STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465085	A. BUILDING _____ B. WING _____	C 11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN RAFAEL HEALTH AND REHABILITATION	455 WEST MILL ROAD FERRON, UT 84523

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F 000	INITIAL COMMENTS A Recertification and Complaint Survey was completed from 10/14/2024 to 11/15/2024. Complaint Intake Number(s) UT00035123, UT00035824, UT00036434, UT00036616 and UT00036726 were investigated. The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000	POC Approved HF 12/16/24	
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 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.	F 565	Corrective Action for Identified Residents: Residents #6, 11, 32, and 13 were identified and currently reside in the facility. DON/ADON have educated the staff are monitoring linen changes daily to make sure they are being done regularly. <u>Measures to Prevent Recurrence:</u> Education has been done with Resident Advocate to document, investigate, and follow up on all grievances. In service was completed on 11/14/2024 with facility staff to know the process for grievances and where residents can get the grievance forms and how they are able to help the residents file a grievance. Grievance book is located on the table by the salon. Once RA has reviewed grievances, RA will turn over documents to the Administrator to assure the grievances have been resolved. Documents will be then kept in the grievance book. Administrator will also sign off and make sure that grievances from resident council have been given to the proper staff and fixed. Administrator will then follow up to make sure they are resolved. Resident Advocate also has had a Resident Council with resident to educate them on where they can file a grievance. A grievance binder is also placed in an area where the residents can access it easily. Documentation will be kept for all grievances, what was done, and a follow up with appropriate residents for input and assurance of completion.	12/13/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	12/13/2024

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F 565	Continued From page 1 §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 interview, facility document review, and facility policy review, the facility failed to consistently follow up on concerns presented by the Resident Council (RC) and provide a verbal or written response to the RC regarding any actions taken to address their concerns. There was incomplete or no follow-up documented for 5 (January, May, July, August, and September 2024) of 10 months of RC minutes reviewed. Findings included: A facility policy titled, "Grievances/Complaints, Recording and Investigating," revised April 2017, indicated, "All grievances and complaints filed with the facility will be investigated and corrective actions will be taken to resolve the grievance(s)." The policy also specified, "5. The grievance officer will record and maintain all grievances and complaints on the 'Resident Grievance Complaint Log.' The following information will be recorded and maintained in the log: a. The date the grievance/complaint was received; b. The name and room number of the resident filing the grievance/complaint (if available); c. The name and relationship of the person filing the grievance/complaint on behalf of the resident (if	F 565	Monitoring/Quality Assurance: Administrator and Resident Advocate reviewed policy and procedure and educated all staff and RA 12/10/2024. RA will audit, investigate, and follow up on all grievances weekly. Process/results to be incorporated into the Quality Assurance Performance Improvement process. All grievances will be reviewed in QAPI Grievances will also be followed up in Resident Council each month.	

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F 565	Continued From page 2	F 565		

available); d. The date the alleged incident took place; e. The name of the person(s) investigating the incident; f. The date the resident, or interested party, was informed of the findings; and g. The disposition of the grievance (i.e. [id est, that is], resolved, dispute, etc [et cetera])."

A review of the grievance log for the timeframe from 01/2024 through 10/2024 revealed no RC grievances were logged into the grievance log.

"Resident Council Minutes," for the timeframe from 01/2024 through 10/2024 were reviewed with the following findings:

- The RC minutes dated 01/10/2024 indicated "New Business" included concerns of "hot water situation" and "other residents yelling out." The minutes form did not provide a space to document any planned actions that would be taken to follow up on the concerns. The following month's RC minutes, dated 02/07/2024, indicated the hot water issues were discussed and the residents felt the action taken for that concern was sufficient. The minutes did not specify what action was taken to address the concern or by whom. There was no documentation on the 02/07/2024 minutes to indicate any response was provided to the RC regarding the 01/10/2024 concern of "other residents yelling out."

- The RC minutes dated 05/02/2024 indicated concerns of "taking juice from residents before they are finished" and "notice about room changes written statement." The minutes form indicated the Resident Advocate (RA) spoke to the kitchen about the juice concern and, "They will ask before they take it." The form indicated

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F 565	Continued From page 3 action taken by the RA for the room change concern was, "They will provide written form before they change rooms." The question, "Do residents feel action taken is sufficient?" did not have a yes or no response for either concern, and the following month's RC minutes, dated 06/06/2024, did not include any documentation to indicate the two concerns from the May RC meeting were discussed with the RC to determine if the actions taken by the RA had improved or resolved the concerns. - RC minutes that were not dated but that appeared to be from the July 2024 RC meeting, based on the bottom of the form indicating, "Date of Next Meeting: August" revealed residents discussed new concerns of "Be able to leave facility 12 consecutive days" and "More brownies." The form did not include any planned actions to address these two concerns/requests, and the following month's RC minutes, dated 08/14/2024 did not include any documentation to indicate any follow-up discussion with the RC about the two concerns/requests from the July meeting. - The RC minutes dated 08/14/2024 indicated the RC discussed new concerns that included: 1.) Beds not being made. 2.) Food not up to par lately - veggies cooked more. 3.) Eye exam not up to par. 4.) More gravy on biscuits. The minutes form did not include any planned actions to be taken to address the concerns. The RC minutes dated 09/05/2024 did indicate a follow-up discussion occurred regarding the "food not up to par" concern and that residents felt the action taken was sufficient; however, there was no documentation to indicate any follow-up	F 565		

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F 565	Continued From page 4 actions or discussion with the RC regarding the other three concerns discussed during the August 2024 meeting (eye exams, beds not made, and more gravy). - The RC minutes dated 09/05/2024 indicated the RC discussed new concerns that included: "1) To [sic - too] rough when changing briefs. 2) Checking garbage at 01:00 to 1:30 AM. 3) Ticking [Resident #13's] feet in night." There was no documentation on the minutes form of any planned actions related to these concerns. The following month's minutes, dated 10/08/2024, indicated the concerns related to brief changes and checking garbage were discussed. There was no documentation of any follow-up discussion of Resident #13's concern related to someone tickling their feet at night. - The RC minutes dated 10/08/2024 indicated the RC discussed a new concern of a resident keeping their television volume too loud at night. A member of the survey team conducted a meeting with RC members on 10/16/2024 at 10:00 AM. The meeting was attended by Resident #11, who was the RC President, as well as Residents #6, #22, #13, and #32. The Resident Council Minutes were reviewed with the group as follows: - Regarding the February 2024 concern related to sheets not being changed, the resident's stated sheets were still not being changed regularly. Resident #6 added that their sheets had not been changed in two weeks, but they had not reported this to anyone. - Regarding the 08/14/2024 concern related to beds not being made, Resident #13 stated they	F 565		

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F 565	Continued From page 5	F 565		

had specifically asked staff to make the bed, and their bed still was not made. Resident #11 added that beds were not consistently made.
- Regarding the 08/14/2024 concerns related to the food and eye exams, Resident #11 stated there had not been much improvement in the food and that eye examinations had not been discussed with the group.
- Regarding the 09/05/2024 concerns, Resident #13 stated someone was still waking them at night by tickling their feet.
- Regarding the 10/08/2024 concern related to a resident keeping their television volume too loud at night, Resident #13 stated even with their hearing aids out, the roommate's loud television and the lights kept them awake at night.

The Resident Advocate (RA) was interviewed on 10/16/2024 at 10:58 AM. The RA stated she was the one who typically took notes during the RC meetings. The RA stated that when residents had concerns, she documented them on the Resident Council minutes and verbally communicated the concerns to the appropriate department managers. The RA stated the residents were then spoken to as a group to make sure any issues were resolved. The RA stated that to make sure issues were resolved, she followed up and documented a quarterly note or a monthly note. The RA agreed that if an issue appeared twice during Resident Council meetings, then the issue had not been resolved. A review of issues identified in the 10/16/2024 meeting as unresolved was made with the RA. The RA stated no plan for resolution of those issues was provided verbally or in writing to the RC. The RA stated the Director of Nursing (DON) had in-serviced the staff on bed-making. The RA

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F 565	Continued From page 6 stated that once the RC indicated a problem was resolved, there was no further follow-up. She stated the RC concerns had never been managed as grievances with a written plan, written summary of actions taken, and resolution. The DON and the Assistant Director of Nursing (ADON) were interviewed on 10/16/2024 at 11:31 AM. The ADON stated if a bed was not made as soon as the resident got out of it, there were a few residents who complained. The DON stated she had received no concerns from the RC about beds not being made. The DON stated she had received a concern about a resident's television being too loud and had instructed staff to turn the television down in the evening so other residents could rest but acknowledged she had not followed up to see if the issue was resolved. The DON stated she had completed written plans for the RC about their concerns because she had not received any concerns from the RC; she added that without knowing about their grievances, there was no opportunity to fix the issues. The Administrator was interviewed on 10/17/2024 at 2:23 PM. The Administrator stated he and the DON had spoken with the staff about changing sheets but had not followed up with the RC. The Administrator stated he expected the RA to take all concerns from the RC to the appropriate department managers. The Administrator stated he expected changes to address the RC's concerns to happen immediately and expected follow-up with the RC within a week.	F 565		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		

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F 600	Continued From page 7 §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 observation, interview, record review, and facility document and policy review, the facility failed to protect Resident #38's right to be free from verbal and physical abuse perpetrated by Registered Nurse (RN) #6. This deficient practice affected 1 (Resident #38) of 4 sampled residents reviewed for abuse. Specifically, on 11/24/2023, RN #6 ; however, the CNA. On 11/26/2023, RN #6 yelled in Resident #38's face, shook the resident, and insisted the resident allow staff to transfer the resident back to bed. It was determined the provider's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.12 Freedom from Abuse, Neglect, and Exploitation, F600, at a scope and severity of "J."	F 600	Resident Identified: Resident #38 no longer resides in facility. <u>Measures to Prevent Recurrence:</u> Corporate Officer, DON, ADON, Resident Advocate (RA), and Administrator completed another full investigation of the alleged abuse incident reported November 2023. The investigation of the incident dated11/14/2024 and was completed 11/15/2024. During investigation, all residents were interviewed along with additional interviews that were in connection with the incident in November 2023. During the investigation RN#6 was suspended pending the findings of the investigation. COO met with Administrator and DON and trained them on abuse investigation to include staff interviews and resident interviews and created an abuse committee that includes administrator, DON, ADON, RA, and COO that will meet and review evidence and interviews to come to the right conclusion. Abuse committee will be part of our regular quality assurance and performance improvement (QAPI) meetings where we will discuss any issues that may have been reported and determine the correct actions. Training was provided 11/14/2024. COO provided training with DON, ADON, Administrator, and RA on proper investigation, to include resident interviews and staff interviews. Training included a resident interview form and staff interview form. Training was completed 11/14/2024	12/13/2024

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F 600	Continued From page 8 The IJ began during the nightshift on 11/24/2023 when RN #6 aggressively transferred Resident #38 from the recliner to the bed without consent from the resident. The certified nurse aides (CNAs) who witnessed the transfer did not immediately report what happened after they witnessed what they considered to be abusive, which allowed RN #6 to continue working with access to the resident. Subsequently, the CNAs witnessed a second incident on 11/26/2023 in which RN #6 grabbed Resident #38 and shook the resident to convince the resident to allow staff to transfer them back to their bed for care. On 11/13/2024 at 5:26 PM, the Administrator was informed of the IJ situation and provided a completed IJ template. A removal plan was requested. The removal plan was accepted by the State Survey Agency (SSA) on 11/15/2024 at 4:44 PM. The IJ was removed on 11/15/2024 at 6:50 PM after the survey team performed onsite verification that the removal plan had been implemented. Noncompliance remained at a lower scope and severity of "D," no actual harm with the potential for more than minimal harm. Findings included: A facility policy titled, "Policy and Procedure for Prohibiting Abuse," dated 02/2017, revealed, "It is the policy of this facility to provide person-centered care by promoting the well-being of its residents in a safe and supportive environment. The facility prohibits any abuse. Our residents have the right to be free from abuse, neglect, misappropriation of property, and exploitation, corporal punishment,	F 600	CEO communicated face to face with each staff member on proper identification of abuse and reporting of abuse timely. Each staff received a copy of the abuse policy and signed that they received the training from CEO prior to coming on shift. All staff were made aware of where to find the Administrator and DON's phone numbers, which are located behind the nurses' station, so they will be able to contact them immediately if an incident needs to be reported. Training started 11/14/2024 and was completed prior to staff members working their next shift. QAPI meeting was scheduled for 11/15/2024. Discussed in the QAPI meeting were abuse policy and procedures, Utah Healthcare Association abuse training from September 2022, investigation training. Investigation and finding of the November 2023 incident. the CEO, DON, ADON, RA, and Administrator were present. <u>Monitoring/Quality Assurance:</u> Policy and Procedures were reviewed and training was done will all staff. Abuse Committee will meet monthly or when necessary to talk about any incidents that may have been reported. Monitoring and review of abuse will be part of our regular Quality Assurance Performance Improvement process.	

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involuntary seclusion and any physical or chemical restraint not required to treat a resident's symptoms." The policy indicated, "Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." The policy defined "verbal abuse" as the "use of oral, written, or gestural language that willfully includes disparaging and derogatory terms to residents or their families or within their hearing distance" and indicated, "Physical abuse includes hitting, slapping, pinching and kicking and controlling behavior through corporal punishment" and, "Mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation including doing so on social media."

An "Admission Record" revealed the facility admitted Resident #38 on 11/01/2023. According to the Admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, muscle wasting and atrophy, difficulty walking, and anxiety disorder. Per the Admission Record, the facility discharged the resident on 08/06/2024.

An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/11/2023, revealed Resident #38 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had physical and verbal behavioral symptoms directed towards others that significantly interfered with the resident's care

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and put others at significant risk for physical injury and disrupted the care and living environment of others. The MDS revealed the resident rejected care one to three days during the assessment look-back period. The MDS revealed that the resident had a functional limitation in range of motion on one side of their upper and lower extremities. Per the MDS, the resident required partial to moderate assistance from staff with upper body dressing and required substantial/maximal assistance with lower body dressing and toileting hygiene. The MDS indicated the resident was always incontinent of bladder and bowel.

A "DLBC [Division of Licensing and Background] - Form 358: Facility Reported Incidents" document revealed that on 11/28/2023 at 2:30 PM, the Administrator reported allegations of "Physical Abuse" and "Mental/Verbal Abuse" of Resident #38 by RN #6. The document revealed CNAs, including CNAs #2, #8, #9, and #10, became aware of the incident on 11/24/2023 in the "Early Morning" and notified administration on 11/28/2023 at 2:00 PM. The document revealed the CNAs were trying to put the resident into bed from the resident's recliner, and when the resident did not want to go to bed, RN #6 went into Resident #38's room, "yelled" in the resident's face that the resident needed to get into bed, grabbed the resident's arms and wrist, and "shook" the resident. Per the document, RN #6 gave the resident a choice to let the CNAs put them in bed or RN #6 would do it, then counted down from five. The document indicated RN #6 then "grabbed" the resident by their arms and legs and moved the resident to their bed. The document indicated Resident #38 told RN #6 to

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F 600	Continued From page 11 stop hurting them. The "DLBC- Form 358: Facility Reported Incidents" document included only information related to an alleged incident on 11/24/2023; however, statements provided by the facility, written by CNAs #2, #8, and #10, detailed allegations regarding incidents that allegedly occurred on 11/24/2023, 11/26/2023, and 11/28/2023. The facility had no documentation of a statement provided by CNA #9. The details of the CNA witness statements were as follows: An undated, handwritten statement provided to the facility by CNA #2 revealed that on 11/24/2023, RN #6 asked that she and CNA #10 attempt to get Resident #38 into bed. The statement indicated that when the resident refused, RN #6 "demanded" the resident get into bed. According to the statement, Resident #38 kept saying they were fine in their chair and did not want to get into bed, but RN #6 "grabbed" the resident by their shirt and told the resident they "had to, no matter what." The statement indicated that the resident crossed their arms in an attempt to get away from RN #6, telling the nurse to get away from them and that RN #6 was hurting them. The statement indicated RN #6 grabbled the resident by the wrist angrily. Per the statement, after about 20 minutes of the RN and the resident going "back and forth," RN #6 told the resident they had five seconds to decide if the CNAs or if he (RN #6) was going to get the resident into bed. The statement indicated that RN #6 then held up five fingers, counted down, then "grabbed" the resident by the wrist and ankle and "pushed" the resident on the bed so "aggressively" that it moved the whole bed.	F 600		

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F 600	Continued From page 12 An undated, typed statement provided to the facility by CNA #10 revealed that on 11/24/2024 RN #6 instructed her and CNA #2 to let him know if Resident #38 refused to allow the CNAs to transfer them. The statement indicated the resident refused to get in bed twice, so the CNAs notified RN #6. The statement indicated RN #6 went into the resident's room and told the resident to "Get in the [expletive] bed." The statement indicated the resident kept refusing, and RN #6 "grabbed" the resident by the top of their shirt and "shook" them, telling the resident, "You need to get in your bed or you'll [you will] die sitting in this chair." Per the statement, the resident still refused and told RN #6, "You should just leave me alone," but RN #6 grabbed both of the resident's arms while they were crossed against the resident's chest and shook the resident. Resident #38 said, "You're [You are] hurting me." Per the statement, CNA #10 and CNA #2 looked at each other and were unsure what to do, while RN #6 continued talking to the resident about a risk versus benefit form that the resident could sign in a few days to allow the resident to stay in bed all the time. Per the statement, Resident #38 responded and said, "I want to leave this place," and "Let me die." The statement indicated RN #6 then "grabbed" the resident by an arm and a leg and threw the resident onto the bed, and the resident almost fell off the bed in the process. Per the statement, RN #6 shoved the bed over "very aggressively" and "grabbed" the resident again and pulled them, then "shoved" the bed back against the wall. Per the statement, the resident stated, "That big guy is a monster." According to the statement, CNA #10 and CNA #2 did not know what to do in the	F 600		

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situation because they both had to work with RN #6 for the remainder of the night, and CNA #10 and CNA #9 had to also work with RN #6 over the following two days. The typed statement revealed, "We [CNA #10 and CNA #2] both decided that we were going to write a report, but we weren't [were not] going to turn it in till [until] the next week when [RN #6] wasn't [was not] working." The report further indicated that following the incident, RN #6 stopped CNA #10 and CNA #2 in the hallway to tell them he did not want any of that to happen; he just did not want anyone to "die on his watch," as though he was "just trying to justify the whole situation." In addition, the statement indicated CNA #10 and CNA #2 also spoke with CNA #9 to see what she felt about it, but it seemed to them that CNA #9 "kept on justifying that what he did was okay." The typed statement from CNA #10 also included details of a second incident that occurred on 11/26/2023. Per the statement, on 11/26/2023, CNA #10 was attempting to change Resident #38's brief while CNA #9 was providing care for the resident's roommate; however, CNA #10 realized Resident #38 had a large bowel movement and needed to transfer to their bed for incontinence care. The statement indicated Resident #38 refused to allow CNA #10 and CNA #9 to use a mechanical lift to transfer the resident to bed. According to the statement, the CNAs also asked CNA #8 to assist with the transfer, but they were unable, so they notified RN #6. The statement indicated that when RN #6 entered the resident's room, he said "I'm here now and you know what that means." The statement indicated that the RN's comment scared the resident and when the resident became upset, RN #6 "got even more angry and grabbed" the resident's

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arms "like he did the other day" (11/24/2023) and started "kinda [kind of] shaking" the resident. Per the statement, the resident repeatedly said RN #6 was hurting them and to stop. The statement indicated she and CNA #8 did not discuss this incident, but "with what happened the other day," she knew she needed to include this encounter in her report.

