STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145930	A. BUILDING _____ B. WING _____	06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - PONTIAC	1225 SOUTH EWING DRIVE PONTIAC, IL 61764

(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
F 000	INITIAL COMMENTS Annual Licensure Certification Survey Complaint #2163746/IL134417 -F607, F610, F689 and F744	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility	F 578		6/23/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/23/2021

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F 578	Continued From page 1 may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to accurately document an advanced directive for one of one resident (R50) reviewed for advanced directives on the sample list of 35 residents. Findings include: The Illinois Department of Public Health Uniform Practitioner Order For Life-Sustaining Treatment (POLST) Form dated 12/14/20 documents R50 wants cardiopulmonary resuscitation to be initiated if R50 has no pulse and is not breathing. The Care Plan dated 5/7/21 documents "(R50) chooses to be a full code with full treatment." The Physician Order Sheet dated 6/3/21 documents R50's advanced directive as "DNR (Do Not Resuscitate)." On 6/3/21 at 1:28 pm V18 Social Services Director stated when R50 was admitted (5/4/21) V18 attempted to discuss R50's advanced directive wishes with R50 but R50 was unable to communicate so V18 spoke with V21 Power of Attorney and V21 stated V21 wanted R50 to be a "Full Code." V18 stated order documenting R50's	F 578	What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: R50; s advanced directive designation was updated in all accessible locations for staff to reflect the wishes of R50 and R50; s power of attorney. R50 discharged on 6/15/2021. How will facility identify other residents having the potential to be affected by the same alleged deficient practice: Advanced directives for all residents have been audited and any discrepancies reviewed with their documented treatment preferences and the residents themselves or their Power of Attorney. What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur: All staff have been instructed where to find advanced directive information.	

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F 578	Continued From page 2 advanced directive status as "DNR" was entered in the computer incorrectly. The Advanced Directives policy revised December 2016 states "The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advanced directives."	F 578	How the facility plans to monitor its performance to make sure that solutions are sustained. All advanced directives for new admissions or changes for current residents will be discussed in the daily QA meeting. Audits will be conducted on a random basis and reviewed in the monthly QAPI meeting.	
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to follow their policy to thoroughly investigate an allegation of physical abuse for two of eight residents (R30 and R50) reviewed for abuse on the sample list of 35 residents. Findings include: The facility's abuse policy dated 4/9/21 states "Each resident has the right to be free from abuse, corporal punishment, and involuntary	F 607	What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: R50 discharged on 6/15/2021. R30 is being monitored for agitation and movement around other residents. How will facility identify other residents having the potential to be affected by the	6/23/21

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F 607	Continued From page 3 seclusion. Residents must not be subject to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals" and "The following are examples of physical abuse: hitting a resident with hand, fist, foot, or object." The policy also states "This facility will thoroughly investigate alleged violations of individual rights and document appropriate action" and "Every employee will be interviewed who was working on the specific hall/wing that the affected resident resides on. Interview the resident if they are cognitively able to answer questions." The facility's abuse investigation dated 5/17/21 documents "(R30) was self propelling in wheel chair and made contact with (R50)." The abuse investigation includes an interview with R50 and no other resident interviews. The facility's abuse investigation does not include interviews with staff present on the unit during the altercation between R30 and R50. On 06/02/21 at 11:16 AM V14 License Practical Nurse stated during morning shift change report (5/17/21) R30 propelled R30's wheelchair to R50 and kicked R30's feet. V14 stated the incident was reported to V1 Administrator by V15 Registered Nurse but no one interviewed V14 about the altercation between R30 and R50. On 6/3/21 at 12:15 PM V15 stated R50 was seated in the common area in a recliner and R30 was also in the common area in a wheelchair. V15 stated when R50 was not paying attention to R30, R30 went up to R50 and started kicking R50. V15 stated R30 kicked R50's feet. V15	F 607	same alleged deficient practice: Random resident interviews are being conducted twice a month to ask if any of them feel they have been abused in any way and to inquire about their interactions with R30. What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur: Education training has been conducted on Abuse Prevention and Reporting including their reporting duties according to facility policy. At orientation and annually Abuse Prevention and Reporting Training will be provided to all employees. How the facility plans to monitor its performance to make sure that solutions are sustained. Random resident interviews will be conducted monthly for 3 additional months. Any allegations of abuse will be reviewed in morning meeting to ensure prompt follow-up was conducted. Abuse interviews and allegations will be reviewed to ensure proper procedures were followed in monthly QAPI meetings.	

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F 607	Continued From page 4 stated V15 separated R30 and R50 and called V1 at home to report the incident. On 06/03/21 at 12:11 PM V1 stated V1 did not interview staff or residents other than R50 when investigating the allegation that R30 kicked R50. V1 reviewed the facility abuse policy and confirmed V1 did not follow the policy when conducting the investigation.	F 607		
F 610 SS=D	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 interview and record review the facility failed to complete a thorough investigation of an allegation of physical abuse for two of eight residents (R30 and R50) reviewed for abuse on the sample list of 35 residents.	F 610	What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice R50 discharged on 6/15/2021.	6/23/21

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F 610	Continued From page 5 Findings included: The Minimum Data Set dated 3/23/21 documents R50 is severely cognitively impaired and requires extensive assistance for transfers. The Minimum Data Set dated 4/12/21 documents R30 is severely cognitively impaired and requires limited assistance with locomotion. R30's Nurse Note dated 5/17/21, written by V15 Registered Nurse, documents "Resident (R30) up since 4:30 (am) wandering in wheelchair into unoccupied rooms, opening outside doors and setting off alarm and yelling "help me" disturbing other residents. Resident wandered up to female resident (R50) sitting in common area numerous times kicking resident's feet and upsetting other resident (R50). (V1 Administrator) contacted regarding kicking. Currently sitting in recliner with attempts to have staff member constantly supervise when not assisting other staff members." The facility's abuse investigation dated 5/17/21 documents "(R30) was self-propelling in wheel chair and made contact with (R50)." The abuse investigation includes an interview with R50 and no other resident interviews. The facility's abuse investigation does not include interviews with staff present on the unit during the altercation between R30 and R50. On 06/02/21 at 11:16 AM V14 License Practical Nurse stated during morning shift change report (5/17/21) R30 propelled R30's wheelchair to R50 and kicked R30's feet. V14 stated the two residents were separated and V15 Registered Nurse notified V1 Administrator of the incident. V14 stated no one interviewed V14 about the	F 610	How will facility identify other residents having the potential to be affected by the same alleged deficient practice: Random resident interviews are being conducted twice a month to ask if any of them feel they have been abused in any way and to inquire about their interactions with R30. Interventions have been implemented to monitor R30; s interactions with other residents. What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur Education training will be conducted on Abuse Prevention and Reporting. At orientation and annually Abuse Prevention and Reporting Training will be provided to all employees. Random resident interviews will be conducted twice a month to ensure that residents don; t feel abused or their personal space has been infringed upon. After one-month random resident interviews will be conducted monthly for 3 additional months. How the facility plans to monitor its performance to make sure that solutions are sustained. Any allegations of abuse will be reviewed in morning meeting to ensure proper procedure was followed such as what was reported and the actions taken thereafter. Abuse interviews and allegations will be addressed to ensure proper procedures	

