to an emergency. A new CNA was assigned to the resident but was feeding other residents at the time that they were reassigned. Resident's call bell was not unplugged by the aide that resident named, as he had already clocked out at 12 pm." The grievance was unsubstantiated.

The grievance file was reviewed; there was no evidence CNA11 was interviewed about the incident. There was no written or signed statement by the R8 beyond the allegation noted in the grievance form. There was no statement by the nurse who was working when the incident occurred or one from the CNA who assumed CNA11's assignment. There was no statement from the staff member who changed R8's brief, allegedly at 2:23 PM. In addition, there was no documentation of staff checking R8's call light to determine if it had been pulled out of the wall.

During an interview on 02/13/24 at 12:54 PM,

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Family Member (F) 8 stated R8 called her when the incident on 01/12/24 occurred. F8 stated R8 told her a male staff member had disconnected the call light because she was using it too much. F8 stated R8 did not know the male staff member's name. F8 stated the incident was reported to the SSD.

During an interview on 02/13/24 at 12:19 PM, F88 stated she was told CNA11 was the CNA who disconnected the call light, but it could have been someone else. F88 stated staff complained R8 used the call light too much. F88 stated they were told the incident never happened. F88 stated, "They deny everything. There is no protection for the patient."

During an interview on 02/13/24 at 5:17 PM, the SSD stated the allegation of not changing R8's incontinence brief and unplugging the call light from the wall due to overuse was handled as a grievance. The SSD stated she had not identified the allegation as meeting the criteria for abuse/neglect and indicated she did not think the call light had been unplugged. The SSD stated her investigation revealed CNA11, who was R8's CNA for day shift, left early at noon and told the DON he was leaving early. The SSD stated the DON assumed CNA11 had notified the RN Supervisor; however, he had not and there was no coverage for his assignment (including R8). The SSD verified R8 waited to have her incontinence brief changed due to CNA11 leaving early, a lack of a CNA assuming the assignment, and the replacement CNA (once notified) being busy with lunch. The SSD stated the allegation was unsubstantiated because CNA11 was not in the facility at 2:23 PM when R8 alleged her call light was unplugged. The SSD verified there was

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no statement from CNA11 or any other staff who were working on R8's unit that day. The SSD verified no one checked the call light to see if it had been disconnected.

During an interview on 02/14/24 at 9:47 AM, the Administrator stated if a staff member pulled resident's call light out of the wall so they would not be able to use it, this could be considered abuse. The Administrator stated the SSD was the abuse coordinator and if an allegation of abuse/neglect were made either the DON or Assistant DON would enter the state reportable incident into the system.

During an interview on 02/15/24 at 5:18 PM, the DON stated the allegation of failure to change R8's brief and the call light being unplugged so she could not use would be an allegation of neglect if the staff was able to substantiate it.

During an interview on 02/16/24 at 4:15 PM, the Administrator stated she had discussed this incident with the SSD and stated if the SSD reported it, she should have followed up which included ensuring all the statements were gathered and included in the file. The Administrator stated she was surprised there were no statements from the staff members who worked with R8 on 01/12/24.

2. Review of a "Face Sheet" found in the "Profile" tab of the EMR revealed R27 was admitted on 09/30/20 with diagnoses including Parkinsons Disease, anxiety disorder and adjustment disorder with mixed anxiety and depression.

Review of the EMR quarterly "MDS," located in the EMR "MDS" tab, with an Assessment

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Reference Date of 12/01/23 revealed a "BIMS" score of 15 out of 15. This indicated R27 was cognitively intact. R27 was care planned for behaviors that included resisting care and making accusations against staff.

During an interview on 02/14/24, R27 stated there have been staff that have been "rough" with her during care and one CNA "yelled at her" when she soiled her bed. She would not provide more specific details but stated she told her nurse when it happened. She stated she needs a lot of help, and some staff do not like taking care of her because it's a lot of work.

3. Review of a "Face Sheet," found in the "Profile" tab of the EMR, revealed R48 was admitted on 06/28/23 with diagnoses including acute on chronic congestive heart failure, history of falls and cerebrovascular disease.

Review of the quarterly "MDS" assessment, found in the EMR "MDS" tab, with an ARD of 12/28/23 revealed a "BIMS" score of 12 of a possible 15 points. This indicated R48 had mild cognitive impairment. R48 intermittently exhibited behaviors including refusals of care and difficulty adjusting to long term care. R48 was care-planned for those behaviors.

During an interview on 02/13/24 at 4:30 PM, R48 stated there were a few staff he did not like because they were "very rude" but he reported it to the facility and to his wife, who "took care of it." R48's wife was called on 02/15/24 at 9:30 AM and confirmed there had been an incident a few weeks ago.

During an interview on 02/14/24 at 3:30 PM, the

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F 610	Continued From page 41 Social Services Director (SSD) stated she was the Grievance Official, and she provided additional grievance/investigative forms for the team to review. Several of the resident complaints/grievances provided by the SSD had been determined to be resolved by the SSD, even if it only included a conversation between the SSD and the aggrieved resident. The SSD stated that ". . .miscommunications and some other things like missing items, can be resolved within the facility . . . as long as the resident is satisfied with the resolution." The SSD did report the two instances for R27 with an incident date of 08/28/23 and for R48 with an incident date of 11/28/23 to the SSA. The SSD stated the accused staff were interviewed and denied being rude or unkind to the residents, so she discussed with R27 and R48 and closed the investigations. The investigations were not thorough and did not include statements from all staff present at the time or other residents. The SSD spoke with the residents and assured them the CNAs in question would not be assigned to care for them again and closed her investigations. During an interview on 02/15/24 at 10:10 AM, the Administrator stated the SSD was the Grievance Official which would make her the Abuse Coordinator. The Administrator stated it was everyone's responsibility to recognize and report potential abuse and/or neglect. The Administrator concurred with the SSD statement that some things needed to be resolved "in-house" and she had discussed this with their state survey agency. She stated the SSD elevated incidents when needed and brought it to her attention. The Administrator stated the former DON/Registered Nurse (RN) 5 completed the 5-day follow ups on all state reportable incidents.	F 610		

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F 610	Continued From page 42 During an interview on 02/15/24 at 4:00 PM, RN5 confirmed she completed the 5-day follow-ups to the state. When asked if she automatically interviewed residents and staff that were present at the time of the incident/allegations, RN5 stated she did not and that interviews should be done by the staff completing the initial reportable incident in the state system. When asked what she did to ensure the grievance was resolved appropriately for the residents, RN5 stated, "I access the complaint in the computer or I get it from the LSW [licensed social worker, SSD] or DON. . ." When asked if she felt there was a disconnect with so many different people involved in their investigations but no one person sees the allegations through from beginning to the end, RN5 stated she did not see that as a concern because it all gets done. Review of the "Kutz Rehabilitation and Nursing Resident Abuse Prevention, Protection, Identification; Suspected Crime, Incident Reporting and Investigation Policies and Procedures" dated December 2023 and provided by the facility revealed, "Investigation - The Director of Nursing or a designee will obtain all information and begin a thorough internal investigation immediately, by interviewing the resident ... interviewing the resident representative, interviewing staff, and interviewing other residents (if appropriate). Residents who are alert and oriented must be interviewed, and the statement must be documented. Handwritten, signed statements are to be obtained, attached to incident report, and maintained with documents ... The results of the investigation are reviewed by Nursing Administration and Administration for action to be taken if necessary ..."	F 610		

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F 610	Continued From page 43 Review of the Review of the "Resident and Family Grievances - Kutz Rehabilitation & Nursing" policy dated 09/01/23 and provided by the facility revealed, "The staff member receiving the grievance will ... Report any allegations involving neglect, abuse ... immediately to the administrator and follow procedures for those allegations ..."	F 610		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of	F 623		4/15/24

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this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402,

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F 623	Continued From page 45 codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure two out of four residents (Resident (R) 35 and R51) reviewed for hospitalization were provided with a written transfer notice upon emergent transfer to the hospital. Findings include: 1. Review of the undated "Profile Face Sheet," provided by the facility, revealed R35 was	F 623	1. Unable to correct. 2. Unable to correct. 3. RCA: Facility knowledge deficit regarding Transfer Notice regulation is to include the resident. "Transitions of Care Policy and Procedure Admission, Transfers, and Discharge" states Upon any discharge, the Resident Representative is to receive a notice in	