An undated, handwritten statement provided to the facility by CNA #8 indicated that on 11/28/2023, she, CNA #10, and CNA #9 were attempting to change Resident #38's brief but the resident refused, and RN #6 was notified. According to the statement, RN #6 "got in [the resident's] face" and yelled at the resident. The statement indicated RN #6 told the resident they were going to place the resident into a mechanical lift without asking. Per the statement, RN #6 was shaking the resident's arms, and the resident kept repeating, "Ow."

Review of timecards for CNAs #2, #8, #9, and #10 and RN #6 revealed CNAs #2, #9, and #10 and RN #6 worked together during the nightshift on 11/24/2023 at the time of the first incident, and CNAs #8, #9, and #10 and RN #6 worked together during the nightshift on 11/26/2023.

During a telephone interview on 11/11/2024 at 3:25 PM, after reading the statement provided to the facility by CNA #2 regarding the alleged incident on 11/24/2023, CNA #2 confirmed she had written the statement and indicated the date and details of the incident were accurate to the best of her knowledge. CNA #2 said the incident occurred approximately a year prior, so she could not recall the exact details. CNA #2 stated the

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incident she witnessed was observed by herself, CNA #9, and CNA #10. According to CNA #2, a second incident was witnessed by CNA #8 on another day, and a few days later, when CNA #2 and CNA #8 were both working, they wrote the statements they provided to the facility.

During a follow-up telephone interview on 11/14/2024 at 3:56 PM, CNA #2 said she considered the incident she witnessed as physical abuse because of the way RN #6 moved Resident #38, despite the resident not wanting to move.

During a telephone interview on 11/11/2024 at 4:06 PM, after reading the statement provided to the facility by CNA #10 regarding the alleged incidents on 11/24/2023 and 11/26/2023, CNA #10 confirmed she had written the statement and indicated the dates of the incidents referenced in her statement were accurate. CNA #10 said she wrote the statement after witnessing the second incident. CNA #10 said she could no longer recall all the details, but she recalled that she and CNA #2 were trying to provide incontinence care to the resident, and the resident refused. According to CNA #10, RN #6 came in and grabbed the resident's hands, and the resident told the nurse to stop because it hurt. CNA #10 said RN #6 grabbed the resident's hand and leg and tossed the resident into bed.

During a follow-up telephone interview on 11/14/2024 at 1:59 PM, CNA #10 said she considered both incidents she witnessed as abuse because Resident #38 did not want RN #6 to move them, but RN #6 did not care what the resident wanted. CNA #10 further stated the

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F 600	Continued From page 16 facility had only questioned her about one of the two incidents she reported. During a telephone interview on 11/11/2024 at 1:18 PM, after reading the statement provided to the facility by CNA #8 regarding the alleged incident on 11/28/2023, CNA #8 confirmed she had written the statement but indicated the date of 11/28/2023 was not correct because RN #6 did not work that day. CNA #8 stated the incident she described occurred over the weekend, either on Saturday (11/25/2023) or Sunday (11/26/2023). CNA #8 said, aside from the date, the details of what she wrote in her statement were accurate. CNA #8 stated on the night in question, she, CNA #2, and RN #6 went into Resident #38's room. According to CNA #8, RN #6 went over and started yelling at the resident, grabbed the resident's shirt, and kind of shook and yelled at the resident. CNA #8 could not recall exactly what RN #6 said to the resident but indicated RN #6 was being very aggressive with the resident. CNA #8 said Resident #38 looked scared during the incident. CNA #8 said that following this incident, CNA #2 told her about another incident CNA #2 had witnessed, so CNA #2 and CNA #8 both wrote the statements they later provided to the facility. CNA #8 said she had never seen RN #6 act this way with other residents and described the incident as shocking. During a follow-up telephone interview on 11/14/2024 at 12:11 PM, CNA #8 clarified that there was one incident involving CNAs #8, #9, and #10, RN #6, and Resident #38, and there was a separate incident that CNA #2 was involved in on a different day. CNA #8 said she considered the incident she witnessed as	F 600		

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F 600	Continued From page 17 physical abuse due to the way RN #6 grabbed Resident #38's shirt and shook the resident. During an interview on 10/17/2024 at 9:41 AM, RN #6 said there was a time when he did pick Resident #38 up and put the resident in bed. According to RN #6, Resident #38 was agitated when RN #6 went into their room. RN #6 said the resident was seated in their recliner with their brief still on and their pants pulled halfway down. RN #6 said fecal matter was coming out of the resident's brief. Per RN #6, he put his arm underneath the resident's left arm and told the resident he could not leave them like that. According to RN #6, Resident #38 required two people for transfers and could not support their weight, so RN #6 had to hold the resident's legs in an awkward position. RN #6 said the resident's recliner was positioned against the bed, and the resident was precariously positioned on the recliner, so he lifted the resident, which caused his shoulder to pop; however, RN #6 stated it felt as though the resident was lying on the ground and felt like he had to "heave" the resident up on the bed. During an interview with the DON on 11/12/2024 at 9:30 AM, the DON confirmed she had received the statements from CNAs #2, #8, and #10; however, the DON stated she was only aware of one incident involving Resident #38. During a follow-up interview on 11/12/2024 at 4:01 PM, the DON stated that after reading the statements from CNA #2, #8, and #10 again, it sounded as though there were two separate incidents. The DON said that according to the statements, the dates were matching up, except	F 600		

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for the one dated 11/28/2023, which she assumed was probably a wrong date because RN #6 did not work that day.

During an interview on 11/12/2024 at 10:49 AM, the Administrator stated he was only aware of one incident between RN #6 and Resident #38. He was not aware of any other incidents.

During a follow-up interview on 11/12/2024 at 3:13 PM, the Administrator read over the statements provided to the facility by CNAs #2, #8, and #10. The Administrator said he obviously forgot there were multiple incidents reported because it had been almost a year. He confirmed that per the statements, multiple incidents were reported and based on the statements, it sounded bad.

The facility submitted a removal plan that was accepted by the SSA on 11/15/2024 at 4:44 PM. The removal plan indicated the following:

"1. Per facility policy, Registered Nurse (RN) #6 was suspended immediately at 11:00 AM on 11/14/2024, pending the outcome of the investigation into the alleged incidents dated November of 2023.

2. With the help of the Corporate Officer, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Resident Advocate (RA), the Administrator will reinvestigate alleged abuse incidents from November 2023. The investigation of the incident dated November 2023 started on 11/14/2024 and will be completed by 11/18/2024 or before. The November 2023 incident is being investigated by the CEO, Administrator and

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F 600	Continued From page 19 DON. All residents were interviewed through this process by RA, ADON and /or DON, additional interviews are being conducted in connection with the incident in November 2023. During this investigation RN #6 has been suspended pending the findings of the investigation. - The Chief Operating Officer (COO) met with the Administrator and DON and trained them on abuse investigation to include staff interviews and resident interviews and to create an abuse committee that includes Administrator, DON, ADON, RA, and COO to meet and review the evidence and interviews to come to the right conclusion. The abuse committee will be part of our regular quality assurance and performance improvement (QAPI) meetings where we will discuss any issues that may have come up and determine the correct actions. The training was provided by the COO to the DON, ADON, and RA on 11/14/2024. - The COO Provided 1:1 training with DON, ADON, Administrator, and Resident Advocate (RA) on proper investigation, to include resident interviews and staff interviews. The training included a resident interview form and staff interview form. This was completed on 11/14/2024. - The Corporate Officer conducting the investigation, having trained the RA, and instructed the RA to conduct all resident interviews. Having trained the DON and ADON on proper staff interviews along with the Administrator, the Corporate Officer directed the DON and ADON to conduct interviews of all staff interviews and provide an opportunity to express	F 600		

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any concerns related to treatment of residents. Training and in-service are being given to all staff members by the CEO on abuse and proper and timely abuse reporting. The CEO, in training, is asking all staff if they have any concerns with the treatment of patients. Training of Administrator, DON, ADON, and RA completed 11/14/2024.

3. After training by Corporate Officer on 11/14/2024 to RA on proper interview questions on an abuse incident, the RA went with the Minimum Data Set (MDS) Coordinator and conducted all interviews with residents. RA conducted all interviews and MDS Coordinator went as a witness to all interviews. Residents that are not able to communicate were assessed to make sure there was no concerns of abuse. Based on interviews with all residents, there was no evidence of abuse of other residents found. All reported they feel safe and know who to report to if abuse occurred.

4. Findings of the November 2023 incident will be reported to the survey team and the state survey and certification agency and the appropriate actions will be taken to either substantiate or unsubstantiate whether abuse occurred.

5. The Chief Executive Officer (CEO) will communicate face to face to each staff member on proper identification of abuse and reporting of abuse timely. Each staff will receive a copy of the abuse policy and will be required to sign they have received the training from the CEO prior to coming on shift. All staff will be made aware of where to find the Administrator and DON's phone numbers, which are located behind the nurses' station, so they will be able to contact them if an

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F 600	Continued From page 21 incident needs to be reported. Training will start 11/14/2024 and will be completed 11/15/2024 or prior to a staff member working their next scheduled shift. 6. The ad hoc quality assurance and performance improvement (QAPI) meeting is scheduled for 11/15/2024. Discussed in the QAPI meeting were abuse policy and procedures, Utah Healthcare Association abuse training from September 2022, investigation training. Investigation and findings of the November 2023 incident. The CEO, DON, ADON, RA, and Administrator are present. 7. The Medical Director was notified on 11/14/2024 at 4:15 PM about the immediate jeopardy and was updated about the current removal plan. MD was in agreement to proceed with removal plan. The immediacy of the IJ was removed on 11/15/2024, 4:37 PM." On 11/15/2024, the survey team conducted on-site verification to confirm the facility had implemented the above written removal plan, as follows: 1. During an interview on 11/15/2024 at 5:51 PM, the Administrator and CEO stated RN #6 was provided disciplinary action over the phone, since he was unable to come to the facility due to an illness. They also reported RN #6 was notified he was suspended pending the outcome of the facility's investigation into the 11/2023 incidents. 2. The survey team reviewed the facility's	F 600		

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F 600	Continued From page 22 investigation into the allegations of abuse from November 2023. The facility's investigation revealed the facility interviewed all 41 residents residing in the facility at the time of the current survey, interviewed all staff involved in the November 2023 incidents, and interviewed other staff who may have had knowledge of the incidents. Per the facility's "Abuse Committee minutes," dated 11/14/2024, the facility was unable to substantiate abuse had occurred after completing their investigation. The team was able to verify that the Administrator, DON, ADON, and the RA received training on abuse investigations, including conducting interviews as part of the investigation. This was verified by conducting interviews with these staff members and reviewing training documentation provided by the facility. "Staff In-Service" sheets revealed facility staff members received copies of and were educated on the facility's abuse policies, including recognizing the signs and symptoms of abuse/neglect, immediate reporting, investigations, and protection measures. Interviews were conducted with 14 staff, including dietary staff, housekeeping staff, laundry staff, two Licensed Practical Nurses (LPNs), one RN, the ADON, DON, RA, and Administrator, to verify they had received and understood the in-service materials. Per the inservice records, the facility was able to in-service all staff except for two, who were out of the state/country. The plan to in-service these staff was to provide the in-service prior to their next scheduled shifts. Neither staff were on the schedule until after the end of the month.	F 600		

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F 600	Continued From page 23 3. The survey team reviewed the facility's investigation into the allegations of abuse from November 2023. The facility's investigation revealed the facility interviewed all 41 residents residing in the facility at the time of the current survey. 4. The survey team reviewed the facility's investigation into the allegations of abuse from November 2023. The facility's investigation revealed the facility interviewed all 41 residents residing in the facility at the time of the current survey, interviewed all staff involved in the November 2023 incidents, and interviewed other staff who may have had knowledge of the incidents. Per the facility's "Abuse Committee minutes," dated 11/14/2024, the facility was unable to substantiate abuse had occurred after completing their investigation. 5. "Staff In-Service" sheets revealed facility staff members received copies of and were educated on the facility's abuse policies, including recognizing the signs and symptoms of abuse/neglect, immediate reporting, investigations, and protection measures. Interviews were conducted with 14 staff, including dietary staff, housekeeping staff, laundry staff, two Licensed Practical Nurses (LPNs), one RN, the ADON, DON, RA, and Administrator, to verify they had received and understood the in-service materials. Per the inservice records, the facility was able to in-service all staff except for two, who were out of the state/country. The plan to in-service these staff was to provide the in-service prior to their next scheduled shifts. Neither staff were on the	F 600		

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F 600	Continued From page 24 schedule until after the end of the month. 6. "QAPI- Abuse Prevention, Reporting & Investigation Sub-Committee" minutes, dated 11/15/2024 at 3:15 PM, revealed the facility's QAPI committee met on 11/15/2024 to discuss abuse policy and procedures and the outcome of the facility's investigation into the 11/2023 incidents. According to the minutes, the facility did not substantiate abuse related to the 11/2023 incidents. 7. During a telephone interview on 11/15/2024 at 5:53 PM, the Medical Director confirmed the facility notified them on 11/14/2024 of the IJ findings and updated them on the removal plan.	F 600		
F 609 SS=J	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	F 609	Training was initiated on 11/14/2024. Training was provided by Chief Operating Officer (COO) to the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) on how to recognize abuse, the types of abuse, when to report abuse, and who to report the abuse to, as well as how to conduct a proper and thorough investigation, to include statements from residents, statements from staff involved, as well as interview other staff and residents. An abuse committee was established that includes Administrator, DON, ADON, RA, and someone from the corporate office to determine the correct outcome of any reported incidence. The abuse committee was established to ensure that abuse is reported timely. The abuse committee will be part of our regularly scheduled quality assurance and performance improvement (QAPI) meetings. In it we will discuss any issues that may have come up and determine appropriate corrective actions. Training was completed 11/14/2024.	12/13/2024

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F 609	Continued From page 25 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 facility document and policy review, the facility failed to ensure staff immediately reported allegations of abuse for 3 (Residents #38, #35 and #3) of 4 residents reviewed for abuse. Specifically, on 11/24/2024, certified nurse aides (CNAs) witnessed an incident involving Registered Nurse (RN) #6 and Resident #38 in which RN #6 aggressively transferred Resident #38 against their will; however, the CNAs who witnessed the transfer did not immediately report that they considered what they witnessed to be abusive, which allowed RN #6 to continue working with access to the resident. Subsequently, the CNAs witnessed a second incident on 11/26/2023 in which RN #6 grabbed Resident #38 and shook the resident to convince the resident to allow staff to transfer them back to their bed for care. It was determined the provider's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State	F 609	CEO from the management company started training 11/14/2024 with individuals, and small groups, with all other employees on company abuse policy and procedures, the importance of reporting immediately any suspected abuse, to report any suspected abuse to the Administrator. All staff were required to have this training prior to working their next shift. CEO communicated via face to face, via Zoom, or Facetime to all staff members currently employed by the facility on proper identification of abuse and immediately reporting of all suspected abuse. Documentation was completed on day of training. Each staff received a copy of the abuse policy and was required to sign they have received the training from the corporate officer prior to coming on shift. All staff was made aware of where to find the Administrator's and DON's numbers which are located behind the nurses' station, so they will be able to contact them immediately if an incident needs to be reported. Training started 11/14/2024 and was completed before each staff member comes on shift. Those employees that failed to report timely that still work at the facility have had 1:1 training about the abuse policy, when to report the abuse, and who to report the abuse to by the CEO prior to their shift on 11/15/2024. Quality Assurance and Performance Improvement (QAPI) was held on 11/15/2024. Discussed in the QAPI meeting was abuse policy and procedures, Utah Healthcare Association abuse training from September 2022, investigation training.	