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F 610	Continued From page 6 altercation between R30 and R50. On 6/3/21 at 12:15 pm V15 stated on 5/17/21 R50 was seated in the common area in a recliner and R30 was also in the common area in a wheelchair. V15 stated R30 wheeled up to R50 numerous times and R50 put R50's walker in front of R50, between R50 and R30 to keep R30 away from R50. V15 stated when R50 was not paying attention to R30, R30 went up to R50 and started kicking R50. V15 stated R30 kicked R50's feet. V15 stated R50 does not speak much but R50 had an unhappy expression on R50's face. V15 stated V15 did not know if R30 was trying to hurt R50 or just trying to get R50's attention. V15 stated V15 separated R30 and R50 and called V1 at home to report the incident. On 6/1/21 V1 Administrator stated to investigate the alleged abuse concerning R30 kicking R50, V1 watched the cameras and saw nothing. V1 confirmed V1 did not interview staff or other residents. V1 also confirmed that the cameras did not show all interactions. V1 stated "I should have interviewed other residents and staff."	F 610	were followed in monthly QAPI meetings.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices 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:	F 689		6/23/21

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F 689	Continued From page 7 A. Based on record review and interview, the facility failed to apply foot pedals to a wheelchair, to provide a safe transport of a resident (R25) when leaving the facility in the facility van. This failure resulted in R25 sustaining a right distal femur and patella fracture, which required emergency treatment, overnight hospitalization and a leg cast. R25 is one of four residents reviewed for accidents/falls on the sample list of 35. B. Based on observation, interview and record review the facility failed to provide supervision to prevent a resident from wandering, impacting six of eight residents (R30, R38, R24, R29, R50 and R13) reviewed for resident to resident altercations on the sample list of 35 residents. Findings include: A. R25's Local Hospital Discharge Summary dated 12/12/20 documents R25 was being discharged to this skilled care facility after an episode of hyperglycemia that resulted in a fall at home which caused R25 an Iliac Wing (Pelvic) fracture. R25's Face Sheet confirms R25 was admitted to the facility on 12/12/20. R25's Minimum Data Set (MDS) to dated 2/8/21 (prior to incident of 3/30/21) documents R25's BIMS score as 14/15 (no cognitive impairment), uses a wheelchair for mobility, does not ambulate, and required physical staff assistance of one person for transfers. On 6/3/21 at 1:25 pm R25 was laying in bed. R25	F 689	What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice R25 will have foot pedals in place when being propelled in a wheelchair. R30; s care plan has been updated for 1:1 activities when in wheelchair. R30 has had a motion detector placed inside room by door frame to alert staff if resident leaves room to wander. R30 was moved to a room closer to the nurse station. How will facility identify other residents having the potential to be affected by the same alleged deficient practice: Random weekly audits will be conducted on scheduled transportation and resident halls to monitor the use of foot pedals for one month. Random resident interviews are being conducted twice a month to ask if they have been abused in any way and to inquire about their interactions with R30. What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur Residents are required to use pedals while propelled. V5, transportation assistant, is no longer employed by the facility. R30; s care plan has been updated for 1:1 activities when in wheelchair. R30 has had a motion detector placed inside room by door frame to alert staff if resident leaves room to	

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F 689	Continued From page 8 stated " I (R25) suffered a fracture to my (R25) right leg from being pushed by (V5, Transportation Assistant) in her wheel chair." R25 pulls back the blankets on her bed to show R25's right leg. R25 had a full length, thigh high immobilizer brace on R25 right leg. R25 stated "I did not have foot peddles on my wheelchair at the time. The transportation person (V5) was pushing my wheel chair without the foot pedals on. My (R25) foot went under the wheelchair. I (R25) have to wear this brace now. My doctor says it will likely not heal completely, as I am getting a little older. I likely will never be able to walk again. I had a cast on (right leg) initially. This happened about two months ago, I don't know the actual date." R25's "Health Status (Nursing) Note" dated 3/30/21 at 9:00 am documents R25 went out of the facility for a follow-up appointment with the dentist (unidentified). R25's "Health Status (Nursing) Note" dated 3/30/21 at 11:13 am documents R25 returned from the dentist appointment. The facility incident investigation includes a signed statement dated 3/31/21, signed by V5, Transportation Department Assistant documents the following: "I (V5, Transportation Department Assistant) transported (R25) to her (R25) Dentist appointment, (V6, Dentist), (local address and phone number) on March 30, 2020 at 9:00 am. As we (V5 and R25) were going into her (R25's) appointment, (R25) dropped her (R25's) foot, stopped holding her (R25's) legs up. Which stopped the wheelchair from it's forward motion, up the handicapped (wheelchair accessible) ramp. (R25) has never used foot rest in the year	F 689	wander. How the facility plans to monitor its performance to make sure that solutions are sustained. Foot Pedal Audits will be reviewed in the monthly QAPI meeting or as needed during the daily QA meeting. R30; s behavior will be discussed in the daily QA meeting. Random resident interviews will be reviewed during the monthly QAPI meeting by the QA committee.	

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F 689	Continued From page 9	F 689		

that I (V5, Transportation Department Assistant) I have been doing Transportation at (the facility name). (R25) said her leg hurt and was pointing just below her (R25) knee. She (R25) asked the receptionist (unidentified at the dentist office) for Tylenol (pain medication). I (V5, Transportation Department Assistant) said no (to R25), she (unidentified receptionist) cannot give you (R25) anything (resident first name used). Then (R25) asked and received an (elastic) bandage. I (V5, Transportation Department Assistant) left to go do another transport. Upon my (V5, Transportation Department Assistant) return to (facility name), I (V5, Transportation Department Assistant) informed Nurse (V7, Registered Nurse) of what happened and got footrest from (R25's) room. When I (V5, Transportation Department Assistant) returned to pick (R25) up at her appointment, she (R25) was in the waiting room (at the dentist office). When we (R25 and V5, Transportation Department Assistant) got back to (facility name), stopped at the nurses desk, as I (V5, Transportation Department Assistant) always do upon returning from appointments. (R25) asked (V7, Registered Nurse) for some Tylenol."

The facility investigation report, had an undated, handwritten witness statement by (V8, Certified Nursing Assistant/CNA) that documents the following: "Transport (V5, Transportation Department Assistant) took resident (R25) to (R25's) room. (R25) complained of pain in knee. Reported to nurse (V9, Licensed Practical Nurse/ LPN). (V9, LPN) told CNA (V8,CNA) to put a warm blanket on (R25's) knee. At 6:00 pm, (R25) could not bear weight, had to use (mechanical stand lift) for transfer.