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	085043	A. BUILDING _____ B. WING _____	C 02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 623	Continued From page 46 admitted to the facility on 07/26/17 with diagnoses including in pertinent part Parkinson's disease, a jejunostomy (J) feeding tube (tube placed through the skin of the abdomen into the midsection of the small intestine), and a gastrostomy (G) feeding tube (tube placed into the stomach). Review of the quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 11/01/23, located in the electronic medical record (EMR) under the "MDS" tab, revealed R35 was moderately impaired in cognition with a "Brief Interview for Mental Status (BIMS)" score of 11 out of 15. Review of a "Nurse's Note," dated 01/25/24 and located in the EMR under the "Progress Notes" tab, revealed R35 was sent to the hospital emergency room, "assessed to have a clogged GJT [G J tubes], MD [medical doctor] and UM [unit manager] attempted to declog the tube with no success . . ." Review of the hospital "Face Sheet," dated 01/25/24 and located in the EMR under the "Misc [miscellaneous]" tab, revealed R36 was admitted due to a "feeding tube obstruction." Review of the letter dated 01/25/24 from the Administrator to R35's family member (F35) revealed the letter was sent informing F35 of the reason for R35's transfer to the hospital. The letter revealed, "As per federal regulation, we are now required to inform resident representatives in writing of any transfer or discharge from the Kutz Senior Living Campus, [R35] was discharged to [name of hospital] due to clogged GJ tube." Review of a "Nurse's Note," dated 01/28/24 and	F 623	writing of the transfer date, location, and the reason for the transfer signed by the Administrator or designee . . ." The policy failed to include the resident. Policy: 'Transitions of Care Policy and Procedure Admission, Transfers, and Discharge" will be updated to include the phrase the resident. The Resident Transfer or Discharge Form will be updated. Upon emergent transfer to the hospital, the shift supervisor will provide the Notice of Resident Transfer or Discharge form to the resident. The shift supervisor is to then complete a Progress Note documenting that this was provided, and to whom. Staff Developer (or designee) will educate shift supervisors on the updated Notice of Resident Transfer or Discharge Form, and to provide the Notice of Resident Transfer or Discharge Form to the resident upon emergent transfer to the hospital, and document in a progress note in the EHR that it was given. 4. Social Service Director (or designee) will conduct a record audit via the Progress Note of all residents who have emergent transfer to the hospital daily x 3 to ensure the Notice of Resident Transfer or Discharge Form was given until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 2 until 100%	

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F 623	Continued From page 47 located in the EMR under the "Progress Notes" tab, revealed R35 readmitted to the facility from the hospital. R35 was hospitalized for three days. During an interview on 02/14/24 at 4:07 PM, the Social Service Director (SSD) stated both the family and ombudsman were notified in writing of residents' emergent transfers to the hospital and the reason for the transfer. The SSD stated she sent the letter to the family and notified the ombudsman monthly of transfers to the hospital. During an interview on 02/16/24 at 1:21 PM, the SSD stated it was not part of her procedure to notify residents in writing of their transfer to the hospital with the reason for transfer. The SSD stated she was not aware of the requirement to notify residents. During an interview on 02/16/24 at 1:24 PM, the Administrator stated F35 was notified in writing on R35's transfer to the hospital; however, she was not aware of the requirement to notify the resident in writing. The Administrator stated the facility had not been notifying residents in writing of the transfer to the hospital and reason for transfer. 2. Review of R51's undated "Admission Record," located in the EMR under the "Profile" tab, revealed R51 was admitted to the facility on 08/07/20 with a diagnosis of hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left dominant side. R51 was readmitted to the facility on 10/26/23 with a diagnosis of gastrointestinal (GI) hemorrhage. Review of R51's "MDS," located in the EMR under the "MDS" tab, revealed a discharge return anticipated "MDS" dated 10/05/23 and an entry tracking record dated 10/26/23.	F 623	compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. 5. Corrective action will be completed 4/15/24.	

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F 623	Continued From page 48 Review of the annual "MDS" with an ARD of 09/25/23, located in the EMR under the "MDS" tab, revealed a "BIMS" score of 15 which indicated R51 was cognitively intact. Review of R51's "Nurses Progress Notes," dated 10/05/23, located in the EMR under the "Prog Note" tab, revealed that R51 was sent to the emergency room (ER) for evaluation of bleeding. Review of R51's "Transfer Notice," dated 10/05/23, provided by the facility, revealed it was addressed to R1's family member and stated the resident was sent to the hospital due to GI issues. During an interview on 02/14/24 at 6:55 PM, R51 confirmed he did not receive a copy of the transfer notice on 10/05/24 but his wife received a letter that indicated the reason for the transfer to the hospital at home. During an interview on 02/16/24 at 1:21 PM, the SSD confirmed that she handled the transfers at the facility and R51 was his own responsibility party however the resident was not provided a copy of the transfer notice. The SSD confirmed the only notice was mailed to his family member. During an interview on 02/16/24 at 1:23 PM, the Administrator stated the transfer notice was mailed to the resident's representative and was not provided to the resident because they were in the hospital. The Administrator stated she was not aware that providing a copy of the transfer notice to the resident was a federal requirement. Review of the "Transitions of Care Policy and Procedure Admission, Transfers, and Discharge"	F 623		

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F 623	Continued From page 49 dated December 2023 and provided by the facility revealed, "Upon any discharge, the Resident Representative is to receive a notice in writing of the transfer date, location, and the reason for the transfer signed by the Administrator or designee . . ." The policy failed to include the resident as a requirement for notification of discharge.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.	F 625		4/15/24

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F 625	Continued From page 50 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the facility failed to ensure two out of four residents (Resident (R) 35 and R51) reviewed for hospitalization were provided with bed hold notices within 24 hours of emergent transfer to the hospital. Findings include: 1. Review of the undated "Profile Face Sheet" provided by the facility revealed R35 was admitted to the facility on 07/26/17 with diagnoses included in pertinent part Parkinson's disease, a jejunostomy (J) feeding tube (tube placed through the skin of the abdomen into the midsection of the small intestine), and a gastrostomy (G) feeding tube (tube placed into the stomach). Review of the quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 11/01/23, located in the electronic medical record (EMR) under the "MDS" tab, revealed R35 was moderately impaired in cognition with a "Brief Interview for Mental Status (BIMS)" score of 11 out of 15. Review of a "Nurse's Note," dated 01/25/24 and located in the EMR under the "Progress Notes" tab, revealed R35 was sent to the hospital emergency room, "assessed to have a clogged GJT [G J tubes] . . ." Review of the hospital "Face Sheet" dated 01/25/24 in the EMR under the "Misc [miscellaneous]" tab revealed R36 was admitted due to a "feeding tube obstruction."	F 625	1. Unable to correct. 2. Unable to correct 3. RCA: Facility knowledge deficit regarding Bed Hold Notice regulation. " Transitions of Care Policy and Procedure Admission, Transfers, and Discharge states Resident and/or Resident Representative. Policy: "Transitions of Care Policy and Procedure Admission, Transfers, and Discharge" will be updated to remove the word or before Resident representative and must be given to the resident. The Notice of Resident Bed Hold form will be updated. Upon emergent transfer to the hospital, the shift supervisor will provide the Notice of Bed Hold form to the resident. The shift supervisor is to then complete a Progress Note that this was provided, and to whom. Staff Developer (or designee) will educate shift supervisors on the updated Notice of Bed Hold Form, and to provide the Notice of Bed Hold Form to the resident upon emergent transfer to the hospital, and document in a progress note in the EHR that it was given. 4. The Social Service Director (or designee) will conduct a record audit via the Progress Note of all residents who have been emergently transferred to the	

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F 625	Continued From page 51 Review of the letter dated 01/25/24 from the Administrator, provided by the facility, revealed it was addressed to R35's family member (F35) and explained the bed hold policy as outlined in the admission policies. There was no documentation showing R35 was provided with a written bed hold notice for the 01/25/24 hospitalization. Review of a "Nurse's Note," dated 01/28/24 and located in the EMR under the "Progress Notes" tab, revealed R35 readmitted to the facility from the hospital. R35 was hospitalized for three days. During an interview on 02/14/24 at 4:07 PM, the Social Service Director (SSD) F35 was notified in writing of the bed hold policy when R35 was transferred to the hospital. During an interview on 02/16/24 at 1:21 PM, the SSD stated it was not part of her procedure to notify residents in writing of the bed hold policy The SSD stated she was not aware of the requirement to notify both residents and family members. During an interview on 02/16/24 at 1:24 PM, the Administrator stated she was not aware of the requirement to notify both the resident and family of the bed hold notice at the time of hospitalization. 2. Review of R51's undated "Admission Record," located in the EMR under the "Profile" tab, revealed R51 was admitted to the facility on 08/07/20 with a diagnosis of hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left dominant side. R51 was readmitted to the facility on 10/26/23 with a	F 625	hospital daily x 3 to ensure the Resident Bed Hold form was given, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. 5. Corrective action will be completed 4/15/24.	