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F 609	Continued From page 26 Operations Manual, Appendix PP, §483.12(c)(1) Reporting of Alleged Violations, F609, at a scope and severity of "J." The IJ began on the nightshift on 11/24/2023 when RN #6 aggressively transferred Resident #38 from a recliner to the bed without consent from the resident, and the CNAs did not immediately report what they witnessed. Subsequently on 11/26/2024, CNAs again witnessed RN #6 grab Resident #38 and shake the resident to convince the resident to allow staff to transfer them back to their bed for care. The CNAs did not report either incident to facility management until 11/28/2023. On 11/13/2024 at 5:26 PM, the Administrator was informed of the IJ situation and provided a completed IJ template. A removal plan was requested. The removal plan was accepted by the State Survey Agency (SSA) on 11/15/2024 at 4:44 PM. The IJ was removed on 11/15/2024 at 6:50 PM after the survey team performed onsite verification that the removal plan had been implemented. Noncompliance remained at the lower scope and severity of "D," no actual harm with the potential for more than minimal harm. Additional findings were identified related to Resident #35 and Resident #3. Specifically, on the evening of 03/19/2024 after being notified of an allegation of potential resident-to resident sexual abuse involving Resident #35, RN #17 failed to immediately notify management of the allegation, and as a result, the facility did not submit an initial report to the SSA until 03/20/2024 at 11:00 AM. In addition, staff members aware of an allegation that Resident #3	F 609	The CEO, DON, ADON, RA, and Administrator were present at the meeting. Training will be done with all new staff in 1:1 or small group orientation and all agency personnel before they start work on any shifts. The HR department, Administrator, or DON will provide training on the abuse policy and procedures. All staff had the opportunity to report any incidents or concerns related to patient safety in 1:1 interviews with DON, ADON, or Administrator. Further opportunity was provided by CEO of the corporate office through the abuse training conducted 1:1 or small groups training as well as via facetime and zoom meetings. Monitoring/Quality Assurance: Policy and Procedures were reviewed and training was done with all staff. Abuse Committee will meet monthly or when necessary to talk about any incidents that may have occurred. Monitoring will be part of our regular Quality Assurance Performance Improvement process. Monitoring and training will be done monthly. Abuse committee will report to QAPI that the process has been followed and the outcomes of any incident.	

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was verbally abused by RN #6 failed to immediately report the allegation to management on 10/11/2024. Also, once management was informed of the allegation of abuse on 10/14/2024, the facility failed to report the allegation to the SSA within two hours.

Findings included:

A facility policy titled, "Policy and Procedure for Prohibiting Abuse," dated 02/2017, revealed, "It is the policy of this facility to provide person-centered care by promoting the well-being of its residents in a safe and supportive environment. The facility prohibits any abuse. Our residents have the right to be free from abuse, neglect, misappropriation of property, and exploitation, corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat a resident's symptoms." The section of the policy titled, "Reporting Protocol" revealed, "1. Any person who suspects that abuse, neglect or misappropriation of property may have occurred, will immediately report the alleged violation to the facility administration and/or advocacy agencies according to the law. 2. The Administration will immediately notify Adult Protective Services or local law enforcement authority, the local long term care Ombudsman and State Survey and Certification for all allegations of abuse, neglect or exploitation."

1. An "Admission Record" revealed the facility admitted Resident #38 on 11/01/2023. According to the Admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis following cerebral

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infarction affecting the right dominant side, muscle wasting and atrophy, difficulty walking, and anxiety disorder. Per the Admission Record, the facility discharged the resident on 08/06/2024.

An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/11/2023, revealed Resident #38 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had physical and verbal behavioral symptoms directed towards others that significantly interfered with the resident's care and put others at significant risk for physical injury and disrupted the care and living environment of others. The MDS revealed the resident rejected care one to three days during the assessment look-back period. The MDS revealed that the resident had a functional limitation in range of motion on one side of their upper and lower extremities. Per the MDS, the resident required partial to moderate assistance from staff with upper body dressing and required substantial/maximal assistance with lower body dressing and toileting hygiene. The MDS indicated the resident was always incontinent of bladder and bowel.

A "DLBC [Division of Licensing and Background] - Form 358: Facility Reported Incidents" document revealed that on 11/28/2023 at 2:30 PM, the Administrator reported allegations of "Physical Abuse" and "Mental/Verbal Abuse" of Resident #38 by RN #6. The document revealed CNAs, including CNAs #2, #8, #9, and #10, became aware of the incident on 11/24/2023 in

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the "Early Morning" and notified administration on 11/28/2023 at 2:00 PM. The document revealed the CNAs were trying to put the resident into bed from the resident's recliner, and when the resident did not want to go to bed, RN #6 went into Resident #38's room, "yelled" in the resident's face that the resident needed to get into bed, grabbed the resident's arms and wrist, and "shook" the resident. Per the document, RN #6 gave the resident a choice to let the CNAs put them in bed or RN #6 would do it, then counted down from five. The document indicated RN #6 then "grabbed" the resident by their arms and legs and moved the resident to their bed. The document indicated Resident #38 told RN #6 to stop hurting them.

Statements provided by the facility, written by CNAs #2, #8, and #10, detailed allegations regarding incidents that allegedly occurred on 11/24/2023, 11/26/2023, and 11/28/2023. The details of the CNA witness statements were as follows:

An undated, handwritten statement provided to the facility by CNA #2 revealed that on 11/24/2023, RN #6 asked that she and CNA #10 attempt to get Resident #38 into bed. The statement indicated that when the resident refused, RN #6 "demanded" the resident get into bed. According to the statement, Resident #38 kept saying they were fine in their chair and did not want to get into bed, but RN #6 "grabbed" the resident by their shirt and told the resident they "had to, no matter what." The statement indicated that the resident crossed their arms in an attempt to get away from RN #6, telling the nurse to get away from them and that RN #6 was hurting

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them. The statement indicated RN #6 grabbled the resident by the wrist angrily. Per the statement, after about 20 minutes of the RN and the resident going "back and forth," RN #6 told the resident they had five seconds to decide if the CNAs or if he (RN #6) was going to get the resident into bed. The statement indicated that RN #6 then held up five fingers, counted down, then "grabbed" the resident by the wrist and ankle and "pushed" the resident on the bed so "aggressively" that it moved the whole bed.

An undated, typed statement provided to the facility by CNA #10 revealed that on 11/24/2024 RN #6 instructed her and CNA #2 to let him know if Resident #38 refused to allow the CNAs to transfer them. The statement indicated the resident refused to get in bed twice, so the CNAs notified RN #6. The statement indicated RN #6 went into the resident's room and told the resident to "Get in the [expletive] bed." The statement indicated the resident kept refusing, and RN #6 "grabbed" the resident by the top of their shirt and "shook" them, telling the resident, "You need to get in your bed or you'll [you will] die sitting in this chair." Per the statement, the resident still refused and told RN #6, "You should just leave me alone," but RN #6 grabbed both of the resident's arms while they were crossed against the resident's chest and shook the resident. Resident #38 said, "You're [You are] hurting me." Per the statement, CNA #10 and CNA #2 looked at each other and were unsure what to do, while RN #6 continued talking to the resident about a risk verses benefit form that the resident could sign in a few days to allow the resident to stay in bed all the time. Per the statement, Resident #38 responded and said, "I

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want to leave this place," and "Let me die." The statement indicated RN #6 then "grabbed" the resident by an arm and a leg and threw the resident onto the bed, and the resident almost fell off the bed in the process. Per the statement, RN #6 shoved the bed over "very aggressively" and "grabbed" the resident again and pulled them, then "shoved" the bed back against the wall. Per the statement, the resident stated, "That big guy is a monster." According to the statement, CNA #10 and CNA #2 did not know what to do in the situation because they both had to work with RN #6 for the remainder of the night, and CNA #10 and CNA #9 had to also work with RN #6 over the following two days. The typed statement revealed, "We [CNA #10 and CNA #2] both decided that we were going to write a report, but we weren't [were not] going to turn it in till [until] the next week when [RN #6] wasn't [was not] working." The report further indicated that following the incident, RN #6 stopped CNA #10 and CNA #2 in the hallway to tell them he did not want any of that to happen; he just did not want anyone to "die on his watch," as though he was "just trying to justify the whole situation." In addition, the statement indicated CNA #10 and CNA #2 also spoke with CNA #9 to see what she felt about it, but it seemed to them that CNA #9 "kept on justifying that what he did was okay." The typed statement from CNA #10 also included details of a second incident that occurred on 11/26/2023. Per the statement, on 11/26/2023, CNA #10 was attempting to change Resident #38's brief while CNA #9 was providing care for the resident's roommate; however, CNA #10 realized Resident #38 had a large bowel movement and needed to transfer to their bed for incontinence care. The statement indicated

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F 609	Continued From page 32 Resident #38 refused to allow CNA #10 and CNA #9 to use a mechanical lift to transfer the resident to bed. According to the statement, the CNAs also asked CNA #8 to assist with the transfer, but they were unable, so they notified RN #6. The statement indicated that when RN #6 entered the resident's room, he said "I'm here now and you know what that means." The statement indicated that the RN's comment scared the resident and when the resident became upset, RN #6 "got even more angry and grabbed" the resident's arms "like he did the other day" (11/24/2023) and started "kinda [kind of] shaking" the resident. Per the statement, the resident repeatedly said RN #6 was hurting them and to stop. The statement indicated she and CNA #8 did not discuss this incident, but "with what happened the other day," she knew she needed to include this encounter in her report. An undated, handwritten statement provided to the facility by CNA #8 indicated that on 11/28/2023, she, CNA #10, and CNA #9 were attempting to change Resident #38's brief but the resident refused, and RN #6 was notified. According to the statement, RN #6 "got in [the resident's] face" and yelled at the resident. The statement indicated RN #6 told the resident they were going to place the resident into a mechanical lift without asking. Per the statement, RN #6 was shaking the resident's arms, and the resident kept repeating, "Ow." During an interview on 10/17/2024 at 8:56 AM, CNA #2 stated she had never experienced a situation like she did in 11/2023 and did not know what to do. CNA #2 said she had the Director of Nursing's (DON's) number but did not know why	F 609		

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F 609	Continued From page 33 she did not call the DON about the incident. During a follow-up telephone interview on 11/11/2024 at 3:25 PM, after reading the statement provided to the facility by CNA #2 regarding the alleged incident on 11/24/2023, CNA #2 confirmed she had written the statement and indicated the date and details of the incident were accurate to the best of her knowledge. CNA #2 said the incident occurred approximately a year prior, so she could not recall the exact details. CNA #2 stated the incident she witnessed was observed by herself, CNA #9, and CNA #10. According to CNA #2, a second incident was witnessed by CNA #8 on another day, and a few days later, when CNA #2 and CNA #8 were both working, they wrote the statements they provided to the facility. CNA #2 said that she and CNA #8 slid their statements under the DON's door. During a telephone interview on 11/11/2024 at 4:06 PM, after reading the statement provided to the facility by CNA #10 regarding the alleged incidents on 11/24/2023 and 11/26/2023, CNA #10 confirmed she had written the statement and indicated the dates of the incidents referenced in her statement were accurate. CNA #10 said she wrote the statement after witnessing the second incident. CNA #10 said she could no longer recall all the details, but she recalled that she and CNA #2 were trying to provide incontinence care to the resident, and the resident refused. According to CNA #10, RN #6 came in and grabbed the resident's hands, and the resident told the nurse to stop because it hurt. CNA #10 said RN #6 grabbed the resident's hand and leg and tossed the resident into bed. CNA #10 said she thought they had reported the incidents a few days later	F 609		

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when they were not scheduled to work with RN #6. According to CNA #10, she was not trained on how to report abuse and did not know how to report abuse until after the incidents with Resident #38 and RN #6.

During a telephone interview on 11/11/2024 at 1:18 PM, after reading the statement provided to the facility by CNA #8 regarding the alleged incident on 11/28/2023, CNA #8 confirmed she had written the statement but indicated the date of 11/28/2023 was not correct because RN #6 did not work that day. CNA #8 stated the incident she described occurred over the weekend, either on Saturday (11/25/2023) or Sunday (11/26/2023). CNA #8 said, aside from the date, the details of what she wrote in her statement were accurate. CNA #8 stated on the night in question, she, CNA #2, and RN #6 went into Resident #38's room. According to CNA #8, RN #6 went over and started yelling at the resident, grabbed the resident's shirt, and kind of shook and yelled at the resident. CNA #8 could not recall exactly what RN #6 said to the resident but indicated RN #6 was being very aggressive with the resident. CNA #8 said Resident #38 looked scared during the incident. CNA #8 said that following this incident, CNA #2 told her about another incident CNA #2 had witnessed, so CNA #2 and CNA #8 both wrote the statements they later provided to the facility. CNA #8 said she and CNA #2 slid their statements under the DON's door, and she thought they discussed the incidents with the DON the following week.

During an interview on 10/18/2024 at 9:42 AM, the DON stated allegation of abuse should be reported immediately. The DON said if the

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F 609	Continued From page 35 alleged abuser was a nurse, the CNAs had her number and could call her. During a follow-up interview on 11/12/2024 at 9:30 AM, the DON said she learned of the alleged incidents involving RN #6 and Resident #38 when she found the statements provided by the CNAs on Tuesday morning (11/28/2023). According to the DON, once she became aware, she immediately notified the Administrator. During an interview on 10/18/2024 at 11:28 AM, the Administrator stated that he reported abuse allegations to the SSA. He stated that any allegations of abuse should be reported within two hours. He stated that CNAs should be reporting to their nurse, then the nurse would report to the manager. The Administrator stated that if a CNA witnessed what they felt was abuse by the charge nurse, they should immediately report it to their manager. The Administrator said the CNAs should have immediately reported the incident on the night they saw it, but he thought they did not report it until a few days later. During an interview on 11/12/2024 at 10:49 AM, the Administrator confirmed the CNAs had not reported the incidents involving Resident #38 and RN #6 until 11/28/2023. The Administrator said staff should always report any allegations of abuse so the facility could take any necessary steps to protects the residents and so the facility could investigate to determine if abuse occurred. The facility submitted a removal plan that was accepted by the SSA on 11/15/2024 at 4:44 PM. The removal plan indicated the following:	F 609		

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F 609	Continued From page 36 "1. Training was initiated on 11/14/2024 at 12:00 PM. The training was provided by Chief Operating Officer (COO) to the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) on how to recognize abuse, the types of abuse, when to report abuse, and who to report the abuse to, as well as how to conduct a proper and thorough investigation, to include statements from residents, statements from staff involved, as well as interview other staff and residents. We also established an abuse committee that includes Administrator, DON, ADON, RA, and someone from the corporate office to determine the correct outcome of the reported incidence. The abuse committee will be part of our regularly scheduled quality assurance and performance improvement (QAPI) meetings. We will discuss any issues that may have come up and determine appropriate corrective actions. Training was completed 11/14/2024. The CEO from the management company started training 11/14/24 with individuals, and small groups, with all other employees on company abuse policy and procedures, the importance of reporting immediately any suspected abuse, to report any suspected abuse to the Administrator. All staff are required to have this training prior to working their next shift beginning 11/15/2024. 2. The Chief Executive Officer (CEO) will communicate via face to face, via Zoom, or Facetime to all staff members currently employed by the facility on proper identification of abuse and immediately reporting of all suspected abuse. Documentation will be completed on day of training. Each staff will receive a copy of the abuse policy and will be required to sign they	F 609		

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F 609	Continued From page 37 have received the training from the corporate officer prior to coming on shift. All staff will be made aware of where to find the Administrator's and DON's numbers which are located behind the nurses' station, so they will be able to contact them if an incident needs to be reported. Training will start 11/14/2024 and will be completed 11/15/2024. 3. Three of the four employees that had knowledge and reported late, no longer work at the facility. Certified Nurse Aide (CNA) #10's term date was 4/23/2024, CNA #8 Term date was 2/11/2024, and CNA #9 term date was 5/6/2024. CNA #2 is currently working at the facility and is getting 1:1 training about the abuse policy, when to report the abuse, and who to report the abuse to by the CEO prior to their shift on 11/15/2024. 4. The ad hoc Quality Assurance and Performance Improvement (QAPI) is scheduled for 11/15/2024. Discussed in the QAPI meeting were abuse policy and procedures, Utah Healthcare Association abuse training from September 2022, investigation training. The investigation process currently ongoing related to one suspended employee. The CEO, DON, ADON, RA, and Administrator were present. 5. Training will be done with all new staff in 1:1 or small group orientation and all agency personnel before they start work on any shifts. The Human Resources department, Administrator or DON will provide training on the abuse policy and procedures. 6. The Medical Director was notified of the immediate jeopardy on 11/14/2024 at 4:15 PM.	F 609		

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F 609	Continued From page 38 The MD was also updated with the current removal plan for the immediate jeopardy. The MD was in agreement to proceed with the removal plan. 7. All staff will have the opportunity to report any incidents or concerns related to patient safety in 1:1 interviews with DON, ADON, or Administrator. Further opportunity has been provided by CEO of the corporate office through the abuse training conducted 1:1 and in small groups training as well as via facetime and zoom trainings. The immediacy of the IJ was removed on 11/15/2024, 4:37 PM." On 11/15/2024, the surveyor team conducted on-site verification to confirm the facility had implemented the above written removal plan, as follows: 1. The team was able to verify that the Administrator, DON, ADON, and the RA received training on abuse investigations, including conducting interviews as part of the investigation. This was verified by conducting interviews with these staff members and reviewing training documentation provided by the facility. "Staff In-Service" sheets revealed facility staff members received copies of and were educated on the facility's abuse policies, including recognizing the signs and symptoms of abuse/neglect, immediate reporting, investigations, and protection measures. Interviews were conducted with 14 staff, including dietary staff, housekeeping staff,	F 609		

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F 609	Continued From page 39 laundry staff, two Licensed Practical Nurses (LPNs), one RN, the ADON, DON, RA, and Administrator, to verify they had received and understood the in-service materials. Per the inservice records, the facility was able to in-service all staff except for two, who were out of the state/country. The plan to in-service these staff was to provide the in-service prior to their next scheduled shifts. Neither staff were on the schedule until after the end of the month. "Abuse Committee minutes," dated 11/14/2024, reveled the facility established an abuse committee that consisted of the Administrator, DON, ADON, RA, and a member of corporate staff. 2. "Staff In-Service" sheets revealed facility staff members received copies of and were educated on the facility's abuse policies, including recognizing the signs and symptoms of abuse/neglect, immediate reporting, investigations, and protection measures. Interviews were conducted with 14 staff, including dietary staff, housekeeping staff, laundry staff, two Licensed Practical Nurses (LPNs), one RN, the ADON, DON, RA, and Administrator, to verify they had received and understood the in-service materials. Per the inservice records, the facility was able to in-service all staff except for two, who were out of the state/country. The plan to in-service these staff was to provide the in-service prior to their next scheduled shifts. Neither staff were on the schedule until after the end of the month. 3. "Staff In-Service" sheets revealed CNA #2 received copies of and was educated on the	F 609		