R25's "Health Status (Nursing) Note" dated

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F 689	Continued From page 10 3/31/21 at 05:39 am, documents the following: "Resident (R25) complained of right knee pain 10 out of 10 (on a scale of one to ten, ten being the worst pain). Unable to bear weight on right leg. Bruising noted on knee. (V10, Nurse Practitioner) notified, awaiting orders (physician)." R25's "Health Status (Nursing) Note" dated 3/31/21 at 09:10 am, documents the following: "X-ray ordered of right knee including distal and lateral femur AP, two views, each scheduled through (private X-ray service) for today." R25's "Health Status (Nursing) Note" dated 3/31/21 at 1:02 pm, documents the following: "(private X-ray service) here to do X-ray." R25's "Health Status Note" nurses note dated 3/31/21 at 1:35 pm documents the following" (V10, Nurse Practitioner) here (in facility) reviewed X-Ray results, new order to transfer to (local hospital) due to distal fracture of right femur." R25's "ED (Emergency Department) to Hospital Admission/ Discharge Summary" Physician Progress Note dated 3/31/21-4/1/21 signed by (V11, Physician) documents the following: " Hospital course: Shows matter (?), further evaluation management of right distal femur fracture. Pain controlled, on oral antibiotics with minimal IV (intravenous) analgesics (pain medication) required. Orthopedic surgery (unidentified person) was consulted, who ordered additional CT (Commuted Tomography) imaging. Recommended non operative management. Short leg cast placed by Ortho (Orthopedic) with instructions for outpatient follow-up." The same "ED (Emergency	F 689		

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(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
F 689	Continued From page 11	F 689		

Department) to Hospital Admission/ Discharge Summary" documents the following Right Femur X-Ray results 3/31/21: "There is a displaced and impacted fracture through the distal femoral metaphysis (end plate of the bone). This is likely comminuted (multiple fragments) There is approximately once centimeter posterior displacement of the distal fragment. No fracture of proximal to mid femur. Stable arthritic changes in the right hip. Diffuse vascular calcifications. Moderate to severe osteoarthritis in the knee." The same "ED (Emergency Department) to Hospital Admission/ Discharge Summary" report documents: "Impression: Acute, impacted, commuted and displaced through the distal metaphysis (end plate of the bone)." The same "ED (Emergency Department) to Hospital Admission/ Discharge Summary" documents the following results of a CT of R25's Right knee results dated 4/1/21 findings: "Twisting injury comparison to Radiograph (X-Ray) 3/31/21. The same CT documents "Injury on wheelchair. Impression: 1. Acute comminuted displaced transverse fracture of the distal femoral diaphysis as described. No intercondylar extension. 2. Acute nondisplaced vertically oriented fracture of the mid- patella (knee cap triangular bone)."

V5, Transportation Department Assistant's " Verbal Discipline Report dated 4/2/21 documents the following: " Please back patients on/off the platform for the lift in the van (facility transportation vehicle). Always use foot pedals on wheelchair for transports."

On 6/3/21 at 3:27 pm V2, Director of Nursing stated "(R25) was taken by our previous transportation staff, (V5, Transportation Department Assistant), to a dentist appointment.

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F 689	Continued From page 12 (V5, Transportation Department Assistant) had not put wheelchair pedals on (R25's) wheelchair before leaving. (R25) should have had foot pedals on her wheelchair before being taken out of the facility. Our expectations for safely transporting residents in a wheelchair, requires staff to put wheelchair foot pedals on when taken residents out." V2 confirmed "(R25's) right leg fracture could have been prevented had the facility protocol been followed." On 6/4/21 at 9:30 am V2, DON and V1, Administrator confirmed R25 was transported without wheelchair pedals on R25's wheel chair which resulted in R25's fractures (right knee and femur. V2, DON also stated "(V5, Transportation Department Assistant) was not following safe transfer procedure when taking R25 out of the facility which caused these preventable fractures." V1, Administrator nodded in agreement. V2, DON also stated "(R25) and should have always had her foot pedals on the wheelchair. I do not have a written policy, but all staff have been educated. Moving forward, they (staff) all know residents being pushed in or outside the facility in their wheelchair should have the foot pedals on at all time. " The Fall policy revised 3/20/18 states "The resident's environment will remain free from accidents and hazards as possible; and each resident will receive adequate supervision and assistance devices to prevent accidents." B. The Care Plan updated 5/26/21 documents R30 has the potential to be physically, verbally and sexually aggressive with staff and that R30 has the potential to be physically aggressive with	F 689		

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other residents related to dementia. The Care Plan also documents R30 has a history of grabbing female staff members inappropriately and that R30 is severely cognitively impaired.

On 6/3/21 at 10:40 am V17 and V19 Certified Nurses Aides (CNAs) transferred R30 from the toilet to the wheel chair. After being assisted into the wheel chair R30 reached out and touched V17's buttock with R30's hand and then R30 propelled R30's self to the door.

The Nurses Note dated 4/27/21 states "(R30) wandering in wheelchair going into other resident's room."

The Nurses Note dated 5/7/21 states "(R30) went into another resident room inside doorway cussing at another resident. Resident was removed from the room and redirected to lounge area."

The Nurse Note dated 5/17/states "Resident (R30) up since 4:30 (am) wandering in wheelchair into unoccupied rooms, opening outside doors and setting off alarm and yelling "help me" disturbing other residents. Resident wandered up to female resident (R50) sitting in common area numerous times kicking resident's feet and upsetting other resident (R50). (V1 Administrator) contacted regarding kicking. Currently sitting in recliner with attempts to have staff member constantly supervise when not assisting other staff members."

The Nurses Note dated 5/18/21 states "(R30) Awake and up since 3:00 am. Wandering hallway in wheelchair and attempting to enter others' rooms. Cursing at staff and combative when

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F 689	Continued From page 14 re-directed. Hits staff and spitting on floor." The Nurses Note dated 5/22/21 states "(R30) wandering in wheelchair into other resident's room, calling staff assholes and saying I'll kick the s**t out of you." Told by female resident he had pulled the covers off her feet and was touching her feet. Another female resident states "is he running around? This is ridiculous." The Nurses Note dated 5/23/21 states "(R30) wandered in wheel chair, needing very frequent redirection to not wheel himself near other residents or into other residents' rooms." The Nurses Note dated 5/25/21 states "(R30) wandering in wheelchair from beginning of night shift until put down for bed at 9:00 PM. Resident opening outside doors and setting off alarms, digging in garbage can and kicking it over, going into female resident's room and touching her feet. Resident hit this nurse in the arm as I walked by him, spitting on the floor, touching sterilizer and moving isolation carts around making it difficult for staff to get work done as he was needing constant attention." The Nurses Note dated 5/27/21 states "(R30) wandering hallways in wheelchair since (6:30 PM) and requiring constant supervision. Attempting to go into others' rooms, getting into garbage, moving furniture around in unit living room, calling staff names and making inappropriate sexual comments to staff and attempting to touch staff. Staff walked with resident in hallways, pulling (R30) out of others' rooms." The Nurses Note dated 5/28/21 states "Resident (R30) then placed in (R30's) wheelchair and	F 689		

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F 689	Continued From page 15 roamed unit yelling "help me" and attempting to enter others' rooms." The Minimum Data Set (MDS) dated 5/6/21 documents R38 is cognitively intact. On 06/02/21 at 09:43 AM R38 stated two or three weeks ago while she was sleeping in her recliner R30 came in her room and pulled her blanket and socks off and told her she had big feet. R38 stated she was startled. R38 stated R30 has tried to get into her room at other times and staff have pulled him out. The MDS dated 3/26/21 documents R24 is cognitively intact. On 06/02/21 at 10:18 AM R24 stated R30 came into her room and she told him to leave but before he left he "tickled" her feet. R24 stated "he gets away from them every now and then." The MDS dated 4/12/21 documents R29 is moderately cognitively impaired. On 6/3/21 at 9:00 am R29 stated R30 has been in her room three or four times. R29 stated "sometimes (R30) gets away from them." R29 stated R30 roots through her dresser drawers and the basket on her table. R29 stated she does not like it when R30 comes in her room. R29 stated her room "is supposed to be private." The MDS dated 3/22/21 documents R13 has severe cognitive impairment. On 6/3/21 at 9:20 am R13 stated R30 has been in her room three times. R13 stated "(R30) is getting to be a problem." R13 stated she has complained to the staff two or three times and she is at the point where she just yells at him when she sees him at her door. R13 stated last night R30 tried to come in her room and she yelled at him and he left.	F 689		