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F 625	Continued From page 52	F 625		

diagnosis of gastrointestinal (GI) hemorrhage.

Review of R51's "MDS," located in the EMR under the "MDS" tab, revealed a discharge return anticipated "MDS" dated 10/05/23 and an entry tracking record dated 10/26/23.

Review of the annual "MDS" with an ARD of 09/25/23, located in the EMR under the "MDS" tab, revealed a "BIMS" score of 15 out of 15 which indicated R51 was cognitively intact.

Review of R51's "Nurses Progress Notes," dated 10/05/23 and located in the EMR under the "Progress Note" tab, revealed that R51 was sent to the emergency room (ER) for evaluation of bleeding.

Review of R51's "Bed Hold Policy," dated 10/05/23 and provided by the facility, revealed it was addressed to R51's family member and explained the bed hold policy as outlined in the admission policies.

During an interview on 02/14/24 at 6:55 PM, R51 confirmed he did not receive a copy of the bed hold policy on 10/05/24 but his wife received a letter that explained the bed hold policy at home.

During an interview on 02/16/24 at 1:21 PM, the SSD confirmed that she handled the transfers at the facility and R51 was his own responsible part but was not provided the bed hold policy in writing, however, the bed hold policy was mailed to his family member on 10/05/23.

During an interview on 02/16/24 at 1:23 PM, the Administrator stated the bed hold policy was mailed to the resident's representative and was

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F 625	Continued From page 53 not provided to the resident because they were in the hospital. Review of the "Bed Hold Policy," dated December 2023 and provided by the facility revealed, "Resident and/or resident representative will be informed in writing of the bed hold policy upon admission to Kutz Rehabilitation and Nursing and again whenever that resident is hospitalized . . ."	F 625		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 657		4/15/24

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F 657	Continued From page 54 assessments. This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review, the facility failed to ensure the care plan was updated for one out of 25 sampled residents (Resident (R) 8) following a change in the resident's ability to ambulate, transfer, use the toilet, and remain continent of urine. This created the potential R8 would not receive appropriate care and services to reach her highest practicable level. Findings include: Review of the undated "Admission Record" in the electronic medical record (EMR) under the "Profile" tab revealed R8 was admitted to the facility on 04/03/17; diagnoses included anxiety disorder, weakness, and chronic kidney disease. Review of the annual "Minimum Data Set (MDS)" with an assessment reference date (ARD) of 09/21/23 in the EMR under the "MDS" tab revealed R8 used a walker for ambulation, and walked in her room with extensive assistance of one person and required extensive assistance from one person for toilet use. R8 was coded as being always continent of urine. Review of the quarterly "Minimum Data Set (MDS)" with an assessment reference date (ARD) of 12/20/23 in the EMR under the "MDS" tab revealed R8's cognition was intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15 (score of 13 - 15 indicates intact cognition). R8 required substantial/maximal assistance with toileting hygiene and she was always incontinent of bowel and bladder. R8 had	F 657	1. Resident #8□s care plan was updated on 2/15/24 by Barbara Martin, LPN. 2. All residents with changes in GG noted from the previous MDS have the potential to be affected by failing to update the care plan. Registered Nurse Assessment Coordinator (or designee) will audit MDS completed since 2/16/2024 to identify residents with changes in GG noted from previous MDS and update the care plans as necessary by 03/27/2024. 3. RCA: Licensed Nurse Assessment Coordinator (LNAC) missed the decline and/or comparing prior GG when completing the MDS and updating care plan, and the RN failed to verify the Care Plan was updated. Before signing and closing an MDS, the Registered Nurse Assessment Coordinator (RNAC) will review the history in the details of the GG section to review for decline in the resident's ability to ambulate, transfer, use the toilet, and remain continent of urine and update the care plan as necessary. RNAC will educate the LNAC to compare previous GG to look for any decline or improvements in function or condition, and care plan accordingly.	

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F 657	Continued From page 55 not transferred to the toilet and did not walk during the assessment period. R8 used a wheelchair for locomotion. Review of R8's care plan dated 04/10/17 in the EMR under the "Care Plan" tab revealed R8 was, "at risk for incontinence of bowel and bladder." The goal was, "Resident will maintain continence x [for] 90 days." Interventions were: -"Anticipate for need to use the bathroom throughout the day. -Assess bowel and bladder upon admission, quarterly and as needed. -Assist to the bathroom as needed and per request -Keep call bell within reach at all times and encourage use as needed for toileting." The care plan for incontinence risk did not identify that R8 had become incontinent, that she no longer used the toilet, and that she wore incontinence briefs. Review of the "Care Plan," dated 07/28/20 and located in the EMR under the "Care Plan" tab, revealed a focus area of, "[R8] had an ADL [activities of daily living] self-care performance deficit. . ." The goal was, "Will maintain current ADL functioning X 90 days." Interventions included: -"Locomotion on/off unit: independent/supervision - limited assistance, support of one, setup help ... -Walk in room: independent with setup help. -Bed mobility: supervision to limited assistance, support of one person . . . -Toilet use: extensive assistance, support of one person -Transfer: Please transfer with one-person limited assist for all out of bed transfer . . ." The "Care Plan" did not identify that R8 no longer walked	F 657	4. Registered Nurse Assessment Coordinator (or designee) will conduct audits of recently completed MDS daily x 3 to ensure that all GG changes from previous assessment have been care planned, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. 5. Corrective action will be completed on April 15, 2024.	

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F 657	Continued From page 56	F 657		

and that a Hoyer lift and two staff were necessary to transfer her.

During an interview on 02/12/24 at 10:00 AM, R8 stated the staff put her in an incontinence brief and she no longer used the toilet. R8 stated she used to be able to walk short distances in the room. R8 verified she no longer walked and was dependent on staff to change her brief. R8 stated when she got out of bed, a Hoyer mechanical lift was used and two staff were needed.

During an interview on 02/13/24 at 3:18 PM, Certified Nursing Assistant (CNA) 12 stated R8 was currently on a check and change program in which her incontinence brief was changed after it was wet. CNA12 verified R8 had previously been toileted when she sat in the recliner (a few months ago); however, she was no longer toileted and remained in the bed and was always incontinent.

During an interview on 02/14/24 at 12:02 PM, Registered Nurse (RN) 1 stated R8 required more care than she had previously. RN1 stated, prior to R8 remaining in the bed, she was continent of urine and used a walker to go to the bathroom. RN1 stated R8 had been in the bed versus the recliner for about three to four months and since staying in bed, R8 was no longer using the toilet and was incontinent.

During an interview on 02/15/24 at 10:07 AM, MDS Coordinator (MDSC) 2 stated R8 used to be continent and could walk to the toilet. MDSC2 stated R8 could not walk anymore and her incontinence brief was now changed while she was in bed. The MDSC2 reviewed R8's care plan and verified it had not been updated to show she

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F 657	Continued From page 57 was incontinent, could no longer walk, did not use the toilet, and a Hoyer lift was needed for transferring the resident. MDSC2 stated the care plan should have been updated to reflect these changes. Review of the "Person-Centered Care Planning" policy dated December 2023 provided by the facility revealed, "The Kutz Home Interdisciplinary team will develop individualized, person-centered care plans that are objective, measurable, and reflect each resident's unique needs and strengths . . . Goals, objectives and measures will be reviewed and/or revised: a. When there has been a change in the resident's condition . . ."	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to notify the wound nurse practitioner when an alteration in skin was identified so wound treatment could be	F 686	1. Wound NP was notified of new skin alteration for Resident R7 on 12/23/2023 and assessed on 12/26.2023.	4/15/24