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F 609	Continued From page 40 facility's abuse policies, including recognizing the signs and symptoms of abuse/neglect and immediate reporting. CNAs #8, #9, and #10's personnel files were reviewed to verify they were no longer employed by the facility. 4. "QAPI- Abuse Prevention, Reporting & Investigation Sub-Committee" minutes, dated 11/15/2024 at 3:15 PM, revealed the facility's QAPI committee, including the CEO, Administrator, DON, ADON, and RA, met on 11/15/2024 to discuss abuse policy and procedures and the outcome of the facility's investigation into the 11/2023 incidents. 5. "Staff In-Service" sheets revealed facility staff members received copies of and were educated on the facility's abuse policies, including recognizing the signs and symptoms of abuse/neglect, immediate reporting, investigations, and protection measures. Interviews were conducted with 14 staff, including dietary staff, housekeeping staff, laundry staff, two Licensed Practical Nurses (LPNs), one RN, the ADON, DON, RA, and Administrator, to verify they had received and understood the in-service materials. Per the inservice records, the facility was able to in-service all staff except for two, who were out of the state/country. The plan to in-service these staff was to provide the in-service prior to their next scheduled shifts. Neither staff were on the schedule until after the end of the month. 6. During a telephone interview on 11/15/2024 at 5:53 PM, the Medical Director confirmed the facility notified them on 11/14/2024 of the IJ findings and updated them on the removal plan.	F 609		

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F 609	Continued From page 41 7. "Staff Investigation Report Forms" revealed the facility conducted staff interviews to determine if any staff had knowledge of any other potential abuse. 2. An "Admission Record" indicated that the facility admitted Resident #35 on 10/06/2023. According to the Admission Record, the resident had a medical history that included diagnoses of dementia, seizures, bipolar disorder, and anxiety disorder. A quarterly Minimum Date Set (MDS), with an Assessment Reference Date (ARD) of 04/16/2024, revealed Resident #35 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had disorganized thinking that fluctuated. An "Admission Record" indicated that the facility admitted Resident #36 on 02/16/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of dementia. An admission MDS, with an ARD of 02/26/2024, revealed Resident #36 had a BIMS score of 10, which indicated the resident had moderate cognitive impairment. Resident #36's "Progress Notes" revealed a "Behavior Note," dated 03/19/2024 at 8:52 PM and electronically signed by Registered Nurse (RN) #17, that revealed Certified Nurse Aide (CNA) #11 reported that Resident #36 was rude	F 609		

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to her when she went to get Resident #35's clothes for a bath. The note indicated that CNA #11 reported that Resident #36 had shown aggression toward Resident #35 and the CNA.

Resident #36's "Progress Notes" revealed a "Behavior Note," dated 03/19/2024 at 9:39 PM and electronically signed by RN #17, that revealed that earlier in the shift, CNA #11 entered Resident #35 and Resident #36's room to assist Resident #35 with a shower. The note indicated that Resident #36 indicated that they were "in charge" of Resident #35 and that they (Resident #36) was not going to let Resident #35 go with the CNA. Per the note, CNA #11 informed Resident #36 that Resident #35 could make their own decisions. The note indicated that Resident #36 got up and tried to block the door, but CNA #11 was able to exit the room.

A "DLBC [Division of Licensing and Background]-358 Facility reported incidents" document, revealed the facility reported "Sexual Abuse, Mental/Verbal Abuse" to the state survey agency on 03/20/2024 at 11:00 AM, indicating that on 03/19/2024 on the evening shift, CNA #11 went to get Resident #35 for a bath. The document revealed that Resident #36 blocked CNA #11 from taking Resident #35, grabbed and shook CNA #11, and told her that they (Resident #36) were in charge of Resident #35. The document indicated that Resident #36 stated that CNA #11 could not take Resident #35 to the shower and tried to lock CNA #11 out of the room. Per the document, a nurse relocated Resident #35 to another part of the facility to get them away from Resident #36. The document indicated that Resident #35 told the nurse in the

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morning that Resident #36 had tried to "force" Resident #35 to have sex. The document indicated that administration was notified of the incident on 03/20/2024 in the "Early Morning" by RN #17.

A handwritten statement, dated 03/26/2024 and signed by CNA #11, indicated that the CNA had walked into Resident #35 and Resident #36's room to help Resident #35 with a shower and Resident #36 became upset. The statement indicated that Resident #36 tried to stop them from leaving the room and became agitated. Per the statement, CNA #11 was able to remove herself from the room and reported the incident to RN #17. The statement indicated while giving Resident #35 a shower, Resident #35 reported that they were "scared" of Resident #36, and revealed that Resident #36 had demanded they (Resident #35) have sex with them (Resident #36). The statement indicated that CNA #11 reported to RN #17 what Resident #35 had said to her after the shower, and Resident #35 was moved to another room.

During a telephone interview on 10/16/2024 at 6:35 PM, CNA #11 stated that on the night of the incident, she was walking with Resident #35 in the room to get ready to go get a shower when Resident #36 got angry, stood up, and started walking toward Resident #35. CNA #11 stated that Resident #36 had started shaking her, then after a minute or two, the resident calmed down and the CNA and Resident #35 left the room. CNA #11 indicated there were times that Resident #35 liked Resident #36 and then times when Resident #35 said they hated Resident #36. CNA #11 stated that Resident #36 tried to

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have sex with Resident #35 but Resident #35 refused. CNA #11 stated that she was not aware of any sexual activity that occurred, and that Resident #35 told the CNA that they had never had sex. CNA #11 stated that she reported the incident to RN #17 that night.

During a telephone interview on 10/17/2024 at 11:34 AM, RN #17 stated that she did not receive a report of Resident #36 trying to force Resident #35 to have sex. RN #17 stated that she was not at the facility when the incident occurred.

During an interview on 10/18/2024 at 9:35 AM, the Director of Nursing (DON) stated that CNA #11 was getting Resident #35 for a shower and Resident #36 became anxious and told CNA #11 that she could not take Resident #35 for a shower. The DON stated that Resident #36 would not let CNA #11 leave, and when she was able to leave, she reported the incident to the nurse. The DON stated that the incident happened after 6:00 PM. The DON stated that whoever received the allegation would initiate a report, then give that to the Administrator and he would notify the state survey agency. She stated that Resident #35 reported that Resident #36 tried to force them to have sex. The DON stated the allegation should have been reported to the state survey agency the night of the incident. The DON stated that the report revealed that RN #17 was the nurse that night and administration was not notified until the following morning. The DON stated that the incident was reported to the state survey agency at 11:00 AM the following day and was not reported in the required timeframe. The DON stated it should have been reported immediately to administration and the

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Administrator should have come in to start the investigation. The DON stated she expected reporting of abuse to be done immediately.

During an interview on 10/18/2024 at 11:28 AM, the Administrator stated that the incident between Resident #35 and Resident #36 occurred on 03/19/2024, and Resident #35 was moved to another room. He stated that it was brought to their attention later that Resident #35 stated that Resident #36 tried having sex with them (Resident #35). The Administrator stated that the state survey agency should have been notified within two hours and stated that it did not look like the allegation had been reported timely, as it was reported at 11:00 AM the following day.

3. An "Admission Record" revealed the facility admitted Resident #3 on 03/11/2020 and most recently on 06/29/2024. According to the Admission Record, the resident had a medical history that included unspecified bipolar disorder, panic disorder, and hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side (paralysis on the left side of the body following a stroke).

A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/03/2024, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated Resident #3 exhibited verbal behavioral symptoms directed toward others four to six days during the assessment timeframe. The MDS revealed the resident rejected care four to six days during the assessment timeframe.

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F 609	Continued From page 46 Resident #3's care plan revealed a diagnosis area revised on 03/24/2023, that indicated the resident had depression with mood swings related to bipolar disorder. Interventions directed staff to discuss with the resident/family/caregivers any concerns, fears, issues regarding their health or other subjects (initiated 01/20/2023); and to monitor, document, and report signs and symptoms of depression (initiated 01/20/2023). During an interview on 10/14/2024 at 10:02 AM, Resident #3 stated that Registered Nurse (RN) #6 did not treat them with dignity and respect. Resident #3 stated RN #6 woke them up, pounded his chest and said, "I'm a smart man and I know you're lying about your condition." Resident #3 stated that on Friday night (10/11/2024) RN #6 told them he was not giving them ordered medication because they did not need the medication. Resident #3 stated that RN #6 told them he was tired of this dump (referring to the facility) and tired of them (Resident #3) and had another job lined up. Resident #3 stated that RN #6 also told them they were a horrible and bad person. Resident #3 stated they considered what RN #6 said verbal abuse. Resident #3 stated Certified Nurse Aide (CNA) #18 witnessed the conversation but CNA #18 said that she was not getting into the middle of the exchange. Resident #3 stated they reported the incident to the Assistant Director of Nursing (ADON) that morning (10/14/2024) and had requested to speak to the Director of Nursing (DON). Resident #3 stated they had been in an abusive relationship before and stated that RN #6 "seemed" the type.	F 609		

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F 609	Continued From page 47 The allegation of verbal abuse was reported to the Administrator on 10/14/2024 at 10:28 AM by the surveyor. A "DLBC [Division of Licensing and Background Checks]-Form 358: Facility Reported Incidents" revealed that an allegation of "Mental/Verbal Abuse" involving Resident #3 was reported to the State Agency on 10/14/2024 at 3:40 PM. The report revealed administration became aware of the incident on 10/14/2024 at 10:30 AM. The report indicated that Resident #3 had reported to a surveyor that on 10/11/2024, RN #6 told them that they were the reason he was going to quit, and that Resident #3 was a "horrible person." Resident #3 was interviewed on 10/15/2024 at 1:40 PM. Resident #3 stated they had asked multiple times that RN #6 not come into their room but on Friday (10/11/2024), the nurse made a point to come into their room. Resident #3 stated RN #6 scared them to the point of getting "knots" in their stomach until they were able to find out if the nurse was working or not. Nurse Aide (NA) #7 was interviewed on 10/16/2024 at 8:37 AM. NA #7 stated that Resident #3 had told her that RN #6 had accused them of "faking it" and stated that the resident did not need medication. NA #7 stated that Resident #3 reported this on 10/14/2024, and she had reported it to the DON and the ADON. NA #7 stated that she was unsure of what time Resident #3 had told her about RN #6. CNA #18 was interviewed via telephone on 10/16/2024 at 5:51 PM. CNA #18 stated that per RN #6's request, she had gone into Resident	F 609		

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#3's room with him on 10/11/2024 at around 9:30 PM. CNA #18 stated that RN #6 was irritated and angry with Resident #3 because the Administrator told RN #6 that Resident #3 had submitted complaints about him. CNA #18 stated that RN #6 had an "attitude" when he went into the room and told the resident that they and residents like Resident #3 were why he was quitting. CNA #18 stated the resident requested as needed (PRN, pro re nata) medications but the nurse told the resident they did not need the medication because he had already given the resident scheduled medication. She stated that RN #6 told the resident that if they wanted medication, the resident could get it from the other nurse. CNA #18 would not comment on if she thought the nurse's interaction with the resident was rude or verbally abusive.

The DON was interviewed on 10/17/2024 at 1:56 PM. She stated she found out about the allegation of abuse after it was reported by the surveyor. The DON stated Resident #3 had reported to her previously that RN #6 refused to give PRN medications, but she had not treated the concern like a grievance but had given disciplinary action to RN #6.

The DON was interviewed on 10/18/2024 at 10:05 AM and stated she was unaware about the timeframe for reporting allegations of abuse but stated that staff should report abuse to their supervisor immediately.

The Administrator was interviewed on 10/17/2024 at 2:35 PM. The Administrator stated he had not known about the allegation of abuse before Monday (10/14/2024), when the surveyor

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F 609	Continued From page 49 informed him. The Administrator stated he was unaware RN #6 denied Resident #3 physician-ordered PRN medications. The Administrator stated he was aware abuse allegations required submission to the state agency within two hours, but with surveyors in the building, the submission of the allegation to the state agency was put aside.	F 609		
F 610 SS=J	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 observation, interview, record review, document review, and facility policy review, the facility failed to thoroughly investigate allegations of abuse for 2 (Resident #35 and Resident #38) of 3 residents reviewed for abuse. Specifically, on 11/26/2023, RN #6 yelled in Resident #38's face, shook the resident, and insisted the	F 610	Training was done on 11/14/2024. Training was provided by Chief Operating Officer (COO) to Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) on how to recognize abuse, the types of abuse, when to report abuse, and who to report the abuse to, as well as how to conduct a proper and thorough investigation, to include statements from residents, statements from staff involved, as well as interview other staff and residents. The facility has also established an abuse committee that includes Administrator, DON, ADON, RA, and COO or CEO from the management company to assure the correct outcome on the reported incidence. The abuse committee will be part of our regularly scheduled QAPI meetings where we will discuss any issues that may have come up and determine the appropriate actions. The training was completed on 11/14/2024. The CEO from the management company started training 11/14/2024 with individuals and in small groups of all other employees on the abuse policy and procedures, reporting, and investigations prior to them working on their next shift. A full investigation of alleged incidents regarding RN#6 from November 2023 was performed with COO, CEO and the Administrator as part of the Administrators training.	12/13/2024

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F 610	Continued From page 50 resident allow staff to transfer the resident back to bed. Staff who witnessed the abuse did not immediately report the incident to administration, which resulted in a delay in initiating an investigation and implementing protective measures to prevent further abuse. As a result, RN #6 continued working in the facility and was involved in another incident of abuse toward Resident #38 on 11/26/2023. The facility's investigation of the incidents did not include interviews with other residents to determine if they had witnessed abuse or may have also been abused by RN #6 and did not include skin assessments to determine if other residents had bruises or other injuries that may have been attributed to abuse. Additionally, on 03/20/2024, the facility reported an allegation of resident-to-resident abuse for Resident #35. The facility's investigation did not include obtaining a copy of the sheriff's office report and a witness statement from the nurse assigned to the resident's care at the time the alleged incident occurred. It was determined the provider's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, F610 §483.12(c)(2) ? (4) Alleged Violations-Investigate/Prevent/Correct at a scope and severity of J. The IJ began on the night shift on 11/24/2023, when RN #6 forcibly transferred Resident #38	F 610	All residents were interviewed in this process by RA. With the COO, CEO, Administrator, and DON, additional interviews were done in connection with the incident back in November 2023. During this investigation, RN#6 was suspended pending the finding of the investigation. COO met with Administrator, DON, ADON, and RA and trained them on abuse training to include staff interviews and resident interviews and created an abuse committee, that includes Administrator, DON, RA, and COO to meet together to review the evidence and interviews to come to the right conclusion. This was completed 11/14/2024. COO from the management company provided 1:1 training with DON, ADON, Administrator, and RA on proper investigation processes, to include resident interviews and staff interviews, which included a resident interview form and staff interview forms. This was completed on 11/14/2024. Having trained the DON and ADON on proper staff interviews, along with the Administrator, the COO then directed the DON and ADON to conduct all staff interviews and gave staff the opportunity to express any concerns they may have had related to proper treatment of residents. The CEO, in training, also asked all staff if they had any concerns with the treatment of patients. This was completed 11/15/2024. Quality Assurance and Performance Improvement (QAPI) meeting was done 11/15/2024. Discussed in the QAPI meeting were abuse policy and procedures, Utah healthcare Association abuse training from September 2022, and investigation training.	

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F 610	Continued From page 51 from a recliner to bed against the resident's will. The certified nurse aides (CNAs) who witnessed the transfer did not immediately report the incident despite feeling they had witnessed verbal and physical abuse, which allowed RN #6 to continue working with access to the resident. As a result of this, RN #6 was involved in a second incident, in which he grabbed Resident #38, shaking the resident by the arms and shirt collar before the resident agreed to allow the CNAs to transfer them back to the bed from their recliner. Once the facility was made aware of the incidents, they did not complete a thorough investigation, to include documenting any interviews completed with the staff involved and interviewing all residents and staff who could have had information regarding the incidents or about RN #6's treatment of residents. Additionally, the facility did not conduct skin assessments of other residents who received care from RN #6 to determine if there were any bruises or other injuries that may have been a result of abuse. On 11/13/2024 at 5:26 PM, the Administrator was informed of the IJ situation and provided a completed IJ template. A removal plan was requested. The removal plan was accepted by the State Survey Agency (SSA) on 11/15/2024 at 4:37 PM. The IJ was removed on 11/15/2024 at 6:50 PM after the survey team performed onsite verification that the removal plan had been implemented. Noncompliance remained at the lower scope and severity of "D," no actual harm with the potential for more than minimal harm. Findings included:	F 610	CEO, DON, ADON, RA, and Administrator were present. CEO and COO will review the incident from November 2023 regarding RN6 through the survey process and future investigations, to ensure timely reporting and making sure that the investigation was done properly, and all documentation and interviews were done. Will review the findings from committee and sign off on investigations after they are completed. Monitoring/Quality Assurance: Policy and Procedures were reviewed and training was done will all staff. Abuse Committee will meet monthly or when necessary to talk about any incidents that may have occurred. Monitoring abuse will be part of our regular Quality Assurance Performance Improvement process.	

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A facility policy titled, "Policy and Procedure for Prohibiting Abuse," dated 02/2017, revealed, " "Administrator or designee will investigate incidents and administrator will be responsible for reporting initial allegations and the results of the investigations to proper authorities." The policy also specified, "3. The administration will initiate the investigation process by immediately interviewing staff and residents who have any knowledge of the allegation." According to the policy, "5. Investigation including documentation of all interviews will be completed within 5 working days," and "8. After the investigation is complete and within no more than 5 working days, the administrator will document a summary of findings and report those findings to all agencies which were initially notified."