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F 689	Continued From page 16 On 6/3/21 at 9:25 am V17 CNA stated If there is a door open (R30) will go in and if staff are with another resident they can't watch him. On 06/03/21 09:58 AM V19 CNA stated R38 reported to V19 that R30 was in R38's room and touched R38's feet. V19 stated R30 used to have a one to one care giver but that ended in March or April 2021. V19 stated V19 does not understand why R30 no longer has a one to one caregiver to supervise him. On 6/3/21 at 11:00 am V16 Registered Nurse (RN) stated they try to watch R30 but if they have to leave him to care for another resident he zooms off down the hallway. On 6/3/21 at 12:15 PM V15 RN stated V15 has seen R30 in other residents' rooms and R30 gets angry when they try to redirect him out of other residents' rooms. V15 stated R30 has been in R13's room and other residents (R38 and R24) have also complained to V15 that R30 has pulled blankets off them and played with their feet. V15 stated R30 "has to be watched constantly but staff have other things to do." V15 stated R30 has made sexual comments to staff and has tried to touch V15's buttocks. On 06/02/21 at 02:36 PM V2 Director of Nurses stated V2 knew R30 was wandering into other resident's rooms but V2 did not know the extent of the problem. On 06/03/21 at 12:11 PM V1 Administrator stated R30 used to have a one to one caregiver but V1 was told by risk management that that is not a service the facility provides.	F 689		

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F 689	Continued From page 17 On 06/04/21 at 08:38 AM V1 Administrator stated R30's one to one caregiver was discontinued in April (2021). V1 stated V1 believes the reason for the one to one caregiver for R30 was "the way he interacts with the staff and due to his wandering into other residents rooms." V1 stated V1 does not know what interventions were put in place to manage R1's behaviors after the one to one caregiver was discontinued.	F 689		
F 744 SS=E	(B) Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to develop and implement interventions for the dementia related behavior of wandering into other resident's rooms impacting	F 744	What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice	6/23/21

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F 744	Continued From page 18 five of nine residents (R30, R38, R24, R13 and R29) reviewed for dementia care on the sample list of 35 residents. Findings: The Care Plan updated 5/26/21 documents R30 has a diagnosis of Dementia with Behavioral Disturbance and that R30 has the potential to be physically, verbally and sexually aggressive with staff and the potential to be physically aggressive with other residents related to dementia. The Care Plan also documents R30 has a history of grabbing female staff members inappropriately and that R30 is severely cognitively impaired. The Care Plan updated 5/26/21 does not documents R30 has a behavior of wandering into other resident's rooms. On 6/3/21 at 10:40 AM V17 and V19 Certified Nurses Aides (CNAs) transferred R30 from the toilet to the wheel chair. After being assisted into the wheel chair R30 reached out and touched V17's buttock with R30's hand and then R30 propelled R30's self to the door. The Nurses Note dated 4/27/21 states "(R30) wandering in wheelchair going into other resident's room." The Nurses Note dated 5/7/21 states "(R30) went into another resident room inside doorway cussing at another resident. Resident was removed from the room and redirected to lounge area." The Nurses Note dated 5/18/21 states "(R30) Awake and up since 3:00 am. Wandering hallway in wheelchair and attempting to enter others'	F 744	R30; s care plan has been updated for 1:1 activities when in wheelchair. R30 has had a motion detector placed inside room by door frame to alert staff if resident leaves room to wander. R30 has been ordered new medication from physician to improve resident; s quality of life and care. The Facility contacted family to request R30 receive and evaluation by behavioral services, family denied request for evaluation when presented. How will facility identify other residents having the potential to be affected by the same alleged deficient practice: Random resident interviews are being conducted twice a month to ask if they have been abused in any way and to inquire about their interactions with R30. What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur Staff has been instructed to closely monitor R30 when he is out of his room. If R30 makes inappropriate contact with a resident, R30 will be moved out of direct contact with other residents at that time. The other resident will be evaluated for mental distress. How the facility plans to monitor its performance to make sure that solutions are sustained. R30; s behavior will be discussed in the	

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F 744	Continued From page 19 rooms. Cursing at staff and combative when re-directed. Hits staff and spitting on floor." The Nurses Note dated 5/22/21 states "(R30) wandering in wheelchair into other resident's room, calling staff assholes and saying I'll kick the s**t out of you." Told by female resident he had pulled the covers off her feet and was touching her feet. Another female resident states "is he running around? This is ridiculous." The Nurses Note dated 5/23/21 states "(R30) wandered in wheel chair, needing very frequent redirection to not wheel himself near other residents or into other residents' rooms." The Nurses Note dated 5/25/21 states "(R30) wandering in wheelchair from beginning of night shift until put down for bed at 9:00 PM. Resident opening outside doors and setting off alarms, digging in garbage can and kicking it over, going into female resident's room and touching her feet. Resident hit this nurse in the arm as I walked by him, spitting on the floor, touching sterilizer and moving isolation carts around making it difficult for staff to get work done as he was needing constant attention." The Nurses Note dated 5/27/21 states "(R30) wandering hallways in wheelchair since (6:30 PM) and requiring constant supervision. Attempting to go into others' rooms, getting into garbage, moving furniture around in unit living room, calling staff names and making inappropriate sexual comments to staff and attempting to touch staff. Staff walked with resident in hallways, pulling (R30) out of others' rooms." The Nurses Note dated 5/28/21 states "Resident	F 744	daily QA meeting. Random twice a month resident interviews will be reviewed during the monthly QAPI meeting by the QA committee.	

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F 744	Continued From page 20	F 744		

(R30) then placed in (R30's) wheelchair and roamed unit yelling "help me" and attempting to enter others' rooms."

The Minimum Data Set (MDS) dated 5/6/21 documents R38 is cognitively intact. On 06/02/21 at 09:43 AM R38 stated two or three weeks ago while she was sleeping in her recliner R30 came in her room and pulled her blanket and socks off and told her she had big feet.

The MDS dated 3/26/21 documents R24 is cognitively intact. On 06/02/21 at 10:18 AM R24 stated R30 came into her room and she told him to leave but before he left he "tickled" her feet.

The MDS dated 4/12/21 documents R29 is moderately cognitively impaired. On 6/3/21 at 9:00 am R29 stated R30 has been in her room three or four times. R29 stated "sometimes (R30) gets away from them."

The MDS dated 3/22/21 documents R13 has severe cognitive impairment. On 6/3/21 at 9:20 am R13 stated R30 has been in her room three times. R13 stated "(R30) is getting to be a problem."

6/3/21 at 12:15 PM V15 Registered Nurse stated V15 has seen R30 in other residents' rooms and R30 gets angry when they try to redirect him out of other residents' rooms. V15 stated R30 has been in R13's room and other residents (R38 and R24) have also complained to V15 that R30 has pulled blankets off them and played with their feet. V15 stated R30 "has to be watched constantly but staff have other things to do." V15 stated R30 has made sexual comments to staff and has tried to touch V15's buttocks.