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F 686	Continued From page 58 ordered and followed by staff for one of three residents (Resident (R) 7) reviewed for pressure ulcers. This failure had the potential to cause infection, and worsening of a pressure ulcer when treatment was not provided to R7's unstageable sacral wound for six days. Findings include: Review of R7's undated "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, revealed R7 was admitted to the facility on 02/09/23 with diagnoses that included heart failure, Parkinson's disease, and vascular dementia. Review of R7's annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/10/23, located in the EMR under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" score of 14 out of 15 which indicated she was cognitively intact. The "MDS" indicated R7 she did not have any pressure ulcers, was at risk for developing pressure ulcers, and was on a turning and repositioning program. Review of R7's "Nursing Progress Notes," dated 12/16/23, located in the EMR under the "Prog Note" tab, revealed "Admission Details: Arrived by: ambulance. Admission mode: stretcher . . . Skin: Skin Issue: #001: New. Issue type: Other skin issue. Location: Coccyx [Back of body above buttocks]. Other skin issue description: open area Length (cm [centimeter]): 0.2 Width (cm): 0.2 Depth (cm): 0.3 Wound exudate: None . . ." Review of R7's "Skin Alteration Record," dated 12/16/23, located in the EMR under the "Prog Note" tab, revealed "Site Coccyx, Type Other	F 686	2. All residents with documented skin alterations have the potential to be affected by failing to notify Wound NP. Director of Nursing (or designee) will audit Skin Alteration UDAs since 2/16/2024 for notifications to Wound NP and make notifications if necessary by 3/27/24 3. RCA: The need for double documentation in a separate handwritten notebook increases the chance of error or omission. WOC NP will assess all admission and re-admissions head-to-toe on 03/19/2024. WOC notebook replaced with Binder. Any UDA with a new skin alteration and the associated progress note will be printed by the nurse identifying the issue and placed in the WOC binder, eliminating the need for additional written documentation in a notebook. Face sheet for all admissions and readmissions will be placed in the binder by the admitting nurse. Staff Developer (or designee) will educate licensed staff on new process for alerting WOC NP for new skin alterations. 4. Director of Nursing (or designee) will conduct audits of skin/admission UDAs daily x 3 to ensure that notification is made to the Wound NP until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI	

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F 686	Continued From page 59 Wound reopened, length 0.2 cm, width 0.2 cm and depth 0.2 cm. Tunneling none, Undermining none, Granulation - pink/beefy red tissue, shiny/moist, Drainage Type none, Pain at site No . . ." Review of R7's "Physician's Orders," start date 12/17/23 and end date 12/18/23, located in the EMR under the "Orders" tab, revealed an order to "Cleanse coccyx with wound cleanser, pat dry, apply Medi honey and cover with CDD [conventional daily dressing] daily every day shift for open area for one day." Review of R7's "Nurse Practitioner Skin and Wound Progress Notes," dated 12/19/23, located in the EMR under the "Prog Note" tab, revealed there was not an assessment of R7's new coccyx wound. Review of R7's "Nurses Progress Notes," dated 12/23/23, located in the EMR under the "Prog Note" tab, revealed "This nurse was approached by [family member of R7 (F7)] in regards to residents wound on her coccyx. This nurse noted redness to residents buttocks and an open area to her coccyx measuring 1.5 [length in cm] x 1 [depth in cm]. Area cleansed with wound cleanser, alginate applied and covered with bordered gauze . . . Supervisor made aware of skin integrity and TX [treatment] order placed. No further complaints voiced from daughter. Resident in lowest position with call light in hand. Plan of care continues." Review of R7's "Physician's Orders," dated 12/24/23, located in the EMR under the "Orders" tab, revealed an order for "Coccyx WC [wound care]: Cleanse area with wound cleanser, pat dry,	F 686	committee monthly x 3 months to ensure compliance is obtained and maintained. 5. Corrective action will be completed on April 15, 2024.	

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apply Alginate, cover with dry sterile bordered gauze daily and prn [as needed] for soiling or lifting." There was no documented evidence of coccyx wound orders from 12/18/23 to 12/23/23, six days.

Review of R7's "Nurse Practitioner Skin and Wound Progress Notes," dated 12/26/23, located in the EMR under the "Prog Note" tab, revealed "Visit Type: Skin and Wound Note . . . Wound Assessment: Wound: 3 Location: sacrum Primary Etiology: Pressure Wound Status: New Odor Post Cleansing: None Stage/Severity: Unstageable Size: 6.8 cm x 7.2 cm x 0.1 cm. Calculated area is 48.96 sq cm. Wound base: 100% slough, 0% eschar, 0% granulation, 0% epithelial Exudate: Moderate amount of serous Wound Pain at Rest: 0 Periwound: Intact, Fragile, Denuded, Scarring Wound Edges: Attached . . . Plan: Wound #3 sacrum pressure treatment recommendations: 1. Cleanse with normal saline. 2. Apply medical grade honey, calcium alginate to base of the wound. 3. Secure with bordered foam. 4. Change daily, PRN . . ."

Review of R7's "Physician's Orders," dated 12/26/23, located in the EMR under the "Orders" tab, revealed an order for "Sacral Wound - cleanse with NSS [normal saline solution], pat dry, apply Medi honey and calcium alginate, cover with bordered foam dressing."

Review of R7's "Medication Administration Record (MAR)," dated December 2023, located in the EMR under the "Orders" tab, revealed wound treatment was provided to the coccyx/sacral pressure injury on 12/17/23, 12/24/23, 12/25/23, 12/26/23, 12/27/23, 12/28/23, 12/29/23, 12/30/23, and 12/31/23. There was no documented

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evidence that wound treatment was provided from 12/18/23 to 12/23/24.

During an interview on 02/15/24 at 9:05 AM, R7 indicated she had a wound on her bottom when she returned from the hospital in December, and it hurt. R7 stated staff have been moving her from side to side and placing a pillow behind her back when she lets them. R7 stated nurses cleaned it and gave her pain medication when she needed it.

During an interview on 02/15/24 at 10:49 AM, Licensed Practical Nurse (LPN) 2 confirmed she was asked by F7 to assess R7's sacral wound on 12/23/23. LPN2 confirmed she cleaned and applied a dressing to the sacral wound, notified Registered Nurse (RN) 1 of the wound, then entered a standard treatment order due to not finding one in the EMR.

During an interview on 02/15/24 at 11:20 AM, RN4 revealed she was the admitting nurse for R7 on 12/16/23 and documented R7's coccyx wound on the admission assessment. RN4 stated nurses were supposed to inform the skin and wound nurse practitioner of the wound by writing the date, resident's name, and location of the wound in the wound logbook at the nurses' station. RN4 stated the nurse practitioner should have seen R7 the next day, so she entered a one day treatment order, but she could not recall if she wrote the information in the wound logbook on 12/16/23. During an interview on 02/15/24 at 4:55 PM, the Director of Nursing (DON) confirmed RN4 did not and should have entered a treatment order until the nurse practitioner rounded at the facility and entered R7's wound information in the wound logbook at the nurses' station so that the nurse

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practitioner would know where the new wound was located on R7. The DON stated she did not know if treatment was provided to the sacral wound by the nurses from 12/18/23 to 12/23/23. The DON stated the process was not followed, and she educated staff on the process when she discovered the error after she was made aware by viewing the nurses' progress note on 12/23/23.

During an interview on 02/15/24 at 3:18 PM, F7 stated when she visited R7 on 12/23/23 R7 complained of pain on her bottom so when the nurse aide was cleaning R7 she asked to see her bottom. F7 stated she saw an open red area on R7's bottom so she asked LPN2 to look at it. F7 indicated LPN2 cleaned and applied a dressing to the area on R7's bottom.

During an interview on 02/16/24 at 12:48 PM, Nurse Practitioner (NP) revealed she was not notified by the nurses that R7 returned from the hospital with a sacral wound on 12/16/23, so she did not assess it when she rounded at the facility on 12/19/23. NP1 confirmed she was not aware of R7's sacral wound until 12/26/23 when she rounded at the facility.