1. An "Admission Record" revealed the facility admitted Resident #38 on 11/01/2023. According to the Admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (right side paralysis and weakness following a stroke), muscle wasting and atrophy, difficulty walking, and anxiety disorder. Per the Admission Record, the facility discharged the resident on 08/06/2024.

An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/11/2023, revealed Resident #38 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had physical and verbal behavioral symptoms directed toward others that

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significantly interfered with the resident's care and put others at significant risk for physical injury and disrupted the care and living environment of others. The MDS revealed that the resident rejected care one to three days during the assessment look-back period and was always incontinent of bladder and bowel.

A "DLBC [Division of Licensing and Background] - Form 358: Facility Reported Incidents" document revealed that on 11/28/2023 at 2:30 PM, the Administrator reported allegations of "Physical Abuse" and "Mental/Verbal Abuse" of Resident #38 by RN #6. The document revealed CNAs, including CNAs #2, #8, #9, and #10, became aware of the incident on 11/24/2023 in the "Early Morning" and notified administration on 11/28/2023 at 2:00 PM. The document revealed the CNAs were trying to put the resident into bed from the resident's recliner, and when the resident did not want to go to bed, RN #6 went into Resident #38's room, yelled in the resident's face that the resident needed to get into bed, grabbed the resident's arms and wrist, and shook the resident. Per the document, RN #6 gave the resident a choice to let the CNAs put them in bed or RN #6 would do it, then counted down from five. The document indicated RN #6 then grabbed the resident by their arms and legs and moved the resident to their bed. The document indicated Resident #38 told RN #6 to stop hurting them.

The facility's investigation documents included an undated, handwritten statement provided to the facility by CNA #2, an undated, handwritten statement provided to the facility by CNA #8, and an undated, typed statement provided to the

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facility by CNA #10, all of which contained a description of RN #6 being verbally and physically abusive to Resident #38. CNA #10's statement indicated she and CNA #2 did not know what to do in the situation because they both had to work with RN #6 for the remainder of the night, and CNA #10 and CNA #9 were also scheduled to work with RN #6 over the following two days. The typed statement revealed, "We [CNA #10 and CNA #2] both decided that we were going to write a report, but we weren't going to turn it in till the next week when [RN #6] wasn't working." CNA #10's statement also included details of a second incident that occurred on 11/26/2023, in which CNA #10 was attempting to change Resident #38's brief while CNA #9 was providing care for the resident's roommate. According to the statement, CNA #10 realized Resident #38 had a large bowel movement and that she needed to transfer the resident to bed for incontinence care. The statement indicated Resident #38 refused to allow CNA #10 and CNA #9 to use a mechanical lift to transfer the resident to bed. According to the statement, the CNAs also asked CNA #8 to assist with the transfer, but they were unable, so they notified RN #6. The statement indicated that when RN #6 entered the resident's room, he said "I'm here now and you know what that means." The statement indicated that the RN's comment scared the resident and when the resident became upset, RN #6 "got even more angry and grabbed" the resident's arms "like he did the other day" (11/24/2023) and started "kinda [kind of] shaking" the resident. Per the statement, the resident repeatedly said RN #6 was hurting them and to stop. The statement indicated she and CNA #8 did not discuss this incident, but "with what happened the other day,"

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she knew she needed to include this encounter in her report.

A "Follow-Up Investigation Report," dated as submitted to the State on 12/04/2023, included a section for the facility to document a summary of interviews with other residents who may have had contact with the alleged perpetrator. This section indicated, "No interviews with other residents occurred." The report indicated that Resident #38 was interviewed and denied being abused. The report revealed the facility unsubstantiated the abuse allegation. The facility's investigation did not include interviews with any other residents regarding their experiences with RN #6 or any skin assessments to determine if there were any bruises or other injuries that may have been attributed to physical abuse.

During an interview on 10/16/2024 at 11:22 AM, the Administrator stated the information he had provided to the survey team was pretty much all the information he had for the investigation. He stated he did not maintain any documentation regarding the incident and just input the information into the reports he sent to the state survey agency. He stated that he could see that by not having the documents, it did not look like a full investigation. He stated, "If it wasn't documented, it didn't happen."

During an interview on 10/16/2024 at 1:33 PM, the Administrator stated he did not have any more information to provide.

During an interview on 10/18/2024 at 9:42 AM, the Director of Nursing (DON) stated that when

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completing an investigation, someone should interview everyone who was involved in an incident, including nurses. She stated she did not interview all the aides who worked the night of the incident. She stated that they tried to investigate the details and find out if it was validated or not. She stated that according to the resident, the incident was a not big issue and there was nothing to worry about. The DON stated she did not feel they did a thorough investigation into the incident. She stated that they did not interview any other residents to see if they had issues with RN #6. She stated that staff did complete skin checks on a daily basis, but there was nothing officially completed for this incident.

During an interview on 10/18/2024 at 11:28 AM, the Administrator stated that aside from the above referenced written statements, he did not document any interviews as a part of the investigation.

During a telephone interview on 11/11/2024 at 3:25 PM, CNA #2 said the incident involving Resident #38 and RN #6 had occurred approximately a year prior, so she could not recall the exact details. CNA #2 stated the incident she witnessed was observed by herself, CNA #9, and CNA #10. According to CNA #2, a second incident was witnessed by CNA #8 on another day, and a few days later, when CNA #2 and CNA #8 were both working, they wrote the statements they provided to the facility.

During a telephone interview on 11/11/2024 at 4:06 PM, CNA #10 stated she wrote her statement after witnessing the second incident.

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F 610	Continued From page 57 CNA #10 indicated she could no longer recall all the details, but she recalled that she and CNA #2 were trying to provide incontinence care to the resident, and the resident refused. According to CNA #10, RN #6 came in and grabbed the resident's hands, and the resident told the nurse to stop because it hurt. CNA #10 said RN #6 grabbed the resident's hand and leg and tossed the resident into bed. During a follow-up telephone interview on 11/14/2024 at 1:59 PM, CNA #10 said she considered both incidents she witnessed to be abuse because Resident #38 did not want RN #6 to move them, but RN #6 did not care what the resident wanted. CNA #10 further stated the facility had only questioned her about one of the two incidents she reported. During a telephone interview on 11/11/2024 at 1:18 PM, CNA #8 stated on the night in question, she, CNA #2, and RN #6 went into Resident #38's room. According to CNA #8, RN #6 went over and started yelling at the resident, grabbed the resident's shirt, and kind of shook and yelled at the resident. CNA #8 could not recall exactly what RN #6 said to the resident but indicated RN #6 was being very aggressive with the resident. CNA #8 said Resident #38 looked scared during the incident. CNA #8 said that following this incident, CNA #2 told her about another incident CNA #2 had witnessed, so CNA #2 and CNA #8 both wrote the statements they later provided to the facility. CNA #8 said she had never seen RN #6 act this way with other residents and described the incident as shocking. During a follow-up telephone interview on	F 610		

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F 610	Continued From page 58 11/14/2024 at 12:11 PM, CNA #8 clarified that there was one incident involving CNAs #8, #9, and #10, RN #6, and Resident #38, and there was a separate incident that CNA #2 was involved in on a different day. CNA #8 said she considered the incident she witnessed to be physical abuse due to the way RN #6 grabbed Resident #38's shirt and shook the resident. During an interview on 10/17/2024 at 9:41 AM, RN #6 said there was a time when he did pick Resident #38 up and put the resident in bed. According to RN #6, Resident #38 was agitated when RN #6 went into their room. RN #6 said the resident was seated in their recliner with their brief still on and their pants pulled halfway down. RN #6 said fecal matter was coming out of the resident's brief. Per RN #6, he put his arm underneath the resident's left arm and told the resident he could not leave them like that. According to RN #6, Resident #38 required two people for transfers and could not support their weight, so RN #6 had to hold the resident's legs in an awkward position. RN #6 said the resident's recliner was positioned against the bed, and the resident was precariously positioned on the recliner, so he lifted the resident, which caused his own shoulder to pop; however, RN #6 stated it felt as though the resident was lying on the ground and felt like he had to "heave" the resident up on the bed. During an interview with the DON on 11/12/2024 at 9:30 AM, the DON confirmed she had received the statements from CNAs #2, #8, and #10; however, the DON stated she was only aware of one incident involving Resident #38.	F 610		

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F 610	Continued From page 59 During an interview on 11/12/2024 at 10:49 AM, the Administrator stated he was only aware of one incident between RN #6 and Resident #38. He was not aware of any other incidents. During a follow-up interview on 11/12/2024 at 3:13 PM, the Administrator read over the statements provided to the facility by CNAs #2, #8, and #10. The Administrator said he obviously forgot there were multiple incidents reported because it had been almost a year. He confirmed that per the statements, multiple incidents were reported and based on the statements, it sounded bad. During an interview on 11/12/2024 at 4:01 PM, the DON stated she would have interviewed about the second incident if she had realized there were two incidents. She did not document her interviews with the aides anywhere. As far as how they came up with their determination of unsubstantiated, she stated they interviewed RN #6 and suspended him and talked to the aides a little bit. She stated, "The resident was the priority and if [the resident] tells me [they are] fine, then I assume [they are] okay." During a telephone interview on 11/13/2024 at 12:12 PM, the Chief Executive Officer (CEO), stated if an alleged perpetrator (AP) was a staff member, they should be suspended and not allowed in the building until the conclusion of the investigation. He stated when conducting the investigation, the staff should interview any potential witnesses, anyone who was in the area who may have seen or heard anything, including any witnesses. He indicated there should be an assessment of the resident to ensure there were	F 610		

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F 610	Continued From page 60 no injuries and that assessment should be documented. He stated if it was determined through investigation that there were any other residents who were potentially involved, they would interview them. He had in the past asked alert and oriented residents if they had had any issues with staff and how they had been treated, without giving the name of the staff person to protect them. He stated any staff who were involved or who were identified during the course of the investigation should also be interviewed. He stated he felt like the Administrator should have had better documentation of the investigation into the allegations and felt the Administrator had done a lot more than what he documented. He stated he knew the Administrator interviewed more people than what he documented. The facility submitted a removal plan that was accepted by the state survey agency on 11/15/2024 at 4:44 PM. The removal plan indicated the following: 1. Training was started on 11/14/2024 at 12:00 PM. Training will be provided by Chief Operating Officer (COO) to Administrator, the Director of Nursing (DON), and Assistant Director of Nursing (ADON) on how to recognize abuse, the types of abuse, when to report abuse, and who to report the abuse to, as well as how to conduct a proper and thorough investigation, to include statements from residents, statements from staff involved, as well as interview other staff and residents. The facility has also established an abuse committee, that includes Administrator, DON, ADON, RA [Resident Advocate], and COO or CEO for the Management Company to assure the correct	F 610		

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F 610	Continued From page 61 outcome of the reported incidence. The abuse committee will be part of our regularly scheduled QAPI [Quality Assurance and Performance Improvement] meetings where we will discuss any issues that may have come up and determine the appropriate actions. The training was completed on 11/14/2024. The CEO from the management company started training 11/14/2024 with individuals and in small groups of all other employees on the abuse policy and procedures, reporting, and investigations prior to them working on their next shift 11/15/2024. 2. The full investigation of alleged incidents regarding Registered Nurse (RN) #6 from November 2023 will be performed with COO, CEO and the Administrator as part of Administrator training. The investigation started 11/14/2024 and will be completed by 11/15/2024. All residents were interviewed in this process by RA. With the COO, CEO, Administrator and DON, additional interviews are being done in connection with the incident back in November 2023. During this investigation, RN #6 has been suspended pending the findings of the investigation. - The COO met with the Administrator, DON, ADON, and RA and trained them on abuse training to include staff interviews and resident interviews and to create an abuse committee, that includes Administrator, DON, ADON, RA, and COO to meet together to review the evidence and interviews to come to the right conclusion. This was completed 11/14/2024. - The COO for the management company provided 1:1 and training with DON, ADON,	F 610		

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F 610	Continued From page 62 Administrator, and RA on proper investigation processes, to include resident interviews and staff interviews, which included a resident interview form and staff interview form. This was completed on 11/14/2024. - Having trained the DON and ADON on proper staff interviews, along with the Administrator, the COO then directed the DON and ADON to conduct all staff interviews and give the staff the opportunity to express any concerns they may have related to proper treatment of residents. The CEO, in training, also asked all staff if they had any concerns with the treatment of patients. This was completed 11/15/2024. 3. The Medical Director was notified on 11/14/2024 at 4:15 PM about the immediate jeopardy and was updated about the current removal plan. MD was in agreement to proceed with removal plan. 4. The ad hoc Quality Assurance and Performance Improvement (QAPI) meeting is scheduled for 11/15/2024. Discussed in the QAPI meeting were abuse policy and procedures, Utah Healthcare Association abuse training from September 2022, investigation training. CEO, DON, ADON, RA, and Administrator were present. 5. CEO and COO will be reviewing incidents from November 2023 regarding RN #6 through the survey process and future investigations, making sure that the investigation was done properly, and all documentation and interviews are done. Will review the findings from the committee and sign off on investigations after they are	F 610		

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F 610	Continued From page 63 completed. Will be reviewed 11/15/2024 before 12:00 PM. The immediacy of the IJ was removed on 11/15/2024, 4:37 PM." On 11/15/2024, the survey team conducted on-site verification to confirm the facility had implemented the above written removal plan, as follows: 1. The team was able to verify that the Administrator, DON, ADON, and the RA received training on abuse investigations, including conducting interviews as part of the investigation. This was verified by conducting interviews with these staff members and reviewing training documentation provided by the facility. "Staff In-Service" sheets revealed facility staff members received copies of and were educated on the facility's abuse policies, including recognizing the signs and symptoms of abuse/neglect, immediate reporting, investigations, and protection measures. Interviews were conducted with 14 staff, including dietary staff, housekeeping staff, laundry staff, two Licensed Practical Nurses (LPNs), one RN, the ADON, DON, RA, and Administrator, to verify they had received and understood the in-service materials. Per the inservice records, the facility was able to in-service all staff except for two, who were out of the state/country. The plan to in-service these staff was to provide the in-service prior to their next scheduled shifts. Neither staff were on the schedule until after the end of the month.	F 610		

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F 610	Continued From page 64 2. The survey team reviewed the facility's investigation into the allegations of abuse from November 2023. The facility's investigation revealed the facility interviewed all 41 residents residing in the facility at the time of the current survey, interviewed all staff involved in the November 2023 incidents, and interviewed other staff who may have had knowledge of the incidents. Per the facility's "Abuse Committee minutes," dated 11/14/2024, the facility was unable to substantiate abuse had occurred after completing their investigation. The team was able to verify that the Administrator, DON, ADON, and the RA received training on abuse investigations, including conducting interviews as part of the investigation. This was verified by conducting interviews with these staff members and reviewing training documentation provided by the facility. 3. During a telephone interview on 11/15/2024 at 5:53 PM, the Medical Director confirmed the facility notified them on 11/14/2024 of the IJ findings and updated them on the removal plan. 4. "QAPI- Abuse Prevention, Reporting & Investigation Sub-Committee" minutes, dated 11/15/2024 at 3:15 PM, revealed the facility's QAPI committee met on 11/15/2024 to discuss abuse policy and procedures and the outcome of the facility's investigation into the 11/2023 incidents. According to the minutes, the facility did not substantiate abuse related to the 11/2023 incidents. 5. The survey team reviewed the facility's investigation into the allegations of abuse from	F 610		

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November 2023. The facility's investigation revealed the facility interviewed all 41 residents residing in the facility at the time of the current survey, interviewed all staff involved in the November 2023 incidents, and interviewed other staff who may have had knowledge of the incidents.

2. An "Admission Record" indicated that the facility admitted Resident #35 on 10/06/2023. According to the Admission Record, the resident had a medical history that included diagnoses of dementia, seizures, bipolar disorder, and anxiety disorder.

A quarterly Minimum Date Set (MDS), with an Assessment Reference Date (ARD) of 04/16/2024, revealed Resident #35 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had disorganized thinking that fluctuated.

Resident #35's care plan included a focus area initiated on 10/23/2023, that indicated the resident had impaired cognitive function or impaired thought processes related to dementia. An intervention directed staff to monitor, document, and report any changes in cognitive function (initiated 10/23/2023). The care plan also revealed a focus area initiated on 07/08/2024, that indicated the resident had a low cognitive level and had difficulties with recall and orientation.

An "Admission Record" indicated that the facility

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admitted Resident #36 on 02/16/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of dementia.

An admission MDS, with an ARD of 02/26/2024, revealed Resident #36 had a BIMS score of 10, which indicated the resident had moderate cognitive impairment.

Resident #36's care plan included a focus area initiated on 05/23/2024, that indicated the resident had a behavior of being possessive of some of the residents. Interventions directed staff to intervene as necessary to protect the rights and safety of others and to redirect the resident from residents of whom they were possessive (initiated 05/23/2024).

Resident #36's "Progress Notes" revealed a "Behavior Note," dated 03/19/2024 at 8:52 PM and electronically signed by Registered Nurse (RN) #17, that revealed Certified Nurse Aide (CNA) #11 reported that Resident #36 was rude to her when she went to get Resident #35's clothes for a bath. The note indicated that CNA #11 reported that Resident #36 had shown aggression toward Resident #35 and the CNA.