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F 744	Continued From page 21 On 06/03/21 at 2:50 pm V4 Assistant Director of Nursing and Minimum Data Set and Care Plan Coordinator stated V4 is aware of R30's behavior of wandering into other residents rooms. V4 reviewed R30's Care Plan and confirmed it does not include a plan or interventions for managing R30's behavior of wandering into other residents rooms. On 6/3/21 at 3:00 PM V18 Social Services Director stated V18 is responsible for developing behavior care plans. V18 stated V18 was not aware of R30's behavior of wandering into other residents' rooms. V18 stated V18 monitors behaviors by reviewing the Certified Nurses Aide's (CNA) documentation. V18 stated the behavior of wandering into other residents' rooms is not a behavior the CNA staff is being prompted to track by the computer system for R30. V18 stated R30's behavior of wandering into other residents rooms needs to be tracked and the behavior care plan needs to be updated with new interventions.	F 744		
F 882 SS=C	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training,	F 882		6/23/21

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F 882	Continued From page 22 experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure the facility's Infection Preventionist had completed required training in infection control and prevention. This failure has the potential to affect all 61 residents residing in the facility. Findings include: On 6/3/21 at 9:40 am, V2, Director of Nursing/DON stated the following: "I am the Infection Control Preventionist, in name only. I have not enrolled in the required course, because I have not had time. I was a floor nurse here previously, and just took over as DON on April 19, 2021. By priority, I have had many responsibilities that require my attention. The course is on my list of to do's ." The Residents Census and Conditions of Residents Report dated 6/04/2021, documents 61 residents residing in the facility.	F 882	What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice Facility is adhering to its infection control policy to prevent, monitor, identify, care for residents with and without active infections. All resident infections are logged and monitored. How will facility identify other residents having the potential to be affected by the same alleged deficient practice: DON is monitoring and tracking all infections within the facility on a weekly basis. What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice	

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F 882	Continued From page 23	F 882	does not recur DON has enrolled in and begun an infection control and preventionist course. How the facility plans to monitor its performance to make sure that solutions are sustained. DON will complete the enrolled infection control and preventionist course to acquire and maintain certification.	

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(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
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to follow their policy to thoroughly investigate an allegation of physical abuse for two of eight residents (R30 and R50) reviewed for abuse on the sample list of 35 residents. Findings include: The facility's abuse policy dated 4/9/21 states "Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subject to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals" and "The following are examples of physical abuse: hitting a resident with hand, fist, foot, or object." The policy also states "This facility will thoroughly investigate alleged violations of individual rights and document appropriate action" and "Every employee will be interviewed who was working on	F 607	What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: R50 discharged on 6/15/2021. R30 is being monitored for agitation and movement around other residents. How will facility identify other residents having the potential to be affected by the same alleged deficient practice: Random resident interviews are being conducted twice a month to ask if any of them feel they have been abused in any way and to inquire about their interactions with R30. What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur:	6/23/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/23/2021

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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	145930	A. BUILDING _____ B. WING _____	C 06/04/2021

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F 607	Continued From page 1 the specific hall/wing that the affected resident resides on. Interview the resident if they are cognitively able to answer questions." The facility's abuse investigation dated 5/17/21 documents "(R30) was self propelling in wheel chair and made contact with (R50)." The abuse investigation includes an interview with R50 and no other resident interviews. The facility's abuse investigation does not include interviews with staff present on the unit during the altercation between R30 and R50. On 06/02/21 at 11:16 AM V14 License Practical Nurse stated during morning shift change report (5/17/21) R30 propelled R30's wheelchair to R50 and kicked R30's feet. V14 stated the incident was reported to V1 Administrator by V15 Registered Nurse but no one interviewed V14 about the altercation between R30 and R50. On 6/3/21 at 12:15 PM V15 stated R50 was seated in the common area in a recliner and R30 was also in the common area in a wheelchair. V15 stated when R50 was not paying attention to R30, R30 went up to R50 and started kicking R50. V15 stated R30 kicked R50's feet. V15 stated V15 separated R30 and R50 and called V1 at home to report the incident. On 06/03/21 at 12:11 PM V1 stated V1 did not interview staff or residents other than R50 when investigating the allegation that R30 kicked R50. V1 reviewed the facility abuse policy and confirmed V1 did not follow the policy when conducting the investigation.	F 607	Education training has been conducted on Abuse Prevention and Reporting including their reporting duties according to facility policy. At orientation and annually Abuse Prevention and Reporting Training will be provided to all employees. How the facility plans to monitor its performance to make sure that solutions are sustained. Random resident interviews will be conducted monthly for 3 additional months. Any allegations of abuse will be reviewed in morning meeting to ensure prompt follow-up was conducted. Abuse interviews and allegations will be reviewed to ensure proper procedures were followed in monthly QAPI meetings.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		6/23/21

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F 610	Continued From page 2 §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 interview and record review the facility failed to complete a thorough investigation of an allegation of physical abuse for two of eight residents (R30 and R50) reviewed for abuse on the sample list of 35 residents. Findings included: The Minimum Data Set dated 3/23/21 documents R50 is severely cognitively impaired and requires extensive assistance for transfers. The Minimum Data Set dated 4/12/21 documents R30 is severely cognitively impaired and requires limited assistance with locomotion. R30's Nurse Note dated 5/17/21, written by V15 Registered Nurse, documents "Resident (R30) up since 4:30 (am) wandering in wheelchair into	F 610	What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice R50 discharged on 6/15/2021. How will facility identify other residents having the potential to be affected by the same alleged deficient practice: Random resident interviews are being conducted twice a month to ask if any of them feel they have been abused in any way and to inquire about their interactions with R30. Interventions have been implemented to monitor R30; s interactions with other residents.	

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F 610	Continued From page 3 unoccupied rooms, opening outside doors and setting off alarm and yelling "help me" disturbing other residents. Resident wandered up to female resident (R50) sitting in common area numerous times kicking resident's feet and upsetting other resident (R50). (V1 Administrator) contacted regarding kicking. Currently sitting in recliner with attempts to have staff member constantly supervise when not assisting other staff members." The facility's abuse investigation dated 5/17/21 documents "(R30) was self-propelling in wheel chair and made contact with (R50)." The abuse investigation includes an interview with R50 and no other resident interviews. The facility's abuse investigation does not include interviews with staff present on the unit during the altercation between R30 and R50. On 06/02/21 at 11:16 AM V14 License Practical Nurse stated during morning shift change report (5/17/21) R30 propelled R30's wheelchair to R50 and kicked R30's feet. V14 stated the two residents were separated and V15 Registered Nurse notified V1 Administrator of the incident. V14 stated no one interviewed V14 about the altercation between R30 and R50. On 6/3/21 at 12:15 pm V15 stated on 5/17/21 R50 was seated in the common area in a recliner and R30 was also in the common area in a wheelchair. V15 stated R30 wheeled up to R50 numerous times and R50 put R50's walker in front of R50, between R50 and R30 to keep R30 away from R50. V15 stated when R50 was not paying attention to R30, R30 went up to R50 and started kicking R50. V15 stated R30 kicked R50's feet. V15 stated R50 does not speak much	F 610	What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur Education training will be conducted on Abuse Prevention and Reporting. At orientation and annually Abuse Prevention and Reporting Training will be provided to all employees. Random resident interviews will be conducted twice a month to ensure that residents don; t feel abused or their personal space has been infringed upon. After one-month random resident interviews will be conducted monthly for 3 additional months. How the facility plans to monitor its performance to make sure that solutions are sustained. Any allegations of abuse will be reviewed in morning meeting to ensure proper procedure was followed such as what was reported and the actions taken thereafter. Abuse interviews and allegations will be addressed to ensure proper procedures were followed in monthly QAPI meetings.	