Review of the facility's policy titled, "Pressure Ulcer Treatment," revised December 2023, provided by the facility, revealed "Policy: It is the policy of this facility to provide guidelines for the care of existing pressure ulcers and the prevention of additional pressure ulcers.
Guidelines:
[The facility] contracts with a Wound and Ostomy Care (WOC) vendor for wound and ostomy care assessments and orders. The WOC Advanced Practice RN [Registered Nurse] provides weekly visits to all residents logged as requiring wound

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F 686	Continued From page 63 consults or follow-up. All WOC recommendations are reviewed with the attending physician for ordering and followed by the [facility] clinical staff . . ." Review of the facility's policy titled, "Skin Alteration Management Procedure," revised December 2023, provided by the facility, revealed "When a skin alteration is identified, the nurse will: 1. Document the following information on the Skin Alteration Record: a. Assessment: . . . 2. Obtain an order for a treatment . . ."	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure one of one resident (Resident (R)11) reviewed for	F 688	1. Unable to correct for R11, as incident occurred in the past.	4/15/24

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F 688	Continued From page 64 range of motion (ROM) received services to maintain range of motion ROM. R11's hand splint was not applied in accordance with Physician's orders. Findings include: Review of the undated "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, revealed R11 was admitted to the facility on 05/03/19 with diagnoses including hemiplegia (severe or complete loss of strength or paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side. Review of the quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 12/18/23, located in the EMR under the "MDS" tab, revealed R11 was unimpaired in cognition with a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15. R8 required substantial/maximal assistance with upper and lower body dressing, toileting hygiene, and personal hygiene. R11 was impaired to her upper extremity (shoulder, elbow, wrist, hand) on one side. Review of the "Order Summary Report," dated 05/03/23 and located in the EMR under the "Orders" tab, revealed the Physician ordered, "Don left hand resting splint in AM, doff left hand resting splint at PM before bedtime." Review of the "Treatment Administration Record (TAR)" for January 2024, located in the EMR under the "Orders" tab, revealed R11's left resting hand splint was donned at 6:00 AM 26 days; was	F 688	2. All residents documented with Splints have the potential to be affected by failing to complete the service. Director of Nursing (or designee) will audit Electronic Treatment Administration Record (eTAR) since 2/16/2024 to identify if services were completed and address issues by 3/27/2024. 3. . RCA: No decrease in Range of Motion (ROM) occurred related to the splint refusals. Resident did have Active and Passive ROM for 15 twice daily, seven days a week that maintained her ROM. Splint has since been discontinued, written by OT, cosigned by Dr. Dattani. Refusals were not reported as a change to the doctor timely. Knowledge deficit of nurse of when to notify physician of refusal of order for splint. The Staff Educator will educate licensed nurses on the refusal policy and process. 4. Director of Nursing (or designee) will conduct audits of Residents with Splinting daily x 3 to ensure that residents refusing splinting 3 days in a row have physician notification completed until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI	

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F 688	Continued From page 65 refused twice; and there was no documentation one day. Review of the "TAR" for February 2024 (up through 02/15/24), located in the EMR under the "Orders" tab, revealed R11's left resting hand splint was donned at 6:00 AM four days (02/03/24 - 02/05/24 and on 02/13/24); was refused 10 days, and there was no documentation one day. Review of the Nursing "Progress Notes" from 02/01/24 - 2/15/24, located in the EMR under the "Progress Notes" tab, showed no documentation of R11 refusing to wear the splint; there was no documentation in the notes about the splint at all. Review of the "Care Plan" dated September 2021, located in the EMR under the "Care Plan" tab, revealed a focus area of, "[R11] has an ADL [activities of daily living] self-care performance deficit r/t [related to] CVA [stroke] with left hemiparesis, balance and endurance deficits . . ." The "Care Plan" did not include use of the left resting hand splint as an intervention. Review of the "Care Plan" dated 09/14/23, located in the EMR under the "Care Plan" tab, revealed the focus area of, "[R11] has left hemiparesis . . . she needs to be reminded to move her joints and needs help to move them." The goal was for the resident to remain free of complications including contractures. Although interventions included the provision of active and passive ROM, the left resting hand splint was not included in the care plan. Review of the "Occupational Therapy (OT) Evaluation and Plan of Care" for the certification period from 03/30/23 through 06/25/23, provided	F 688	committee monthly x 3 months to ensure compliance is obtained and maintained. 5. Corrective action will be completed on April 15, 2024.	

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by the facility, revealed R11 had a contracture to her left hand. The reason for the referral was the new onset of decrease in ROM and joint instability. One of the long-term goals was for R11 to wear the resting hand splint on the left hand for up to eight hours a day.

Observations during the survey revealed R11 was in her room and was not wearing the left-hand splint on 02/12/24 at 10:47 AM, 12:00 PM, and 2:04 PM; on 02/13/24 at 10:10 AM, 10:32 AM, and 2:44 PM; and on 02/15/24 at 8:31 AM.

During an interview on 02/13/24 at 2:44 PM, R11 stated she used to wear a left-hand splint but the staff had not brought it and applied to her left hand for over a week. During an interview on 02/15/24 at 8:31 AM, R11 again stated the left-hand splint had not been applied by staff this week.

During an interview on 02/13/24 at 2:59 PM, Certified Nursing Assistant (CNA) 12 stated R11 had a left-hand splint but she had not seen R11 wearing it in a while.

During an interview on 02/14/24 at 12:15 PM, Registered Nurse (RN) 1 stated she thought R11 had a left-hand splint but was not sure if R11 was still wearing it. RN1 stated if there was an order for a splint, the nurses would put it on, typically in the morning.

During an interview on 02/15/24 at 9:42 AM, the Director of Rehabilitation (DOR) stated R11 had a left resting hand splint that should be applied in the morning and removed before bedtime. The DOR verified the last certification period for OT was from 03/30/23 through 06/25/23, which had

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F 688	Continued From page 67 included working the application of the left-hand splint for contracture management. During an interview on 02/15/24 at 12:51 PM, the Administrator stated that according to the February 2024 TAR, R11 had been refusing the splint or removing it and would need to be evaluated for another one. During an interview on 02/15/24 at 3:25 PM, RN3 stated he had not seen R11 wear the resting hand splint. RN3 stated there should be documentation in the progress notes if R11 refused to wear the splint. During an interview on 02/15/24 at 5:40 PM, the Director of Nursing (DON) stated if R11 was refusing to wear the splint, the nurses who cared for R11 should document this in nursing notes. During an interview on 02/15/24 at 3:55 PM, the Administrator stated R11 had been moved from the 500 hall to the 100 hall and the staff on the 100 hall might not have seen the splint and/or known to put it on. A request was made for the policy for splint use. Review of the policy provided titled, "Use of Assistive Devices" dated January 2023 and provided by the facility revealed, "The purpose of this policy is to provide a reliable process for the proper and consistent use of assistive devices for those residents requiring equipment to maintain or improve function . . . The facility will provide assistive devices for residents who need them. Nursing, dietary, social services, and therapy departments will work together to ensure availability of devices . . ."	F 688		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices	F 689		4/15/24

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F 689	Continued From page 68 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to prevent a fall for one of seven residents reviewed for falls (Resident (R) 30). This failure resulted in harm to R30 when the nursing assistant failed to ensure R30 was safe while dressing her in her room; R30 fell and suffered a concussion and an abrasion to her forehead and was hospitalized for eight days. Findings include: Review of R30's undated "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, revealed R30 was admitted to the facility on 09/01/20 with multiple diagnoses to include dementia with agitation, epilepsy, and heart failure. Review of R30's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 09/01/23, located in the EMR under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" score of 99 which indicated the resident was not interviewable. The facility assessed R30 as severely impaired cognitively for decision making. The "MDS" indicated R30	F 689	1. Incident occurred in the past and unable to correct. 2. All residents who impulsively attempt to walk with poor safety awareness and unsteadiness have potential to be affected by this practice. DON, or designee, will audit the care plans and orders for all residents who impulsively attempt to walk with poor safety awareness and unsteadiness and update to include the gait belt for ambulation, transfers and ADL care while out of bed. 3. RCA: CNA had the gait belt off as she was dressing the resident, not transferring the resident. was not transferring the resident, she was dressing the resident and did not know why she removed the gait belt before pulling resident□s pants up. Resident□s orders and care plan will be updated for use of gait belt with transfers, ambulation, and ADL□s while out of bed.	