Resident #36's "Progress Notes" revealed a "Behavior Note," dated 03/19/2024 at 9:39 PM and electronically signed by Registered Nurse (RN) #17, that revealed that earlier in the shift, CNA #11 entered Resident #35 and Resident #36's room to assist Resident #35 with a shower. The note indicated that Resident #36 indicated that they were "in charge" of Resident #35 and that they (Resident #36) were not going to let

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F 610	Continued From page 67 Resident #35 go with the CNA. Per the note, CNA #11 informed Resident #36 that Resident #35 could make their own decisions. The note indicated that Resident #36 got up and tried to block the door, but CNA #11 was able to exit the room. A "DLBC [Division of Licensing and Background]-358 Facility reported incidents" document, revealed the facility reported "Sexual Abuse, Mental/Verbal Abuse" to the state survey agency on 03/20/2024 at 11:00 AM. According to the report, on 03/19/2024 on the evening shift, CNA #11 went to get Resident #35 for a bath. Resident #36 blocked CNA #11 from taking Resident #35, grabbed and shook CNA #11, and told her that they (Resident #36) were in charge of Resident #35. The document indicated that Resident #36 stated that CNA #11 could not take Resident #35 to the shower and tried to lock CNA #11 out of the room. Per the document, a nurse relocated Resident #35 to another part of the facility to get them away from Resident #36. The document indicated that Resident #35 told the nurse in the morning that Resident #36 had tried to "force" Resident #35 to have sex. The document indicated that administration was notified of the incident on 03/20/2024 in the "Early Morning" by RN #17. A "Follow-Up Investigation Report," submitted to the state survey agency on 03/26/2024, revealed that the sheriff's office interviewed Resident #35 and indicated they did not feel like the situation needed any further investigation because Resident #35 stated that nothing happened. The Follow-Up Investigation Report did not include an interview or statement from RN #17.	F 610		

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The investigation provided by the facility did not include a copy of the sheriff's office report or a statement from RN #17.

A handwritten statement, dated 03/26/2024 and signed by CNA #11, indicated that the CNA had walked into Resident #35 and Resident #36's room to help Resident #35 with a shower and Resident #36 became upset. The statement indicated that Resident #36 tried to stop them from leaving the room and became agitated. Per the statement, CNA #11 was able to remove herself from the room and reported the incident to RN #17. The statement indicated while giving Resident #35 a shower, Resident #35 reported that they were "scared" of Resident #36, and revealed that Resident #36 had demanded they (Resident #35) have sex with them (Resident #36). The statement indicated that CNA #11 reported to RN #17 what Resident #35 had said to her after the shower, and Resident #35 was moved to another room.

During a telephone interview on 10/16/2024 at 6:35 PM, CNA #11 stated that on the night of the incident, she was walking with Resident #35 in the room to get ready to go get a shower when Resident #36 got angry, stood up, and started walking toward Resident #35. CNA #11 stated that Resident #36 had started shaking her, then after a minute or two, the resident calmed down and the CNA and Resident #35 left the room. CNA #11 indicated there were times that Resident #35 liked Resident #36 and then times when Resident #35 said they hated Resident #36. CNA #11 stated that Resident #36 tried to have sex with Resident #35 but Resident #35

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refused. CNA #11 stated that she was not aware of any sexual activity that occurred, and that Resident #35 told the CNA that they had never had sex. CNA #11 stated that she reported the incident to RN #17 that night.

During an interview on 10/18/2024 at 9:35 AM, the Director of Nursing (DON) stated that CNA #11 was getting Resident #35 for a shower and Resident #36 became anxious and told CNA #11 that she could not take Resident #35 for a shower. The DON stated that Resident #36 would not let CNA #11 leave, and when she was able to leave, she reported the incident to the nurse. The DON stated that the incident happened after 6:00 PM. The DON stated that whoever received the allegation would initiate a report, then give that to the Administrator and he would notify the state survey agency. She stated that Resident #35 reported that Resident #36 tried to force them to have sex. The DON stated that the investigation was not thorough and stated that they should have a copy of the sheriff office's report to keep with the facility's documentation.

During an interview on 10/18/2024 at 11:28 AM, the Administrator stated that the incident between Resident #35 and Resident #36 occurred on 03/19/2024, and Resident #35 was moved to another room. He stated that it was brought to their attention later that Resident #35 stated that Resident #36 tried having sex with them (Resident #35). The Administrator stated that staff spoke with Resident #35, who denied anything happened. The Administrator stated that a sheriff's deputy interviewed the resident and determined that nothing happened. He stated

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F 610	Continued From page 70 that he did not have a copy of the sheriff's office report but that he should. He stated that not everything was in the facility's investigation, to include the sheriff's office report and nurse witness statements. He stated that he expected a more thorough investigation and to have evidence of what the facility had done.	F 610		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F 656	F656 We, San Rafael Health and Rehabilitation, are in compliance with development/implement a comprehensive person centered care plan for each resident, consistent with residents rights set forth at 483.21 (c) (2) and 483.10 (c) (2) that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	12/13/2024

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F 656	Continued From page 71 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to develop individualized resident-centered care plans with measurable objectives for 4 (Residents #1, #3, #24, and #4) of 14 residents whose care plans were reviewed. Specifically, the facility failed to ensure care plans addressed oxygen use for Resident #1 and Resident #3, failed to ensure a care plan addressed an indwelling urinary catheter for Resident #24, and failed to ensure a care plan addressed respiratory care for a diagnosis of chronic obstructive pulmonary disease (COPD) and respiratory medications for Resident #4. Findings included: A facility policy titled, "Care Plans, Comprehensive, Person-Centered," revised 03/2022, indicated, "A comprehensive,	F 656	Corrective Action for identified residents: Resident #1 currently resides in the building. Assessment/evaluation done on resident for oxygen use i.e. use, deliverance, humidification, flow rate and frequency. Care plan updated accordingly. Educated MDS/Nurses about care plan and importance of providing all the necessary information for use of oxygen therapy. Note placed in Electronic Health record. Resident #3 currently resides in the building. Assessment/evaluation done on resident for oxygen use i.e. use, deliverance, humidification, flow rate and frequency. Care plan updated accordingly. Educated MDS/ Nurses about care plan and importance of providing all the necessary information for use of oxygen therapy. Note placed in Electronic Health record. Resident #24 still resides in building. Resident's catheter was discontinued on 10/24/2024.	

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F 656	Continued From page 72 person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident." The policy specified, "7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being" and "e. reflects currently recognized standards of practice for problem areas and conditions." 1. An "Admission Record" revealed the facility admitted Resident #1 on 07/25/2021. According to the Admission Record, the resident had a medical history that included a diagnosis of unspecified heart failure. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/23/2024, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #1 received oxygen therapy. Resident #1's "Order Summary Report," listing active orders as of 10/18/2024, contained an order, dated 02/08/2023, for oxygen at 2 liters per minute by nasal cannula "due to heart failure with hypoxia." Resident #1's care plan, last revised on 08/18/2024, did not include a "Diagnosis" area or interventions addressing oxygen use. On 10/17/2024, during the survey, an intervention	F 656	Resident's catheter was discontinued on 10/24/2024. Educated nurses and MDS coordinator of importance for care plans to accurately reflect current conditions as well as chronic. Resident #4 Currently resides in facility. Assessment/evaluation done on resident to establish cognitive ability and safety with medication administration. Care plan updated to accurately reflect accurate diagnosis information/reasoning for self administration. Education given to nursing staff regarding accurate care plans and medication at bedside. Measures to prevent recurrence: Education and teaching for nurses and MDS coordinator on accurate documentation of care plans, including updating cares to reflect any current condition/illness or change and create measurable goals and interventions in attempt to keep care plans accurate and residents safe. Further interventions will be implemented if initial interventions are not successful.	

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F 656	Continued From page 73 was added to a Diagnosis area addressing congestive heart failure, atrial fibrillation, and hypertension, initiated on 12/30/2021, that specified, "OXYGEN SETTING: O2 [oxygen] via (SPECIFY: nasal prongs/mask) @ SPECIFY)L (SPECIFY FREQ [frequency]). Humidifier (SPECIFY);" however, the intervention was incomplete and did not reflect the resident's ordered oxygen flow rate, the mechanism of delivery, frequency of use, or whether the resident's oxygen should be humidified. The MDS Coordinator was interviewed on 10/17/2024 at 12:09 PM. The MDS Coordinator stated she was responsible for completion of the MDS and completion of some care plans. The MDS Coordinator stated the use of oxygen should be care planned. The MDS Coordinator reviewed Resident #1's care plan and confirmed that oxygen usage was not included and stated it was an oversight. The Director of Nursing (DON) was interviewed on 10/17/2024 at 1:32 PM. The DON stated she expected the use of oxygen to be care planned and added it was important to care plan oxygen so the resident received the correct amount of oxygen. The Administrator was interviewed on 10/17/2024 at 2:29 PM and stated he expected Resident #1's oxygen usage to be care planned. 2. An "Admission Record" revealed the facility initially admitted Resident #3 on 03/11/2020 and most recently admitted the resident on 06/29/2024. According to the Admission Record, the resident had a medical history that included a	F 656	Monitoring/Quality Assurance: The DON or designee will complete a weekly audit of care plans and orders to assure all documentation is accurate and up to date. Any variance will be fixed as soon as possible. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee in regularly scheduled monthly meetings or until it is determined that staff education has reached implementation of interventions appropriately. We allege compliance on 12/13/2024	

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F 656	Continued From page 74 diagnosis of morbid (severe) obesity due to excess calories. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/03/2024, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated Resident #3 received oxygen therapy. Resident #3's "Order Summary Report," listing active orders as of 10/15/2024, contained an order, dated 02/08/2023, for oxygen at 2 liters per minute by nasal cannula continuously for hypoxia (low oxygenation) related to morbid obesity due to excess calories. Resident #3's care plan, last revised on 09/25/2024, did not include a "Diagnosis" area or interventions addressing oxygen use. The MDS Coordinator was interviewed on 10/17/2024 at 12:55 PM. The MDS Coordinator stated oxygen should be care planned. The MDS Coordinator reviewed Resident #3's care plan and confirmed that oxygen usage was not included and stated it was an oversight. The Director of Nursing (DON) was interviewed on 10/17/2024 at 1:32 PM. The DON stated she expected the use of oxygen to be care planned and added it was important to care plan oxygen so the resident received the correct amount of oxygen. The DON stated oxygen should have been added to Resident #3's care plan. The Administrator was interviewed on 10/17/2024	F 656		

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F 656	Continued From page 75 at 2:29 PM and stated he expected Resident #3's oxygen usage to be care planned. 3. An "Admission Record" revealed the facility initially admitted Resident #24 on 06/01/2022 and most recently admitted the resident on 01/06/2023. According to the Admission Record, the resident had a medical history that included diagnoses of unspecified obesity and chronic diastolic (congestive) heart failure. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/03/2024, revealed Resident #24 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had severe cognitive impairment. Resident #24's "Order Summary Report," listing active orders as of 10/16/2024, contained an order, dated 09/25/2024, for catheter care to be completed each shift. Resident #24's care plan, last revised on 10/01/2024, did not include a "Diagnosis" area or interventions addressing the resident's indwelling urinary catheter. During an interview on 10/16/2024 at 11:15 AM, the Director of Nursing (DON) stated she expected Resident #24's indwelling urinary catheter to be on their care plan. The Administrator was interviewed on 10/17/2024 at 2:29 PM and stated he expected Resident #24's indwelling urinary catheter to be part of the resident's care plan.	F 656		

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F 656	Continued From page 76 4. An "Admission Record" indicated the facility admitted Resident #4 on 10/03/2019. According to the Admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease (COPD) and asthma. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/14/2024, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #4's "Order Summary Report," listing active orders as of 10/15/2024, contained an order dated 12/20/2019 for fluticasone propionate suspension 50 micrograms (mcg) /(per) actuation (act) with instructions to give two spays in each nostril two times a day for nasal congestion. The Order Summary Report also contained an order dated 10/08/2021 for albuterol sulfate hydrofluoroalkane (HFA) with instructions for two puffs inhaled orally every four hours as needed for wheezing related to COPD and asthma. The albuterol sulfate HFA order specified, "May keep at bedside." The Order Summary Report contained an order dated 02/16/2022 for Spiriva Respimat Aerosol Solution 2.5 mcg/act with instructions to inhale two puffs in the morning for COPD. During an observation on 10/14/2024 at 10:05 AM, Resident #4 was in their room with a Spiriva inhaler, albuterol inhaler, and fluticasone nasal spray on the overbed table. Resident #4 stated the nurse would bring their pills in, they would take them, and then the nurse left the two inhalers and the nose spray. Resident #4 stated	F 656		

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F 656	Continued From page 77 the albuterol inhaler was their emergency inhaler. During an observation on 10/15/2024 at 8:57 AM, Resident #4 was in their room with their fluticasone nasal spray and albuterol inhaler on the overbed table. Resident #4's care plan did not address respiratory issues or the need for respiratory medications and did not address the resident's ability to keep their albuterol sulfate HFA inhaler at their bedside. During an interview on 10/17/2024 at 8:42 AM, the Director of Nursing (DON) stated the MDS Coordinator was responsible for care plans. The DON reviewed Resident #4's care plan and stated the respiratory issues and the need for the emergency inhaler were not on the care plan but should have been. The DON stated she expected respiratory issues and medications to be care planned. During an interview on 10/17/2024 at 12:08 PM, the MDS Coordinator stated she was responsible for initial comprehensive care plans. The MDS Coordinator reviewed Resident #4's care plan and stated respiratory, COPD, and asthma were not on the care plan but should have been. The MDS Coordinator further stated the resident's need for an emergency inhaler should have been care planned. The MDS Coordinator stated the information needed to be on the care plan to inform the nurses that the resident had asthma, inhalers, and oxygen, and to ensure staff were aware of the resident's needs. During an interview on 10/18/2024 at 11:28 AM,	F 656		

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F 656	Continued From page 78 the Administrator stated the nurses and the MDS Coordinator were responsible for ensuring respiratory issues and medications were addressed on the care plan. The Administrator stated he expected respiratory issues and medications to be addressed on the care plan.	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure physician's orders included all necessary components, including the specified dosages for 2 (Residents #13 and Resident #20) of 3 residents who were observed during the medication administration task. Findings included: A facility policy titled, "Physician Medication Orders," revised in 04/2010, specified, "6. Orders for medications must include: a. Name and strength of the drug" and "c. Dosage and frequency of administration." A facility policy titled, "Medication Orders," revised in 11/2014, specified, "1. Medication Orders- When recording orders for medication, specify the type, route, dosage, frequency and strength of the medication ordered."	F 658	F 658 Services Provided Meet Professional Standards Corrective Action for Identified Residents: Resident #13 was identified and currently resides in the building. The medication orders were reviewed and updated to accurately reflect strength and amount to ensure physician's orders included all necessary components. Resident #20 was identified and currently resides in building. The medication orders were reviewed and updated to accurately reflect strength and amount to ensure physician's orders included all necessary components including dose and amount. Identification of Residents Potentially Affected: All residents, current and future, have the potential to be affected.	12/13/2024

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F 658	Continued From page 79 1. An "Admission Record" indicated the facility admitted Resident #13 on 01/03/2024. According to the Admission Record, the resident had a medical history that included diagnoses of type two diabetes mellitus, chronic kidney disease, hypertension, intervertebral disc degeneration, and osteoporosis. Resident #13's "Order Summary Report," listing active orders as of 10/16/2024, revealed orders dated 01/03/2024 for vitamin C, one tablet by mouth one time a day "for immunity" and vitamin D3, one capsule by mouth one time a day "for vitamin deficiency;" however, the physician's orders did not include the specified dosages. 2. An "Admission Record" indicated the facility admitted Resident #20 on 01/11/2023. According to the Admission Record, the resident had a medical history that included diagnoses of hypertensive heart disease with heart failure, tremor, atherosclerotic heart disease, and atrial fibrillation. Resident #20's "Order Summary Report," listing active orders as of 10/16/2024, revealed an order dated 01/11/2022 for a vitamin D3 tablet by mouth one time a day "for supplement;" however, the physician's order did not include the specified dosage. During an interview on 10/17/2024 at 8:42 AM, the Director of Nursing (DON) stated physician's orders for vitamin C and vitamin D should include the intended dosages. During an interview on 10/18/2024 at 11:28 AM, the Administrator stated he expected staff to	F 658	Measures to Prevent Recurrence: Education given to all nursing staff and MDS coordinator, regarding entering in medication orders accuracy on route, dose, and frequency on 12/10/2024. DON/ADON did a full audit on all current residents to assure medication orders were accurate and appropriate. Monitoring/Qualtiy Assurance: DON/ADON reviewed policy and procedure and educated all nursing staff and MDS coordinator on 12/10/2024. DON or designee will audit orders weekly until 100% compliant for 60 days. Process/results to be incorporated into the Quality Assurance Performance Improvement process. Any variances will be resolved as soon as possible.	

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F 658	Continued From page 80 ensure physician's orders included the specified dosages.	F 658		
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: Based on observation, interview, facility document review, and facility policy review, the facility failed to put interventions in place to prevent future falls for 2 (Resident #35 and Resident #27) of 2 residents reviewed for falls. The failure resulted in Resident #35 sustaining falls on 11/04/2023 which resulted in a laceration to the resident's head, 12/19/2023, 02/23/2024 which resulted in a right clavicle fracture, 05/21/2024 which resulted in an abrasion to their left knee, 07/12/2024, 07/22/2024 which resulted in swelling to the face and an abrasion on the nose, 07/27/2024, and 08/06/2024 with no evidence the facility initiated interventions after the falls to prevent future falls. Additionally, the facility failed to complete wandering assessments, ensure a resident was safe from eloping from the facility, and failed to investigate to find the root cause of an elopement for 1 (Resident #190) of 3 residents reviewed for elopement; and failed to ensure they assessed for resident safety before leaving medications at a resident's bedside for 1 (Resident #4) of 1	F 689	F 689 San Rafael Health and Rehabilitation is in compliance with Free of Accident Hazards/supervision/Devices. Resident #35: Currently resides in facility. Assessment/evaluation done on resident for fall risk and safety. Care plan updated accordingly. Resident #27: Currently resides in facility. Assessment/evaluation done on resident for fall risk and safety. Care plan updated accordingly. Resident #190: No longer resides in facility. Identification of Residents Potentially Affected: All residents have the potential to be affected current and future. Measures to prevent Recurrence: Education and teaching done on 12/10/2024 for nurses, CNA's and MDS coordinator on documentation of care plans, including updating care plans to accurately reflect and falls/incidents or significant change, steps taken to improve safety for all residents.	12/13/2024

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F 689	Continued From page 81 resident reviewed for accident hazards. Findings included: 1. A facility policy titled, "Falls-Clinical Protocol," revised 09/2012, indicated, "1. For an individual who has fallen, staff will attempt to define possible causes within 24 hours of the fall." The policy also indicated that based on assessment, "The staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. An "Admission Record" indicated the facility admitted Resident #35 on 10/06/2023. According to the Admission Record, the resident had a medical history that included diagnoses of dementia, seizures, bipolar disorder, and anxiety disorder. A quarterly Minimum Date Set (MDS), with an Assessment Reference Date (ARD) of 07/16/2024, revealed Resident #35 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had disorganized thinking that fluctuated, had no limitation in range of motion, and did not use mobility devices. The MDS indicated the resident was independent with rolling left and right in bed and required supervision to move from sitting to lying or standing. Resident #35's care plan, included a diagnosis area initiated on 10/23/2023, that indicated the resident was at very high risk for falls with	F 689	Monitoring/Quality Assurance: DON or designee to educate all nursing staff and MDS coordinator on importance of updating care plans to reflect residents accurately. DON will audit care plans weekly until 100% compliant for 60 days. Process/results to be incorporated into the Quality Assurance Performance Improvement process and monitor for compliance.	