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F 610	Continued From page 4 but R50 had an unhappy expression on R50's face. V15 stated V15 did not know if R30 was trying to hurt R50 or just trying to get R50's attention. V15 stated V15 separated R30 and R50 and called V1 at home to report the incident. On 6/1/21 V1 Administrator stated to investigate the alleged abuse concerning R30 kicking R50, V1 watched the cameras and saw nothing. V1 confirmed V1 did not interview staff or other residents. V1 also confirmed that the cameras did not show all interactions. V1 stated "I should have interviewed other residents and staff."	F 610		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices 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: A. Based on record review and interview, the facility failed to apply foot pedals to a wheelchair, to provide a safe transport of a resident (R25) when leaving the facility in the facility van. This failure resulted in R25 sustaining a right distal femur and patella fracture, which required emergency treatment, overnight hospitalization and a leg cast. R25 is one of four residents reviewed for accidents/falls on the sample list of 35. B. Based on observation, interview and record	F 689	What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice R25 will have foot pedals in place when being propelled in a wheelchair. R30; s care plan has been updated for 1:1 activities when in wheelchair. R30 has had a motion detector placed inside room by door frame to alert staff if resident leaves room to wander. R30 was moved to a room closer to the nurse station.	6/23/21

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F 689	Continued From page 5 review the facility failed to provide supervision to prevent a resident from wandering, impacting six of eight residents (R30, R38, R24, R29, R50 and R13) reviewed for resident to resident altercations on the sample list of 35 residents. Findings include: A. R25's Local Hospital Discharge Summary dated 12/12/20 documents R25 was being discharged to this skilled care facility after an episode of hyperglycemia that resulted in a fall at home which caused R25 an Iliac Wing (Pelvic) fracture. R25's Face Sheet confirms R25 was admitted to the facility on 12/12/20. R25's Minimum Data Set (MDS) to dated 2/8/21 (prior to incident of 3/30/21) documents R25's BIMS score as 14/15 (no cognitive impairment), uses a wheelchair for mobility, does not ambulate, and required physical staff assistance of one person for transfers. On 6/3/21 at 1:25 pm R25 was laying in bed. R25 stated " I (R25) suffered a fracture to my (R25) right leg from being pushed by (V5, Transportation Assistant) in her wheel chair." R25 pulls back the blankets on her bed to show R25's right leg. R25 had a full length, thigh high immobilizer brace on R25 right leg. R25 stated "I did not have foot peddles on my wheelchair at the time. The transportation person (V5) was pushing my wheel chair without the foot pedals on. My (R25) foot went under the wheelchair. I (R25) have to wear this brace now. My doctor says it will likely not heal completely, as I am getting a little	F 689	How will facility identify other residents having the potential to be affected by the same alleged deficient practice: Random weekly audits will be conducted on scheduled transportation and resident halls to monitor the use of foot pedals for one month. Random resident interviews are being conducted twice a month to ask if they have been abused in any way and to inquire about their interactions with R30. What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur Residents are required to use pedals while propelled. V5, transportation assistant, is no longer employed by the facility. R30; s care plan has been updated for 1:1 activities when in wheelchair. R30 has had a motion detector placed inside room by door frame to alert staff if resident leaves room to wander. How the facility plans to monitor its performance to make sure that solutions are sustained. Foot Pedal Audits will be reviewed in the monthly QAPI meeting or as needed during the daily QA meeting. R30; s behavior will be discussed in the daily QA meeting. Random resident interviews will be reviewed during the monthly QAPI	

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F 689	Continued From page 6 older. I likely will never be able to walk again. I had a cast on (right leg) initially. This happened about two months ago, I don't know the actual date." R25's "Health Status (Nursing) Note" dated 3/30/21 at 9:00 am documents R25 went out of the facility for a follow-up appointment with the dentist (unidentified). R25's "Health Status (Nursing) Note" dated 3/30/21 at 11:13 am documents R25 returned from the dentist appointment. The facility incident investigation includes a signed statement dated 3/31/21, signed by V5, Transportation Department Assistant documents the following: "I (V5, Transportation Department Assistant) transported (R25) to her (R25) Dentist appointment, (V6, Dentist), (local address and phone number) on March 30, 2020 at 9:00 am. As we (V5 and R25) were going into her (R25's) appointment, (R25) dropped her (R25's) foot, stopped holding her (R25's) legs up. Which stopped the wheelchair from it's forward motion, up the handicapped (wheelchair accessible) ramp. (R25) has never used foot rest in the year that I (V5, Transportation Department Assistant) I have been doing Transportation at (the facility name). (R25) said her leg hurt and was pointing just below her (R25) knee. She (R25) asked the receptionist (unidentified at the dentist office) for Tylenol (pain medication). I (V5, Transportation Department Assistant) said no (to R25), she (unidentified receptionist) cannot give you (R25) anything (resident first name used). Then (R25) asked and received an (elastic) bandage. I (V5, Transportation Department Assistant) left to go do another transport. Upon my (V5, Transportation	F 689	meeting by the QA committee.	

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F 689	Continued From page 7	F 689		

Department Assistant) return to (facility name), I (V5, Transportation Department Assistant) informed Nurse (V7, Registered Nurse) of what happened and got footrest from (R25's) room. When I (V5, Transportation Department Assistant) returned to pick (R25) up at her appointment, she (R25) was in the waiting room (at the dentist office). When we (R25 and V5, Transportation Department Assistant) got back to (facility name), stopped at the nurses desk, as I (V5, Transportation Department Assistant) always do upon returning from appointments. (R25) asked (V7, Registered Nurse) for some Tylenol."

The facility investigation report, had an undated, handwritten witness statement by (V8, Certified Nursing Assistant/CNA) that documents the following: "Transport (V5, Transportation Department Assistant) took resident (R25) to (R25's) room. (R25) complained of pain in knee. Reported to nurse (V9, Licensed Practical Nurse/ LPN). (V9, LPN) told CNA (V8,CNA) to put a warm blanket on (R25's) knee. At 6:00 pm, (R25) could not bear weight, had to use (mechanical stand lift) for transfer.

R25's "Health Status (Nursing) Note" dated 3/31/21 at 05:39 am, documents the following: "Resident (R25) complained of right knee pain 10 out of 10 (on a scale of one to ten, ten being the worst pain). Unable to bear weight on right leg. Bruising noted on knee. (V10, Nurse Practitioner) notified, awaiting orders (physician)."

R25's "Health Status (Nursing) Note" dated 3/31/21 at 09:10 am, documents the following: "X-ray ordered of right knee including distal and lateral femur AP, two views, each scheduled through (private X-ray service) for today."