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F 689	Continued From page 69 required extensive assistance of one person for bed mobility, transfers, walking in the room and corridor, locomotion on and off the unit, dressing, eating, toilet use, and personal hygiene. The "MDS" revealed R30 was not steady, only able to stabilize with staff assistance when moving from seated to standing position, walking, turning around, moving on and off the toilet, and surface-to-surface transfer. Review of R30's "Care Plan," dated 10/05/22 and located in the EMR under the "Care Plan" tab, revealed the problem "[R30] likes to walk but is unsteady" with care planned interventions as "NURSING REHAB[Rehabilitation]/RESTORATIVE: Walking program will Ambulate up to 300 ft. [feet] 1 [one] time/day with hand held assist 1-2 [one to two] person 7 [seven] days/wk. [week]." Continued review of the care plan, dated 02/24/23, revealed R30 was at high risk for falls. Continued review of the care plan, dated 09/05/20, revealed the problem "ADL self-care performance deficit r/t [related to] Confusion, Dementia, decrease in mobility, OA [osteoarthritis], IBS [irritable bowel syndrome], muscle weakness" with interventions of "Dressing: extensive assistance, support of one person" and "Toilet Use: extensive assistance, support of one person." Review of R30's "Fall Risk Evaluation," dated 12/01/23 and located in the EMR under the "Evaluations" tab, revealed the facility assessed R30 with a score of 13 which indicated she was at risk for a fall due to having a balance problem while walking. Review of R30's "Nursing Progress Notes," located in the EMR under the "Prog Note" tab	F 689	All residents who impulsively attempt to walk with poor safety awareness and unsteadiness will be care planned to use the gait belt with transfer, ambulating AND for ADL care. Staff Development, or designee, to educate nursing staff on new process for gait belt use during ambulation, transfers, and ADL care while out of bed for residents who impulsively attempt to walk and who have poor safety awareness and unsteadiness. 4. Director of Nursing (or designee) will conduct audits of Residents who need Gait Belts daily x 3 to ensure that Gait Belts are used until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. 5. Corrective action will be completed on April 15, 2024.	

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revealed the following:

On 01/08/24, "Nurse called stat [immediately] to room, upon enter [sic] the room resident was found on floor face down on floor. CNA [certified nursing assistant] stated that she was giving resident AM [morning] care when she pulled away and fell forward, hitting head and face. This nurse log rolled resident and found her unresponsive with snoring respiration, positive pulse, pupils was non-reactive then she begin [sic] to shot [sic] them tight and I was unable to open her [sic] reopen her eyes. 911 called and emergency transfer made, MD [medical director] made aware, resident family also made aware. Resident left facility 911 at 8:41[AM]."

On 01/10/24, "Hospital Update today, 01/10/24: Resident continues with poor responsiveness although awake. CT [computed tomography] was negative for fracture and brain bleed. Continues to be monitored for neuro status. No further updates at this time."

On 01/16/24, "'. . . Admission Details: Arrived by: ambulance. Admission mode: stretcher . . . Skin: Skin Issue: #001: New. Issue type: Skin tear. Location: Right anterior elbow. Length (cm [centimeter]): 0.5 Width (cm): 0.5 Depth (cm): 0 Peri wound: Normal. Painful: No. Normal skin turgor. Skin note: right inner elbow skin tear .5cm and bruise left hip 2cm . . ."

Review of the facility-provided "5-day Report/Findings," dated 01/13/24, revealed "Result of investigation: Employee stated she was providing care. She put her shirt on while in the chair and her pants on resting below the knees. Employee stated, she stood the resident up to

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complete incontinence care, changed incontinence garment, and leaned down to grab resident's pants from around her ankles attempting to pull her pants up. The employee stated the resident quickly turned and attempted to move away from the caregiver and fell face down. The RN [Registered Nurse] that arrived found the resident face down with a piece of incontinence tab found torn and near the resident on the floor. The residents' pants were down around her ankles. Shoes and socks on. Head towards reclining chair, feet towards resident's bathroom. Resident was initially unresponsive, and initial assessment warranted an emergency transport to the ER [emergency room]. MD immediately informed. Hospital findings/ verbal report CT Head - shows no brain bleed, + [positive] concussion. Large hematoma noted to right side of forehead, right eye is swollen. Slight bruise to right back of shoulder and on right side of neck- Resident is intermittently awake. Opens both eyes. Starting to take in small amounts of food by mouth. root cause analysis res [resident] impulsive with no safety awareness. transfer status of one and ambulates with one with hands on assistance and a safety belt to avoid falling. ho [history of] wanting to stand and walk in the middle of care. res ho attempting to move away during care when in the bathroom or when in upright position. Per multiple staff members, care easily provided when res lying in bed. Care planned revisions: increased safety awareness secondary to actual fall during care/ staff to request assistance toileting, and dressing due to impulsivity and risk for falls with care."

Observation on 02/16/24 at 9:58 AM with Licensed Practical Nurse (LPN) 1 revealed when she stood R30 up out of the wheelchair, R30

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leaned forward and was reaching her hands for assistance. Attempts to interview R30 were not possible because the resident was nonverbal. During an interview at this time, LPN1 stated R30 was steady on her feet when standing at times but she would start walking as soon as you stood her up prior to the fall and the restorative aides were aware of her unsteadiness on her feet as well.

During an interview on 02/15/24 at 1:32 PM, RN5 revealed she investigated R30's fall that occurred on 01/08/24 and wrote and sent the 5-day investigation report to the State Agency (SA). RN5 stated her investigation revealed CNA4 began performing care to R30 in the bathroom in her room and CNA4 applied the gait belt to the resident and walked then seated R30 in the recliner where she put on her pants around her ankles, socks, shoes, and top. RN5 stated CNA4 stood R30 up from the recliner without the gait belt on and went behind R30 then pulled up her pants then moved forward then she tripped and fell. RN5 indicated R30 was unresponsive after the fall and was sent to the hospital immediately. RN5 confirmed that CNA4 did not ensure R30 was safe when she was providing care to her.

During an interview on 02/16/24 at 10:05 AM, LPN4 acknowledged she was assigned to R30 and when R30 was assisted from a sitting to standing position, she was steady on her feet for a few seconds then she would start walking. LPN4 stated the aides should stand in front of her when dressing her to keep her from falling because she would start walking immediately and was a high fall risk due to her impaired cognition.

During an interview on 02/16/24 at 10:10 AM,

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CNA4 verified she had walked R30 in the past and knew R30 was impulsive and would start walking when stood up. CNA4 confirmed that on 01/08/24, she moved R30 from the bathroom to the recliner in her room with a gait belt on her, removed the gait belt after seating her in the recliner, stood R30 up from the recliner to pull up her pants from behind her, then R30 walked away and fell. CNA4 stated R30 was steady on her feet without the gait belt on when she stood her up from the recliner and felt it was a safe decision at that point to leave it off and pull up her pants from behind R30.

During an interview on 02/16/24 at 10:26 AM, Physical Therapist (PT)1 verified R30 was a high fall risk due to impaired cognition and did not follow commands. PT1 stated R30 for most part was steady on her feet but could not walk alone, would lean forward, and start to walk when stood up and moved fast.

During an interview on 02/16/24 at 11:03 AM, CNA15 stated she had worked at the facility for one year and was always assigned to R30. CNA15 stated she performed R30's bed bath in the bed then dressed her because it was not safe to wash her in the bathroom. CNA15 confirmed R30 was steady on her feet sometimes but would start walking so she stood in front of her to keep her from falling. CNA15 indicated R30 was a high fall risk due to her impaired cognition and lack of safety awareness.

During an interview on 02/16/24 at 11:35 AM, the Staff Development Coordinator (SDC) stated she began employment at the facility in October 2023 and started auditing falls to develop a working plan on how to move forward in training the

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nursing assistants but had not implemented trainings yet. The SDC stated if a resident was not able to bear weight they should be dressed in bed, then transferred to the chair for meals. The SDC confirmed R30 had a history of trying to walk away during care, and the fall could have been avoided by requesting staff assistance with care, not removing the gait belt, and standing in front of the resident while pulling up her pants.

During an interview on 02/16/24 at 1:39 PM, the Medical Director verified she was notified on 01/08/24 that R30 fell in her room and was sent to the emergency room per her orders. The Medical Director stated R30 was found unresponsive after hitting her head on the floor. The Medical Director stated R30 had a concussion and an abrasion on her forehead. The Medical Director confirmed R30 was a high falls risk because she was unsteady on her feet and had dementia so severe that she thinks she can walk.