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F 689	Continued From page 82 fractures related to seizure disorder, osteoarthritis, and confusion. A risk management form, dated 11/04/2023 at 7:30 PM, indicated Resident #35 fell in the common area when they got up from a recliner. The form revealed the resident hit their head on the floor, causing a 4-centimeter laceration. The form and Resident #35's care plan revealed no evidence there were interventions initiated related to this fall. Resident #35's "Progress Notes," dated 12/19/2023 at 9:14 AM, indicated Resident #35 was found sitting on the floor next to their bed and had spilled their juice on the floor next to them. The notes revealed the resident had no injury. The Progress Notes and Resident #35's care plan revealed no evidence there were interventions initiated related to this fall. A risk management form, dated 02/23/2024 at 1:30 PM, indicated Resident #35 was found on the floor next to their bed. The form revealed the fall resulted in a right clavicle fracture that required a sling, and an orthopedic doctor follow-up. The form revealed no evidence there were interventions initiated related to this fall. Resident #35's care plan was updated to include details about the fall; however, the care plan revealed no evidence there were interventions initiated related to this fall. A risk management form, dated 05/21/2024 at 8:45 PM, indicated Resident #35 tripped as they were coming in from outside. The form revealed the resident stated they tripped on their boot or slipper. The form revealed the resident had an	F 689		

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abrasion to their left knee that measured 2 centimeters by 1 centimeter. The form and Resident #35's care plan revealed no evidence there were interventions initiated related to this fall.

A risk management form, dated 07/12/2024 at 8:00 PM, indicated Resident #35 was found sitting on the floor in their room. The form revealed the resident stated they did not know what happened. The form revealed the resident had no injury. The form and Resident #35's care plan revealed no evidence there were interventions initiated related to this fall.

A risk management form, dated 07/22/2024 at 7:24 PM, indicated Resident #35 fell outside and reported they had possibly had a seizure. The form revealed the resident had swelling to the face and an abrasion on the nose. The form revealed no evidence there were interventions initiated related to this fall. Resident #35's care plan was updated to include details about the fall; however, the care plan revealed no evidence there were interventions initiated related to this fall.

A risk management form, dated 07/27/2024 at 9:50 PM, indicated Resident #35 fell in their room and had no injuries. The form revealed the resident was placed in the common area for monitoring. The form revealed the resident had no injury. The form and Resident #35's care plan revealed no evidence there were interventions initiated related to this fall.

A risk management form, dated 08/06/2024 at 12:15 AM, indicated Resident #35 fell in their

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room next to the bed. The form revealed the resident had no injury. The form and Resident #35's care plan revealed no evidence there were interventions initiated related to this fall.

During an interview on 10/17/2024 at 9:12 AM, the Director of Nursing (DON) stated she expected fall interventions to be put in place to help potentially prevent falls. The DON stated that for Resident #35's fall on 07/27/2024 the risk management form indicated there was poor lighting in the room, so the intervention was for the bathroom light to remain on for lighting. The DON stated, however, the intervention for the bathroom light to remain on for lighting was not documented in the resident's progress notes or on the resident's care plan. The DON stated there was a lack of fall interventions.

During an interview on 10/16/2024 at 1:47 PM, Certified Nursing Aide (CNA) #1 stated the nurses completed the fall investigations. CNA #1 stated the nurses, and the DON implemented fall interventions.

During an interview on 10/16/2024 at 2:16 PM, Registered Nurse (RN) #12 stated when a resident fell, the nurses completed a risk management form in the computer that tracked the falls. RN #12 stated the nurses were responsible for updating the care plan with new interventions. RN #12 stated the MDS Coordinator also checked the care plan for interventions.

During an interview on 10/16/2024 at 2:26 PM, RN #4 stated when a fall occurred the nurses were to write an incident note and then complete

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a risk management form that tracked falls. RN #4 stated the nurse had to review the care plan to implement more personalized interventions.

During an interview on 10/17/2024 at 9:42 AM, RN #6 stated the nurse on duty and management were responsible for completing fall investigations. RN #6 stated the nurse on duty would implement an intervention and then update the care plan after a fall.

During a telephone interview on 10/17/2024 at 11:34 AM, RN #17 stated the nurses completed a risk management form for a fall, and then document a nurses note. RN #17 stated the DON and the Administrator went through the risk management forms to determine interventions.

During an interview on 10/17/2024 at 12:08 PM, the MDS Coordinator stated the care plan was completed after the MDS assessment. The MDS Coordinator stated other staff also updated care plans, and the nurses would update fall care plans, as the fall happened.

During an interview on 10/18/2024 at 9:35 AM, the DON reviewed falls for Resident #35 for 07/12/2024 and 05/21/2024 and stated she did not see any interventions for the falls. The DON stated the forms should have been completed better. The DON stated that staff knew Resident #35 was a frequent faller who had seizures and maybe just thought falls were a common occurrence. The DON stated she read through the incident reports but did not review the care plan to make sure interventions were placed. The DON stated the nurses were responsible for investigating the root cause of a fall and to put

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new interventions in place. The DON stated she expected the nurses to look for a root cause, to place an intervention, and let the CNAs know the intervention. The DON stated she expected for everybody to follow through to keep the residents safe and that it was documented.

During an interview on 10/18/2024 at 11:28 AM, the Administrator stated the nurses should investigate, put in a risk assessment and then implement interventions for a fall. The Administrator stated he and the DON were responsible for reviewing falls in morning meetings and in Quality Assurance Performance Improvement meetings. The Administrator stated they tried to determine what caused the fall. The Administrator stated he had not looked to ensure an intervention was in place. The Administrator stated that fall investigations and interventions were to protect the resident. The Administrator stated he expected staff to document everything and to look deeper into the incident to put things in place to best protect Resident #35.

2. A facility policy titled, "Self-Administration of Medications," revised 02/2021, indicated, "1. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident." The policy also specified, "3. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan."

An "Admission Record" indicated the facility admitted Resident #4 on 10/03/2019. According

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F 689	Continued From page 87 to the Admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease (COPD) and asthma. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/14/2024, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #4's "Order Summary Report," with active orders as of 10/15/2024, contained an order dated 12/20/2019 for fluticasone propionate suspension 50 micrograms (mcg) /(per) actuation (act) with instructions to give two spays in each nostril two times a day for nasal congestion. The Order Summary Report also contained an order dated 10/08/2021 for albuterol sulfate hydrofluoroalkane (HFA) with instructions for two puffs inhaled orally every four hours as needed for wheezing related to COPD and asthma. The Order Summary Report contained an order dated 02/16/2022 for Spiriva Respimat Aerosol Solution 2.5 mcg/act with instructions to inhale two puffs in the morning for COPD. Resident #4's care plan did not address respiratory issues or the need for respiratory medications specifically the albuterol sulfate HFA inhaler. During an observation on 10/14/2024 at 10:05 AM, Resident #4 was in their room with a Spiriva inhaler, albuterol inhaler, and fluticasone nasal spray on the overbed table. Resident #4 stated the nurse would bring their pills in, they would take them and then the nurse left the two inhalers	F 689		

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and the nose spray. Resident #4 stated the albuterol inhaler was their emergency inhaler.

During an observation on 10/15/2024 at 8:57 AM, Resident #4 was in their room, sitting in a recliner drinking with the fluticasone nasal spray and albuterol inhaler on the overbed table.

During an interview on 10/16/2024 at 8:29 AM, Registered Nurse (RN) #12 stated medications were not left in the resident rooms. RN #12 stated residents were not allowed to self-administer medications. RN #12 stated Resident #4 was approved by the Director of Nursing (DON) and the physician for the albuterol to be in the room but not the nasal spray. RN #12 stated Resident #4 informed the nurse when he used the inhaler because if the resident was short of breath, they called us to the room, and we would cue Resident #4 to use the albuterol inhaler. RN #12 stated she was not aware of a self-administration assessment form.

During an interview on 10/16/2024 at 8:40 AM, RN #4 stated medications were not left in resident rooms. RN #4 stated Resident #4 was allowed to keep the rescue inhaler (albuterol sulfate) at bedside. RN #4 stated she observed the resident administering the medication, but they wanted to keep the inhaler. RN #4 stated she did not know if the resident had been assessed to self-administer the inhaler. RN #4 stated the resident was good about letting staff know if they needed the inhaler.

During an interview on 10/17/2024 at 8:42 AM, the DON stated the facility did not document Resident #4's medication self-administration

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assessment anywhere. The DON stated she expected for a resident's medication self-administration assessment to be conducted and documented.

During an interview on 10/18/2024 at 11:28 AM, the Administrator stated residents were not allowed to keep medications in their room unless it was deemed safe to do so.

3. A facility policy titled, "Wandering and Elopements," dated 2001, revealed, "The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents." The section titled "Policy Interpretation and Implementation" included "1. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety."

An "Admission Record" revealed the facility admitted Resident #190 on 08/04/2023. According to the Admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease; insomnia; dementia in other diseases classified elsewhere, unspecified severity, with agitation; and bipolar disorder.

An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/14/2023, revealed Resident #190 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. The MDS revealed the resident wandered daily during the assessment period. The MDS revealed the resident's wandering put the resident at significant risk of getting to a

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potentially dangerous place. The MDS revealed the resident required supervision with locomotion on and off the unit.

Resident #190's undated "Baseline Care Plan" revealed that the resident was at risk for elopement.

Resident #190's "Care Plan" included a diagnosis area, initiated on 08/22/2023, that indicated the resident was an elopement risk and wandered related to a history of attempts to leave the facility unattended and wandering aimlessly.

The "Admission Record" and MDS revealed an admission date of 08/04/2023; in contrast, an admission summary "Progress Notes" identified an admission date of 08/05/2023.

Resident #190's admission summary "Progress Notes," dated 08/05/2023 at 1:43 PM, revealed Registered Nurse (RN) #5 documented that the resident arrived with family and had diagnoses of Alzheimer's disease, dementia, and insomnia. The notes revealed the family seemed in a hurry and did not stay long, although the nurse did go over the paperwork with them. The notes revealed the resident was extremely forgetful and confused as to why they were in the facility. The note revealed, per the family, the resident had dementia for a while and had been living with another family member until they could no longer take care of the resident. The notes revealed the family reported that there had been multiple incidents when the resident left the house and no one could find them, and the police would get involved. The notes revealed the family reported they took the resident to the hospital, where they

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assessed and referred the resident for long-term care.

A "DLBC [Division of Licensing and Background Checks] - Form 358: Facility Reported Incidents," sent to the State Agency on 08/05/2023 at 9:25 PM, revealed that, on 08/05/2023 at 7:15 PM, Resident #190 eloped from the facility. The form revealed the facility provided a detailed account of the incident, which included the "Resident is new to the facility and has dementia. Family needed more help with [the resident] because [the resident] wanders and was becoming more than family could handle. Resident came into a new environment and was wanting to leave because it was unfamiliar to [the resident]. [The resident] was wondering the building trying to get out and staff was trying to help [the resident] fill [sic] welcome and safe. Multiple calls were placed to residents [family] to help calm [the resident]. Resident then went out back door where the alarmed [sic] sounded. By the time staff got there resident had already made it out of the building and resident was not in sight when staff when [sic] out doors [sic]. Staff looked around the inside and outside of the building and resident could not be found. Sheriff's office was called and [Administrator] was called. Deputy found resident down the road at a house close by the facility. Resident was taken back to the facility where they were able to help [the resident] back into the building gaining [the resident's] trust. Resident is happy and relaxed currently in the building after talking with [Administrator] and resident's [family]."

The "DLBC - Form 358: Facility Reported Incidents" revealed Resident #190 eloped from

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the facility on 08/05/2023 at 7:15 PM through a back door where the alarm sounded; in contrast, behavior "Progress Notes" revealed the resident eloped on 08/06/2024 at 4:00 PM through an emergency exit in the kitchen.

Resident #190's behavior "Progress Notes," dated 08/06/2023 at 4:00 PM, revealed RN #6 documented that, at approximately 4:00 PM, Resident #190 left the security of the facility through an emergency exit in the kitchen. The notes revealed the sheriff's office was called within five minutes of the resident's absence, and the resident was soon located and brought back to the facility by a sheriff's deputy. The notes revealed the resident was agitated at that time but was able to be calmed. The notes revealed a facility aide was able to sit with the resident, one-on-one, and for a period of time, noting this intervention offered improvement to the resident's mood and disposition. The notes revealed that, at approximately 8:00 PM, the resident was highly agitated and attempted to leave the facility for a second time. The notes revealed multiple aides were involved with reorienting the resident and encouraging them to remain calm. The notes revealed the resident became belligerent and yelled profanities at staff. The notes revealed the resident was also aggressive toward the aides, pushing them out of the way of the direction the resident was traveling. The notes revealed that, at approximately 9:00 PM, with direction from facility management, facility staff was able to reason with the resident and the resident agreed to take bedtime medications and after a period of an hour retired for the evening.

The admission summary "Progress Notes," dated

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F 689	Continued From page 93 08/05/2023 at 1:43 PM, revealed the family reported that there had been multiple incidents when the resident left the house and no one could find them, and the police would get involved; in contrast, the "DLBC - HS FORM 359: Follow-Up Investigation Report" revealed the facility indicated that, at the time the resident was admitted, the only information provided was a diagnosis of dementia and that the resident wandered, with no indication that there was a risk of elopement at that time. A "DLBC - HS FORM 359: Follow-Up Investigation Report," sent to the state agency on 08/10/2023 at 3:11 PM, revealed the facility indicated that there was not "very much information" given due to the elopement occurring on the same day the resident was admitted to the facility. The facility indicated that, at the time the resident was admitted, the only information provided was a diagnosis of dementia and that the resident wandered. The facility identified there was no indication that there was a risk of elopement at that time. The form revealed the investigation did not include any interviews or statements from staff or law enforcement, did not include any corrective actions taken to keep the resident safe, and did not include how the facility ensured no other residents were at risk of elopement. An undated "[Facility Name] Admit Check-Off List" revealed in a section titled "DO: ASSESSMENTS (SHOULD AUTOMATICALLY POPULATE)" that the admitting nurse should have completed a "Wandering Risk Assessment" for each new admission.	F 689		

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During an interview on 10/17/2024 at 1:53 PM, the MDS Coordinator stated she was unable to find any wandering or elopement risk assessments for Resident #190.

During an interview on 10/16/2024 at 11:22 AM, the Administrator stated he did not maintain any documentation regarding the incident in question and simply inputted the information into the reports that he sent to the state. He stated he could see that by not having the documents, it did not look like a full investigation. The Administrator stated, "If it wasn't documented, it didn't happen."

During a follow-up interview on 10/16/2024 at 1:33 PM, the Administrator stated he understood the importance of being able to show their full investigation, including any interviews conducted, skin assessments conducted, and any interventions added as a result of the incident, as well as any training of staff.

During an interview on 10/16/2024 at 6:15 PM, Certified Nursing Aide (CNA) #8 stated Resident #190 would try to leave and was very physical. She stated she remembered a couple of instances where the resident would wander off during the daytime but would not wander at night. CNA #8 stated the resident was very nervous and kept asking where they were and where their children were.

During an interview on 10/16/2024 at 6:37 PM, Licensed Practical Nurse (LPN) #19 stated Resident #190 was very anxious and just wanted to leave, but mentally was not in a state to do that. LPN #19 stated facility staff had the doors

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locked but forgot about the loading dock (this statement is in contrast to the "DLBC - Form 358: Facility Reported Incidents" that revealed Resident #190 eloped from the facility through a back door where the alarm sounded). LPN #19 stated it was just one of those things that happened, noting Resident #190 was so desperate that the resident tried every door. LPN #19 stated they called the police. LPN #19 stated the resident ran and the police found Resident #190 two to four blocks away. LPN #19 stated it took them a while to convince Resident #190 to come back inside. LPN #19 stated it was evening shift, not dark out yet, and might have been right around shift change. LPN #19 stated a lot of care was given to try to ease the resident's fears. LPN #19 stated that after the incident they always made sure the door in question was locked. LPN #19 stated it was Resident #190's first day in the facility. LPN #19 stated Resident #190 was strong-willed and decided they were not going to stay. LPN #19 stated the police department was struggling with the resident not wanting to come back into the facility, so LPN #19 tried to make them understand the resident did not have a choice, and they called their Captain who reassured them that the facility was responsible for the resident. LPN #19 stated she thought she was the charge nurse the night Resident #190 eloped but was not sure. She stated she did not know much about the resident, only that Resident #190 did not want to be there, and the family had admitted the resident. She stated the family could not handle the resident anymore and the resident was doing things that they were concerned about for the resident's safety. LPN #19 stated the facility's doors were locked and a code was needed to get out.