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F 689	Continued From page 8 R25's "Health Status (Nursing) Note" dated 3/31/21 at 1:02 pm, documents the following: "(private X-ray service) here to do X-ray." R25's "Health Status Note" nurses note dated 3/31/21 at 1:35 pm documents the following" (V10, Nurse Practitioner) here (in facility) reviewed X-Ray results, new order to transfer to (local hospital) due to distal fracture of right femur." R25's "ED (Emergency Department) to Hospital Admission/ Discharge Summary" Physician Progress Note dated 3/31/21-4/1/21 signed by (V11, Physician) documents the following: " Hospital course: Shows matter (?), further evaluation management of right distal femur fracture. Pain controlled, on oral antibiotics with minimal IV (intravenous) analgesics (pain medication) required. Orthopedic surgery (unidentified person) was consulted, who ordered additional CT (Commuted Tomography) imaging. Recommended non operative management. Short leg cast placed by Ortho (Orthopedic) with instructions for outpatient follow-up." The same "ED (Emergency Department) to Hospital Admission/ Discharge Summary" documents the following Right Femur X-Ray results 3/31/21: "There is a displaced and impacted fracture through the distal femoral metaphysis (end plate of the bone). This is likely comminuted (multiple fragments) There is approximately once centimeter posterior displacement of the distal fragment. No fracture of proximal to mid femur. Stable arthritic changes in the right hip. Diffuse vascular calcifications. Moderate to severe osteoarthritis in the knee." The same "ED (Emergency Department) to	F 689		

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F 689	Continued From page 9 Hospital Admission/ Discharge Summary" report documents: "Impression: Acute, impacted, commuted and displaced through the distal metaphysis (end plate of the bone)." The same "ED (Emergency Department) to Hospital Admission/ Discharge Summary" documents the following results of a CT of R25's Right knee results dated 4/1/21 findings: "Twisting injury comparison to Radiograph (X-Ray) 3/31/21. The same CT documents "Injury on wheelchair. Impression: 1. Acute comminuted displaced transverse fracture of the distal femoral diaphysis as described. No intercondylar extension. 2. Acute nondisplaced vertically oriented fracture of the mid- patella (knee cap triangular bone)." V5, Transportation Department Assistant's " Verbal Discipline Report dated 4/2/21 documents the following: " Please back patients on/off the platform for the lift in the van (facility transportation vehicle). Always use foot pedals on wheelchair for transports." On 6/3/21 at 3:27 pm V2, Director of Nursing stated "(R25) was taken by our previous transportation staff, (V5, Transportation Department Assistant), to a dentist appointment. (V5, Transportation Department Assistant) had not put wheelchair pedals on (R25's) wheelchair before leaving. (R25) should have had foot pedals on her wheelchair before being taken out of the facility. Our expectations for safely transporting residents in a wheelchair, requires staff to put wheelchair foot pedals on when taken residents out." V2 confirmed "(R25's) right leg fracture could have been prevented had the facility protocol been followed." On 6/4/21 at 9:30 am V2, DON and V1,	F 689		

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F 689	Continued From page 10 Administrator confirmed R25 was transported without wheelchair pedals on R25's wheel chair which resulted in R25's fractures (right knee and femur. V2, DON also stated "(V5, Transportation Department Assistant) was not following safe transfer procedure when taking R25 out of the facility which caused these preventable fractures." V1, Administrator nodded in agreement. V2, DON also stated "(R25) and should have always had her foot pedals on the wheelchair. I do not have a written policy, but all staff have been educated. Moving forward, they (staff) all know residents being pushed in or outside the facility in their wheelchair should have the foot pedals on at all time. " The Fall policy revised 3/20/18 states "The resident's environment will remain free from accidents and hazards as possible; and each resident will receive adequate supervision and assistance devices to prevent accidents." B. The Care Plan updated 5/26/21 documents R30 has the potential to be physically, verbally and sexually aggressive with staff and that R30 has the potential to be physically aggressive with other residents related to dementia. The Care Plan also documents R30 has a history of grabbing female staff members inappropriately and that R30 is severely cognitively impaired. On 6/3/21 at 10:40 am V17 and V19 Certified Nurses Aides (CNAs) transferred R30 from the toilet to the wheel chair. After being assisted into the wheel chair R30 reached out and touched V17's buttock with R30's hand and then R30 propelled R30's self to the door.	F 689		

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F 689	Continued From page 11 The Nurses Note dated 4/27/21 states "(R30) wandering in wheelchair going into other resident's room." The Nurses Note dated 5/7/21 states "(R30) went into another resident room inside doorway cussing at another resident. Resident was removed from the room and redirected to lounge area." The Nurse Note dated 5/17/states "Resident (R30) up since 4:30 (am) wandering in wheelchair into unoccupied rooms, opening outside doors and setting off alarm and yelling "help me" disturbing other residents. Resident wandered up to female resident (R50) sitting in common area numerous times kicking resident's feet and upsetting other resident (R50). (V1 Administrator) contacted regarding kicking. Currently sitting in recliner with attempts to have staff member constantly supervise when not assisting other staff members." The Nurses Note dated 5/18/21 states "(R30) Awake and up since 3:00 am. Wandering hallway in wheelchair and attempting to enter others' rooms. Cursing at staff and combative when re-directed. Hits staff and spitting on floor." The Nurses Note dated 5/22/21 states "(R30) wandering in wheelchair into other resident's room, calling staff assholes and saying I'll kick the s**t out of you." Told by female resident he had pulled the covers off her feet and was touching her feet. Another female resident states "is he running around? This is ridiculous." The Nurses Note dated 5/23/21 states "(R30) wandered in wheel chair, needing very frequent	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145930	A. BUILDING _____ B. WING _____	C 06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 12 redirection to not wheel himself near other residents or into other residents' rooms." The Nurses Note dated 5/25/21 states "(R30) wandering in wheelchair from beginning of night shift until put down for bed at 9:00 PM. Resident opening outside doors and setting off alarms, digging in garbage can and kicking it over, going into female resident's room and touching her feet. Resident hit this nurse in the arm as I walked by him, spitting on the floor, touching sterilizer and moving isolation carts around making it difficult for staff to get work done as he was needing constant attention." The Nurses Note dated 5/27/21 states "(R30) wandering hallways in wheelchair since (6:30 PM) and requiring constant supervision. Attempting to go into others' rooms, getting into garbage, moving furniture around in unit living room, calling staff names and making inappropriate sexual comments to staff and attempting to touch staff. Staff walked with resident in hallways, pulling (R30) out of others' rooms." The Nurses Note dated 5/28/21 states "Resident (R30) then placed in (R30's) wheelchair and roamed unit yelling "help me" and attempting to enter others' rooms." The Minimum Data Set (MDS) dated 5/6/21 documents R38 is cognitively intact. On 06/02/21 at 09:43 AM R38 stated two or three weeks ago while she was sleeping in her recliner R30 came in her room and pulled her blanket and socks off and told her she had big feet. R38 stated she was startled. R38 stated R30 has tried to get into her room at other times and staff have pulled him out.	F 689		

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F 689	Continued From page 13 The MDS dated 3/26/21 documents R24 is cognitively intact. On 06/02/21 at 10:18 AM R24 stated R30 came into her room and she told him to leave but before he left he "tickled" her feet. R24 stated "he gets away from them every now and then." The MDS dated 4/12/21 documents R29 is moderately cognitively impaired. On 6/3/21 at 9:00 am R29 stated R30 has been in her room three or four times. R29 stated "sometimes (R30) gets away from them." R29 stated R30 roots through her dresser drawers and the basket on her table. R29 stated she does not like it when R30 comes in her room. R29 stated her room "is supposed to be private." The MDS dated 3/22/21 documents R13 has severe cognitive impairment. On 6/3/21 at 9:20 am R13 stated R30 has been in her room three times. R13 stated "(R30) is getting to be a problem." R13 stated she has complained to the staff two or three times and she is at the point where she just yells at him when she sees him at her door. R13 stated last night R30 tried to come in her room and she yelled at him and he left. On 6/3/21 at 9:25 am V17 CNA stated If there is a door open (R30) will go in and if staff are with another resident they can't watch him. On 06/03/21 09:58 AM V19 CNA stated R38 reported to V19 that R30 was in R38's room and touched R38's feet. V19 stated R30 used to have a one to one care giver but that ended in March or April 2021. V19 stated V19 does not understand why R30 no longer has a one to one caregiver to supervise him.	F 689		