Review of the facility-provided policy titled, "Fall Program," dated March 2017, revealed "Policy: It is the policy of this facility to institute individualized practices to minimize the resident's risk of falling. The facility will monitor safety and implement preventative interventions. Procedure: . . . 3. In the event of a fall: a. The RN will assess the resident before he/she is moved and document the findings. b. The physician will be notified of assessment findings. The MD [medical director] will make the determination if hospitalization is indicated. c. Resident's representative will be notified and made aware of the physician recommendation. d. An incident report will be completed by the charge nurse/nursing supervisor. The report will be sent

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F 689	Continued From page 75 electronically to the Long Term Care Resident Protection Division as per state guidelines. e. A Post incident note will be completed by the charge nurse/nursing supervisor. f. Documentation will include witness statements and nursing assessment . . . Any abnormal findings will be reported to the physician as soon as possible. i. Nursing administration will complete a 5 day follow up of the incident and document findings accordingly as needed . . ."	F 689		
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore	F 690		4/15/24

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F 690	Continued From page 76 continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure one out of two residents (Resident (R) 8) reviewed for bowel and bladder was assessed following a decline in continence. In addition, the facility failed to ensure R8 had services and care implemented to maintain as much continence as possible. R8 declined from being continent/mostly continent of urine to becoming incontinent of urine and wearing incontinent briefs following a decline in her ability to use the walker and go to the toilet. Findings include: Review of the undated "Admission Record" in the electronic medical record (EMR) under the "Profile" tab revealed R8 was admitted to the facility on 04/03/17 with diagnoses including anxiety disorder, weakness, and chronic kidney disease. Review of the annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 09/21/23, located in the EMR under the "MDS" tab, revealed R8 used a walker for ambulation, and walked in her room with extensive assistance of one person and required extensive assistance	F 690	1. Unable to Correct 2. All residents with continence changes noted from the previous B/B Program Screener UDA can be affected by failing to implement services/care. Registered Nurse Assessment Coordinator (or designee) will audit B/B Program Screener UDA completed since 2/16/2024 to identify residents with decline in continence noted from previous and ensure services/care provided as necessary by 03/27/24. 3. RCA: A.) The B/B Program Screener UDA for September 2023 was completed; the December 2023 B/B Screener UDA was not completed timely, and a supervisor rescheduled it to March 2024. B.) Nurses have not been looking at the scheduled UDAs to alert them which ones are due, but opening new ones when they are notified by LNAC/RNAC. This has led to some UDAs being missed. C.) The Policy has older names for the UDA and the task to track the elimination pattern listed in the policy.	

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F 690	Continued From page 77 from one person for toilet use. R8 was coded as being always continent of urine. Review of the quarterly "Bowel and Bladder Program Screener" signed on 09/27/23 in the EMR under the "Assessment" tab revealed R8 was identified as voiding appropriately without incontinence "Not always, but at least daily." R8 was able to get to the bathroom and transfer to the toilet or commode with the assistance of one person. R8 was usually aware of the need to use the toilet. The resident's score was 15 and R8 was noted to be a "good candidate for retraining." Review of the quarterly "MDS" with an ARD of 12/20/23 in the EMR under the "MDS" tab revealed R8's cognition was intact with a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15. R8 required substantial/maximal assistance with toileting hygiene and she was always incontinent of bowel and bladder. No trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) had been attempted since urinary incontinence was noted. R8 had not transferred to the toilet or walked during the assessment period. R8 used a wheelchair for locomotion. Review of the EMR revealed the quarterly "Bowel and Bladder Program Screener" to be completed with the quarterly "MDS" with an ARD of 12/20/23 was not completed. Review of the EMR revealed the "Elimination Pattern Evaluation tool," triggered due to R8's decline in urinary continence between 9/21/23 and 12/20/23, had not been completed. The facility failed to complete the five-day voiding pattern and evaluate the potential for an individualized toileting/training program as directed by the "Bladder Management Program"	F 690	D.) Tasks for B/B Elimination Pattern (found in PCC Daily Tasks) were not being used as it did not contain the correct questions, and have not been used as a voiding diary. There was inconsistency between the September Quarterly B/B Program Screener and the MDS, which reflected R8□s varying abilities from one day to the next. They both reflected R8□s abilities for only one particular day. Per the interdisciplinary staff progress notes for R8 from 9/1/2023 to 9/30/2023, the notes reflect R8□s ability on one day, followed by inability or refusal on the next, and so on. The Policy was updated to reflect the proper names for the B/B Program Screener, removal of the B/B Elimination Pattern task, and the B/B Elimination Pattern Evaluation form was added. Licensed staff will be educated on how to open UDAs that are due from the New Assessment Schedule, and CNAs will be educated on utilizing the B/B Elimination Pattern Evaluation form. LNAC/RNAC will trigger the B/B Elimination Pattern task for the CNAs to complete when they note a decline in Bowel and Bladder status. LNAC/RNAC will write a progress note in the resident□s electronic medical record when they find inconsistencies between a B/B Program Screener UDA and their MDS assessment to explain the difference.	

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F 690	Continued From page 78 policy. Review of the "POC [Point of Care] Response History" from 01/18/24 - 02/16/24 revealed that R8 was incontinent 86 times and was continent once. Review of the "Care Plan" dated 04/10/17 in the EMR under the "Care Plan" tab revealed R8 was at risk for incontinence of bladder and directed staff to take R8 to the toilet. The care plan was not updated. Cross reference F657. During an interview on 02/12/24 at 10:00 AM, R8 stated she had been not allowed to go to the bathroom during certain times of the day, such as during lunch because the staff were serving lunch and feeding residents. R8 stated the staff put her in an incontinence brief and she no longer used the toilet. R8 stated she used to sit in a recliner in the room and she had been able to walk short distances in the room such as to the toilet with staff assistance. R8 stated it had been decided she would now stay in bed versus sitting in the recliner since she lost her ability to use her walker due to a loss of function in her hand. R8 verified she no longer walked and was dependent on staff to change her brief. R8 stated when she got out of bed, a Hoyer mechanical lift was used. Observations during the survey revealed that R8 remained in her bed and she was not observed in a recliner. R8 was in bed on 02/12/24 at 11:45 AM; 02/13/24 at 10:13 AM, 10:19 AM, 10:22 AM, 10:26 AM, 10:31 AM, 2:50 PM; and on 02/15/24 at 8:40 AM. During an interview on 02/13/24 at 3:18 PM, Certified Nursing Assistant (CNA) 12 stated R8	F 690	Staff Developer, or designee, to educate Licensed staff on the updated Policy, completing the B/B Program Screener UDA from schedule (not opening a new one) and CNA staff on completing the B/B Elimination Pattern Evaluation form when scheduled. 4. Registered Nurse Assessment Coordinator (or designee) will conduct audits of recently completed B/B Program Screener UDA daily x 3 to ensure that all residents with decline in continence from previous UDA have care/services implemented until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 2 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. 5. Corrective action will be completed on April 15, 2024.	

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	085043	A. BUILDING _____ B. WING _____	C 02/16/2024

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was currently on a check and change program in which her incontinence brief was changed after it was wet. CNA12 verified R8 had previously been toileted when she sat in the recliner (a few months ago); however, she was no longer toileted and remained in the bed and was always incontinent.

During an interview on 02/14/24 at 12:02 PM, Registered Nurse (RN) 1 stated R8 required more care than she had previously. RN1 stated, "I think she knows when [she] needs changed." RN1 stated, prior to R8 remaining in the bed, she was continent of urine and used a walker to go to the bathroom. RN1 stated R8 previously needed assistance with wiping and pulling her pants up after using the toilet. RN1 stated R8 had been in the bed versus the recliner for about three to four months and since staying in bed, RN1 stated R8 could no longer ambulate using the walker due to the loss of function to her hand and that was why she was no longer taken to the toilet. RN1 stated R8 was no longer using the toilet and was incontinent. RN1 stated staff did not use the Hoyer to transfer R8 to the toilet or to a commode.

During an interview on 02/15/24 at 10:07 AM, MDS Coordinator (MDSC) 2 stated R8 used to be continent and could walk to the toilet. MDSC2 stated R8 could not walk anymore and her incontinence brief was now changed while she was in bed. MDSC2 verified the MDS assessments from September 2023 to December 2023 showed a decline in R8's continence. MDSC2 stated the quarterly "Bowel and Bladder Program Screener" due in December 2023 had not been completed. MDSC2 stated R8 was identified as being a good candidate for a toileting

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program; however, a toileting program had not been attempted.

During an interview on 02/16/24 at 10:14 AM, RN2 stated when R8 used the toilet previously she wore a pad in her underwear for dribbling. R8 voided on the toilet and knew when she needed to void. RN2 stated R8 lost her physical ability to hold the walker due to an issue with her hand. This had prevented R8 from being able to use the toilet.