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F 689	Continued From page 14 On 6/3/21 at 11:00 am V16 Registered Nurse (RN) stated they try to watch R30 but if they have to leave him to care for another resident he zooms off down the hallway. On 6/3/21 at 12:15 PM V15 RN stated V15 has seen R30 in other residents' rooms and R30 gets angry when they try to redirect him out of other residents' rooms. V15 stated R30 has been in R13's room and other residents (R38 and R24) have also complained to V15 that R30 has pulled blankets off them and played with their feet. V15 stated R30 "has to be watched constantly but staff have other things to do." V15 stated R30 has made sexual comments to staff and has tried to touch V15's buttocks. On 06/02/21 at 02:36 PM V2 Director of Nurses stated V2 knew R30 was wandering into other resident's rooms but V2 did not know the extent of the problem. On 06/03/21 at 12:11 PM V1 Administrator stated R30 used to have a one to one caregiver but V1 was told by risk management that that is not a service the facility provides. On 06/04/21 at 08:38 AM V1 Administrator stated R30's one to one caregiver was discontinued in April (2021). V1 stated V1 believes the reason for the one to one caregiver for R30 was "the way he interacts with the staff and due to his wandering into other residents rooms." V1 stated V1 does not know what interventions were put in place to manage R1's behaviors after the one to one caregiver was discontinued.	F 689		

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F 689	Continued From page 15	F 689		
F 744 SS=E	(B) Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to develop and implement interventions for the dementia related behavior of wandering into other resident's rooms impacting five of nine residents (R30, R38, R24, R13 and R29) reviewed for dementia care on the sample list of 35 residents. Findings: The Care Plan updated 5/26/21 documents R30 has a diagnosis of Dementia with Behavioral Disturbance and that R30 has the potential to be physically, verbally and sexually aggressive with staff and the potential to be physically aggressive with other residents related to dementia. The	F 744	What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice R30; s care plan has been updated for 1:1 activities when in wheelchair. R30 has had a motion detector placed inside room by door frame to alert staff if resident leaves room to wander. R30 has been ordered new medication from physician to improve resident; s quality of life and care. The Facility contacted family to request R30 receive and evaluation by behavioral services, family denied request for evaluation when presented.	6/23/21

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F 744	Continued From page 16 Care Plan also documents R30 has a history of grabbing female staff members inappropriately and that R30 is severely cognitively impaired. The Care Plan updated 5/26/21 does not documents R30 has a behavior of wandering into other resident's rooms. On 6/3/21 at 10:40 AM V17 and V19 Certified Nurses Aides (CNAs) transferred R30 from the toilet to the wheel chair. After being assisted into the wheel chair R30 reached out and touched V17's buttock with R30's hand and then R30 propelled R30's self to the door. The Nurses Note dated 4/27/21 states "(R30) wandering in wheelchair going into other resident's room." The Nurses Note dated 5/7/21 states "(R30) went into another resident room inside doorway cussing at another resident. Resident was removed from the room and redirected to lounge area." The Nurses Note dated 5/18/21 states "(R30) Awake and up since 3:00 am. Wandering hallway in wheelchair and attempting to enter others' rooms. Cursing at staff and combative when re-directed. Hits staff and spitting on floor." The Nurses Note dated 5/22/21 states "(R30) wandering in wheelchair into other resident's room, calling staff assholes and saying I'll kick the s**t out of you." Told by female resident he had pulled the covers off her feet and was touching her feet. Another female resident states "is he running around? This is ridiculous." The Nurses Note dated 5/23/21 states "(R30)	F 744	How will facility identify other residents having the potential to be affected by the same alleged deficient practice: Random resident interviews are being conducted twice a month to ask if they have been abused in any way and to inquire about their interactions with R30. What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur Staff has been instructed to closely monitor R30 when he is out of his room. If R30 makes inappropriate contact with a resident, R30 will be moved out of direct contact with other residents at that time. The other resident will be evaluated for mental distress. How the facility plans to monitor its performance to make sure that solutions are sustained. R30; s behavior will be discussed in the daily QA meeting. Random twice a month resident interviews will be reviewed during the monthly QAPI meeting by the QA committee.	

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F 744	Continued From page 17 wandered in wheel chair, needing very frequent redirection to not wheel himself near other residents or into other residents' rooms." The Nurses Note dated 5/25/21 states "(R30) wandering in wheelchair from beginning of night shift until put down for bed at 9:00 PM. Resident opening outside doors and setting off alarms, digging in garbage can and kicking it over, going into female resident's room and touching her feet. Resident hit this nurse in the arm as I walked by him, spitting on the floor, touching sterilizer and moving isolation carts around making it difficult for staff to get work done as he was needing constant attention." The Nurses Note dated 5/27/21 states "(R30) wandering hallways in wheelchair since (6:30 PM) and requiring constant supervision. Attempting to go into others' rooms, getting into garbage, moving furniture around in unit living room, calling staff names and making inappropriate sexual comments to staff and attempting to touch staff. Staff walked with resident in hallways, pulling (R30) out of others' rooms." The Nurses Note dated 5/28/21 states "Resident (R30) then placed in (R30's) wheelchair and roamed unit yelling "help me" and attempting to enter others' rooms." The Minimum Data Set (MDS) dated 5/6/21 documents R38 is cognitively intact. On 06/02/21 at 09:43 AM R38 stated two or three weeks ago while she was sleeping in her recliner R30 came in her room and pulled her blanket and socks off and told her she had big feet. The MDS dated 3/26/21 documents R24 is	F 744		

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F 744	Continued From page 18	F 744		

cognitively intact. On 06/02/21 at 10:18 AM R24 stated R30 came into her room and she told him to leave but before he left he "tickled" her feet.

The MDS dated 4/12/21 documents R29 is moderately cognitively impaired. On 6/3/21 at 9:00 am R29 stated R30 has been in her room three or four times. R29 stated "sometimes (R30) gets away from them."

The MDS dated 3/22/21 documents R13 has severe cognitive impairment. On 6/3/21 at 9:20 am R13 stated R30 has been in her room three times. R13 stated "(R30) is getting to be a problem."

6/3/21 at 12:15 PM V15 Registered Nurse stated V15 has seen R30 in other residents' rooms and R30 gets angry when they try to redirect him out of other residents' rooms. V15 stated R30 has been in R13's room and other residents (R38 and R24) have also complained to V15 that R30 has pulled blankets off them and played with their feet. V15 stated R30 "has to be watched constantly but staff have other things to do." V15 stated R30 has made sexual comments to staff and has tried to touch V15's buttocks.

On 06/03/21 at 2:50 pm V4 Assistant Director of Nursing and Minimum Data Set and Care Plan Coordinator stated V4 is aware of R30's behavior of wandering into other residents rooms. V4 reviewed R30's Care Plan and confirmed it does not include a plan or interventions for managing R30's behavior of wandering into other residents rooms.

On 6/3/21 at 3:00 PM V18 Social Services Director stated V18 is responsible for developing

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F 744	Continued From page 19 behavior care plans. V18 stated V18 was not aware of R30's behavior of wandering into other residents' rooms. V18 stated V18 monitors behaviors by reviewing the Certified Nurses Aide's (CNA) documentation. V18 stated the behavior of wandering into other residents' rooms is not a behavior the CNA staff is being prompted to track by the computer system for R30. V18 stated R30's behavior of wandering into other residents rooms needs to be tracked and the behavior care plan needs to be updated with new interventions.	F 744		