During an interview on 02/16/24 at 3:00 PM, the Former DON stated there should be a form in the software to record voiding patterns and completion of the form should be triggered from the change from being continent to incontinent. The Former DON stated interventions should be implemented following the change to becoming incontinent.

During an interview on 02/16/24 at 4:36 PM, the Administrator stated the facility used to implement toileting plans. The Administrator reviewed R8's EMR and verified there was no voiding pattern form completed. The Administrator stated the forms had changed recently with a software change. The Administrator stated if documents were not opened correctly, additional assessments such as for incontinence, would not trigger when they should.

Review of the "Bladder Management Program" dated December 2023 and provided by the facility revealed, "It is the policy of this facility to assess residents for continence and to provide the care and treatment required to reach his/her highest level of continence possible. Procedure: 1. The Bowel and Bladder Program Screener tool will be

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F 690	Continued From page 81 utilized on admission, readmission, and quarterly and/or in response to a change in a resident's status . . . A score of 7-14 points= Resident is likely to benefit from a bladder toileting schedule (timed voiding) . . . A score of 15 - 21 pointes= Resident is likely to benefit from a bladder toileting schedule . . . The resident's voiding pattern will be evaluated for 5-10 days utilizing the Elimination Pattern Evaluation tool on residents Task . . . Once the voiding pattern form is completed, the Nurse Assessor will review findings and determine appropriate program . . ."	F 690		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, the facility failed to ensure the	F 812	1. 1a) Lodge Kosher Tray shelf was cleaned	4/15/24

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F 812	Continued From page 82 kitchen was maintained in a sanitary condition for 79 out of 82 total residents (three residents received nutrition via feeding tubes). Specifically, foods and utensils were not stored appropriately and kitchen surfaces were not clean. Findings include: 1. The initial kitchen inspection was conducted without the Dietary Manager (DM); he was not in the facility when the inspection was completed. During the initial inspection on 02/12/24 from 9:06 AM through 9:26 AM the following concerns were noted: a. Observations revealed there were three lids (that covered plates for meal service to residents' rooms) stored on the shelf for clean items that had food residue and crumbs on the interior surface of the lids. In addition, there was a large tray, stored as clean, with scattered food crumbs on the surface. b. Observations in the dry food storeroom revealed there were two spoodles stored on top of two five-gallon buckets with bulk foods. There was a box of cornstarch with the top of the box torn open, exposing the contents. There was a large resealable plastic bag with food that was not identified (looked like breadcrumbs) with the name of the food; there was no label on the resealable bag. c. Observations in the dish room revealed the counter on the clean side where dishes were removed from the dish machine was noted with numerous food crumbs and particles covering the stainless-steel counter. In addition, there was discolored black and brown/orange-tinged	F 812	by Food Service Director on 2/14/2024. 1b) Spoodles x 2 on buckets were not there during the 2nd observation. 1c) Dishwasher debris was in part related to a hose that was incorrectly directed which was corrected by EcoLabs on 2/20/2024, walls and floor were cleaned by housekeeping on 2/20/24 1d) Food residue on cups was not there during the 2nd observation. 2a) Same as 1c 2b) Food residue on bowls, removed and placed for rewashing by Food Service Director on 2/14/2024. 2c) Open box discarded by Food Service Director on 2/14/2024. 2d) Ice touching the Walk-in freezer floor was discarded by 2/18/2024 and a pallet placed on the floor for the remainder of the ice to sit on. 2e) Same as 1a 2f) Spoodle on lid was removed and placed for rewashing by Food Service Director on 2/14/2024. 2. Unable to identify other residents. 3. RCA: Cleaning schedules of listed items did not match items necessary in kosher kitchen. Staff not completing task because they are not specifically assigned. Spoodles do not have signage with permanent storage area assigned. Updated cleaning schedule to reflect areas identified, current kitchen layout,	

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F 812	Continued From page 83 residue along the walls under the dish machine area and on the floor underneath the dish machine. There was brown residue on the stainless-steel wall in the dish room adjacent to where the clean dishes came out of the dish machine. d. There was a stack of several plastic cups some food residue adhered to the interior drinking surface; the cups were stored with clean items. 2. Observations were made in the kitchen with the Dietary Manager (DM) on 02/14/24 from 11:09 AM through 11:52 AM. The following concerns were noted: a. Observations in the dish room revealed the counter on the clean side where dishes were removed from the dish machine was noted with numerous food crumbs and particles covering the entire counter. In addition, there was discolored black and brown/orange-tinged residue along the walls under the dish machine area and on the floor underneath the dish machine. There was brown residue on the stainless-steel wall in the dish room adjacent to where the clean dishes came out of the dish machine. The DM verified the soiled areas and stated the counter needed to be cleaned and there should not be food residue on the counter. b. Observations in the kitchen revealed there were two bowls on the shelf for clean dishes that were noted with food residue/particles on the inside surface; the DM verified the bowls were not clean. c. Observations in the dry storeroom revealed	F 812	changed to weekly instead of monthly, assignment of tasks to specific staff at the beginning of the week. Created labels with permanent storage information for Spoodles. Using a degreaser U4, Environmental Services Director (ESD) cleaned the floor under the dishwasher, however the paint is worn and will need to be repainted. The brown residue on the stainless-steel wall in the dish room adjacent to where the clean dishes came out of the dish machine was cleaned with multiple methods. However, it is not a residue on the surface. It is a pitting that occurs when the protective oxide layer of the stainless steel breaks down, causing the bare metal to oxidize. It appears as small, dull-looking dots that can spread around the sur4face of the metal. Will follow up with Ecolabs for restoration or replacement of that area. Food Service Director (or designee) to educate kitchen staff on new cleaning schedule and permanent storage of Spoodles. 4. Food Service Director (or designee) will conduct audits of Kitchen daily x 3 to ensure that it maintains a sanitary condition, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI	

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F 812	Continued From page 84 there was an opened box (lid was not closed) of corn starch. The DM stated the lid should have been closed and removed the box of corn starch from the shelf for disposal. d. Observations in the walk-in freezer revealed there were numerous large bags of ice stored directly on the floor of the freezer. The DM stated the ice machine broke on the previous Friday and 1000 pounds of ice had been delivered the day before, indicating the bags observed were what remained from the delivery. The DM stated the ice should be stored on a shelf or a palette and not directly on the floor. The DM stated he had not been present when the ice was delivered and if he had, he would have ensured the ice was stored off the floor. The walk-in refrigerator was inspected and the DM stated food should be labeled with the name of the item, the date the food was placed in the walk-in refrigerator and the date the food expired. e. Observations revealed there were two lids (that covered plates for meal service to residents' rooms) stored on the shelf for clean items that had food residue and crumbs on the interior surface of the lids. f. Observation revealed there was a spoodle stored on top of the lid of a bulk container of thickener. The DM stated the spoodle should not be stored directly on the lid, indicating this was not a clean surface. 3. During an interview on 02/16/24 at 11:32 AM, the Registered Dietitian (RD) stated foods should be completely covered when stored and should not be exposed to air. The RD stated clean scoops should be stored in holder to keep them	F 812	committee monthly x 3 months to ensure compliance is obtained and maintained. 5. Corrective action will be completed on April 15, 2024.	

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F 812	Continued From page 85	F 812		

sanitary/clean; the RD verified storing scoops/utensils on top of bulk bins was not sanitary. The RD verified that bags of ice should not be stored directly on the floor in the walk-in freezer.

Review of the "Food Storage: Dry Good" policy dated February 2023 provided by the facility revealed, "All dry goods will be appropriately stored in accordance with the FDA [Food and Drug Administration] Food Code . . . All packaged and canned food items will be kept clean, dry, and properly sealed."

Review of the "Food Storage: Cold Foods" policy dated February 2023 provided by the facility revealed, "All food items will be stored 6 inches above the floor . . . All foods will be stored in wrapped or in covered containers . . ."

Review of the "Warewashing" policy dated February 2023 provided by the facility revealed, "All dishware, serviceware, and utensils will be clean and sanitized after each use . . . All dishware will be air dried and properly stored . . ."

Review of the "Environment" policy dated September 2017 provided by the facility revealed, "All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition . . . The Dining Services Director will ensure the kitchen is maintained in a clean and sanitary manner including floors, walls . . ."