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F 689	Continued From page 96 During an interview on 10/16/2024 at 6:59 PM, CNA #11 stated that when she worked at the facility, Resident #190 was trying to leave and did "escape" sometimes (other dates of elopement, if any, were not able to be ascertained) when the nurse would unlock the door, or the resident would try to get out another door that was not locked. She stated she did not remember how long after admission the resident escaped. She stated that there were times when the resident was especially confused, and during these times staff provided one-to-one oversight. CNA #11 stated the CNAs took turns watching the resident so one person did not have to spend the whole shift with Resident #190. During an interview on 10/17/2024 at 11:15 AM, RN #16 stated they had to lock the front door because Resident #190 would try to go out the door. RN #16 stated there was a time, maybe twice, the resident climbed the fences and was found by the cops in the community (other dates of elopement, if any, were not able to be ascertained). During an interview on 10/17/2024 at 3:46 PM, the MDS Coordinator stated she documented in the MDS if the resident had been wandering, but she did not do a formal assessment. She stated she did the care planning for the residents. The MDS Coordinator stated the Director of Nursing (DON) usually told her if a person had been wandering, and they could develop a care plan. She stated that she thought the facility used a wandering assessment, but did not know if there was an elopement assessment. The MDS Coordinator stated the charge nurses completed	F 689		

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F 689	Continued From page 97 the admission assessments. The MDS Coordinator reviewed Resident #190's electronic medical record (EMR) and said she did not see an elopement assessment. The MDS Coordinator stated that she did not generally conduct those assessments. During an interview on 10/17/2024 at 3:24 PM, RN #4 stated that when a resident was admitted, the nurses did a thorough head-to-toe skin assessment for any issues, checked for edema, reconciled the medication list with the resident/representative, and asked orientation questions. RN #4 also stated a baseline care plan was always completed and done within two hours of admission. She stated she brought a laptop to a resident's room and completed any needed assessments. RN #4 stated that, every time she did an admission, she completed a wandering risk assessment. RN #4 stated that the wandering risk assessment did not auto-populate for assessments, but it was on the admission check list staff had. During an interview on 10/18/2024 at 8:15 AM, the Maintenance Manager stated he remembered when Resident #190 got out of the facility. He stated the resident did not go out the loading dock door. The Maintenance Manager stated the resident went out the kitchen door (this statement is in contrast to the "DLBC - Form 358: Facility Reported Incidents" form that revealed Resident #190 eloped from the facility through a back door where the alarm sounded). The Maintenance Manager stated that, at the time, they did not keep the kitchen door locked when the dietary staff went home. The Maintenance Manager stated the resident walked through the	F 689		

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F 689	Continued From page 98 kitchen door and right out the back door. The Maintenance Manager stated the door was not locked at the time and was not alarmed. During a telephone interview on 10/18/2024 at 9:20 AM, RN #5 stated she thought a wandering/elopement assessment was on the list of assessments that admitting nurses were supposed to do. She stated she did not complete a wandering/elopement assessment for Resident #190 because the resident did not really exhibit an issue until the resident eloped. RN #5 stated the wandering/elopement assessment was not on the list of assessments required to be completed upon admission (this statement is in contrast to the "[Facility Name] Admit Check-Off List" that revealed the admitting nurse should have completed the "Wandering Risk Assessment" for each new admission). RN #5 stated the wandering assessment did not populate in the EMR as a required assessment. During an interview on 10/18/2024 at 9:42 AM, the DON stated the charge nurses had a check list in their admission packet that included skin assessments, immunizations, nursing assessments, and vital signs. The DON stated the nurse completed a wandering assessment. The DON stated no one audited or monitored to verify the assessments were completed. The DON stated Resident #190 could not understand why their family left them there and the resident was agitated and immediately was exit-seeking. The DON stated they were supposed to do a wandering/elopement assessment, and she just saw that RN #5 missed it. The DON stated the assessment was one that popped up in the EMR. The DON stated it was after noon when the	F 689		

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resident was admitted, though she did not remember the exact time, knowing only that it was in the late afternoon. The DON stated when the family left, the resident was actively exit-seeking. The DON stated when Resident #190 ran out the kitchen door, all she heard was that the resident got out; the resident had gone around and checked all the doors until finding the kitchen door was open and then went out the door. The DON stated they called the Administrator, and he called the police. The DON stated the resident was wandering around the building, and staff tried to call the family, who did not answer. The DON stated the family was very hard to contact. The DON stated someone should have been with Resident #190 to help calm the resident. The DON stated they did not receive a lot of information about Resident #190 as the resident was not a direct placement from the hospital. The DON stated they did not have the staff to do one-on-one monitoring, but they knew they had to keep an eye on Resident #190. The DON stated they tried to keep the resident in the common area and keep the resident distracted. The DON stated there was no other instance that the resident eloped that she was aware of. The DON stated the information should have been passed on that Resident #190 was recently admitted and was exit-seeking, and it should have been passed on in report. She stated that she did not know how often the wandering assessments should be completed, but thought they should be done quarterly, especially if they had a resident who was actively wandering. The DON stated wandering assessments were not currently being done quarterly. She stated the kitchen door was supposed to be locked. The DON stated an

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F 689	Continued From page 100 investigation should start as soon as staff sent the information to the Administrator. She stated the staff did not call her; they called the Administrator. She stated the Administrator told her he would handle it, so she did not come to help. The DON stated they did not do a root cause analysis that she was aware of, but there should have been one completed. She stated she expected some resolutions to be found before an elopement could happen again. She stated she expected staff to find ways to educate, redirect, and distract the resident and to keep them calm and inside the facility. The DON stated wandering assessments needed to be done. The DON stated the resident's elopement investigation needed to be more thorough, with more detail, and documented. During an interview on 10/18/2024 at 11:28 AM, the Administrator stated that what was listed on the admission checklist should be completed. The Administrator stated a wandering assessment was not completed for Resident #190. The Administrator stated staff should have completed a wandering/elopement assessment after Resident #190's elopement. The Administrator stated when Resident #190 was admitted to the facility, the resident wandered, but they did not know that at first. The Administrator stated the family just dropped the resident off and left without even saying goodbye and did not give much history (this statement is in contrast to the admission summary "Progress Notes" dated 08/05/2023 at 1:43 PM that revealed the family reported that there had been multiple incidents when the resident left the house and no one could find them, and the police would get involved). The Administrator stated it	F 689		

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was a new building to the resident, who was just looking for a way out. The Administrator stated Resident #190 was able to get out theside door, the alarm sounded, then the resident was out the door and out of the area (this statement is in contrast to the "DLBC - Form 358: Facility Reported Incidents" that revealed Resident #190 eloped from the facility through the back door where the alarm sounded). The Administrator stated the sheriff was called immediately and was trying to find the resident as well. He stated deputies were out looking for the resident; there was someone down the road who called, and the deputies brought the resident back. The Administrator stated it took a lot of convincing to get Resident #190 back into the building. The Administrator stated deputies were there the entire time and finally got the resident to come back in. The Administrator stated he left when they were finally able to get the resident calm and back in the facility. The Administrator stated Resident #190 was fine the rest of the night. The Administrator stated the resident did not go out the dock doors. The Administrator stated the resident went out the kitchen door. The Administrator stated staff were in the kitchen; he was not sure how the resident made it out without them knowing. The Administrator stated the resident was found a few minutes after it happened. The Administrator stated this happened on the resident's second day at the facility. The Administrator stated after the incident they probably placed the resident on one-on-one monitoring, but he did not remember specifically. He stated he could see that it would be helpful to have a full investigation documented with a summary so if someone asked about it, they would be able to explain what happened at the

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time. He stated he did not want any of this to happen. He stated the facility needed to be doing the preventive measures to be sure it did not happen. He stated that he expected to be better at investigating to ensure the investigations were thorough and to ensure the staff were trained on what needed to be done.

On 10/16/2024 at 10:40 AM, 10/17/2024 at 12:55 PM, and 10/18/2024 at 9:15 AM, calls were placed to the county sheriff's office with return calls requested. As of the time of exit conference, no calls were received from the county sheriff's office.

Due to discrepancies identified between information contained in documents and interviews conducted with staff, the specific date(s) of any elopement(s) involving Resident #190 was/were unable to be determined.
4. A facility policy titled, "Falls-Clinical Protocol," revised 09/2012, indicated, "1. For an individual who has fallen, staff will attempt to define possible causes within 24 hours of the fall." The policy also indicated that based on assessment, "The staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling.

An "Admission Record" revealed the facility admitted Resident #27 on 03/07/2023. According to the Admission Record, the resident had a medical history that included diagnoses of unspecified bipolar disorder, mild dementia with anxiety, hypertension, and age-related osteoporosis without a current pathological fracture.

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F 689	Continued From page 103 An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/12/2024, revealed Resident #27 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident required partial to moderate assistance from staff for toileting hygiene, putting on and taking off footwear, and personal hygiene. The MDS revealed the resident required supervision or touching assistance from staff to sit to stand, transfer from bed to chair, walk ten feet, walk fifty feet, and to walk 150 feet. The MDS indicated Resident #27 had no falls since admission, re-entry, or the prior assessment. Resident #27's care plan, revealed a diagnosis area initiated on 03/27/2024, that indicated Resident #27 was at risk for falls related to confusion, deconditioning, and gait/balance problems. Interventions directed staff to anticipate and meet the resident's needs (initiated 03/27/2023); make sure the resident's call light was in reach (initiated 03/27/2023); encourage the resident to use the call light as needed and to respond promptly to requests for assistance (initiated 03/27/2023); educate the resident/family/caregivers about safety reminders and what to do if a fall occurs (initiated 03/27/2024); encourage the resident to participate in activities that promote exercise; physical activity for strengthening and improved mobility (initiated 03/27/2023); follow the facility fall protocol (initiated 03/27/2023); physical therapy evaluation and treatment as ordered (initiated 03/27/2023); add nonslip strips to the floor (initiated 06/04/2024); regularly clean the	F 689		

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resident's room, keep the room free from clutter, place the resident on every-two-hour checks, try a bathroom commode as the resident continues to fall by the bedside going to the bathroom, and apply anti-slip tape to the ground (initiated 07/02/2024); and educate and encourage the resident to wear proper footwear (initiated on 08/16/2024).

Resident #27's "Progress Notes" dated 05/02/2024 at 8:50 AM, revealed a "Nurses Note" that indicated Resident #27 was found in the bedroom on the floor between the vanity and the room door. The note indicated Resident #27 was unable to recall what happened and was crying out in pain. The note revealed the resident was transported to the hospital for an evaluation.

A risk management form, dated 05/02/2024 at 8:50 AM, indicated Resident #27 had been found on the bedroom floor on their right side. The report indicated there had been no clutter or objects present that the resident had fallen over. The report indicated Resident #27 was unable to recall why the fall occurred. The report revealed Resident #27 cried out in pain, was guarding their left shoulder and arm, and reported pain in their rib area. The report revealed the resident was transported to the emergency department (ED) for further evaluation. Further review revealed there were no interventions documented to prevent further falls for the resident.

Resident #27's hospital "Physician Documentation," dated 05/02/2024 at 10:15 AM, indicated Resident #27 arrived at the ED with complaints of fall injury. The physician's note

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F 689	Continued From page 105 indicated the resident only complained of rib pain and left shoulder pain. The physician's examination noted tenderness with any range of motion of the left shoulder. X-ray results dated 05/02/2024 indicated Resident #27 had sustained a fracture of the left proximal humerus (left upper arm). Hospital discharge instructions, dated 05/02/2024, indicated Resident #27 had a diagnosis of fracture of the upper end of the humerus. The instructions included using an elastic bandage, RICE (rest, ice, compression, and elevation) therapy and rehabilitation. Resident #27's care plan revealed there was no evidence interventions were revised or initiated related to the resident's fall on 05/02/2024. An incident report for an unwitnessed fall, dated 06/03/2024 at 7:15 PM, indicated a Certified Nursing Aide (CNA) came into the hallway and requested assistance for Resident #27. The report revealed the resident had fallen on the floor between the chair and the bed. The report indicated Resident #27 stated the only thing hurting was their broken arm. The report revealed the immediate intervention taken was to assist with a clothing change and place Resident #27 back in bed. The report revealed the resident's mental status at the time of the fall was not identified and predisposing environmental factors was listed as "None." The report revealed predisposing physiological factors included confusion, a urinary tract infection, impaired memory, and a gait imbalance.	F 689		

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F 689	Continued From page 106 An observation was made on 10/15/2024 at 1:45 PM of Resident #27 lying in bed with eyes closed. The bed was in a low position with non-skid strips on the floor beside the bed. The resident's shoes with non-skid soles were sitting by the resident's bed. Nursing Assistant (NA) #7 was interviewed on 10/16/2024 at 8:32 AM. NA #7 stated fall prevention interventions for Resident #27 included a low bed and assisting the resident with ambulation. Registered Nurse (RN) #4 was interviewed on 10/16/2024 at 1:19 PM. RN #4 stated that the Director of Nursing (DON) was responsible for completion of fall investigations. RN #4 stated the assigned nurse was responsible for assessing residents that had fallen, completing the risk management report, and updating the resident's care plan. CNA #15 was interviewed on 10/17/2024 at 8:30 AM. CNA #15 stated she knew a resident was a fall risk if the resident was shaky or she read the resident's care plan on the kiosk. CNA #15 stated fall prevention interventions or fall program meant to work with a resident so the resident did not remain a fall risk. CNA #15 stated interventions to prevent falls for Resident #27 included one-to-two-person assistance with ambulation, checking on the resident every two hours, and a low bed. CNA #15 stated that Resident #27 was taken to the bathroom every two hours both on the day shift and night shift. CNA #15 stated she had not worked when the resident fell and broke their arm, but prior to the fall with fracture the resident ambulated	F 689		

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F 689	Continued From page 107 independently. RN #6 was interviewed on 10/17/2024 at 10:45 AM. RN #6 stated that when a resident fell, the assigned nurse was responsible for the physical assessment, neurological assessments, and completing the incident report. He stated the assigned nurse was also responsible for placing interventions, writing a nurse's note, and revising the care plan. RN #6 stated immediate actions to prevent falls included taking residents to common areas or providing one-on-one supervision if needed. RN #6 stated the CNAs were notified of residents at high risk of falls verbally and residents were placed on a list for staff to check every two hours. A telephone interview was held with RN #16 on 10/17/2024 at 11:07 AM. RN #16 was the nurse assigned to Resident #27 on 05/02/2024 when the resident fell and fractured their arm. RN #16 stated the resident was in their room alone with the door closed, and staff heard someone yelling for help. RN #16 stated she and another staff person (name unknown) started checking rooms and found Resident #27 on the floor. RN #16 stated that prior to the fall, Resident #27 ambulated independently and usually had a steady gait, adding Resident #27 used no assistive devices. RN #16 stated Resident #27 was assessed, and she had called emergency services due to the resident's complaints of pain in the upper arm and shoulder. RN #16 stated the assigned nurse was responsible for revising the care plan, but she was unable to remember if she had revised Resident #27's care plan. RN #16 stated the facility implemented no fall prevention interventions for Resident #27 that	F 689		

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F 689	Continued From page 108 stood out and she was unaware of any place CNAs found fall prevention interventions other than verbal communication from the nurse. RN #17 was interviewed on 10/17/2024 at 11:39 AM. RN #17 stated that prior to Resident #27 falling in the bathroom and breaking their arm, the resident's gait was steady, and they were independent with ambulation. RN #17 stated that when a resident fell the assigned nurse was responsible for the assessment of the resident. RN #17 defined the fall program as making sure the resident was fine, and the neurological status of the resident was intact, and nothing was altered from the resident's baseline. RN #17 stated that when a resident fell, the nurse was responsible for the documentation of the fall, which included completing the risk management form that indicated what the nurse saw when the room was entered, what the resident reported, notification of the family and physician, and any environmental issues. RN #17 stated the nurse was also responsible for documentation in the nurse's notes and for placing interventions to prevent further falls. RN #17 stated the DON, and the Administrator were responsible for determining the reason the resident fell and placing interventions to keep the resident from getting hurt when they fell. RN #17 stated interventions that had been placed to prevent Resident #27 from falling included assisting the resident to the bathroom and assisting with activities of daily living. The MDS Coordinator was interviewed on 10/17/2024 at 12:09 PM. The MDS Coordinator stated she was responsible for completing the MDS and some care plans. She stated if any new	F 689		

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F 689	Continued From page 109 orders were taken the expectation was for the nurse taking the order to revise the care plan or let her know so she could revise the care plan. The MDS Coordinator stated there should be an intervention to prevent falls placed after falls. She reviewed the care plan for Resident #27 and confirmed there were no interventions placed after Resident #27's 05/02/2024 fall. The DON was interviewed on 10/17/2024 at 1:32 PM. The DON stated the nurse on duty when a fall occurred was responsible for finding the root cause of the fall. She stated she reviewed falls as soon as possible after the fall occurred. The DON stated that prior to Resident #27's fall, on 05/02/2024, the resident was independent in ambulation and remained independent. The DON stated she expected interventions to be placed after falls and the care plans revised after falls. The DON reviewed the care plan for Resident #27's 05/02/2024 fall and acknowledged no interventions had been added after the fall in which the resident fractured their arm. The DON was interviewed on 10/18/2024 at 9:37 AM and stated she read the incident reports but had not regularly made sure interventions were placed for falls. The DON stated that she would need to start reviewing incident reports. The DON stated she was made aware of residents' falls by text and then reviewed incident reports to make sure the care plan was revised. The DON stated she was unsure how she had missed the intervention omission on Resident #27's care plan after the 05/02/2024 fall. The DON stated the nurses were responsible for determining the root cause of falls and placing interventions. The DON stated she also expected the nurses to	F 689		

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F 689	Continued From page 110 complete the investigations and revise care plans with new interventions. She stated she expected everyone to follow through to keep residents safe, and all information was documented. The Administrator was interviewed on 10/18/2024 at 11:45 AM. The Administrator stated the nurses were aware they were responsible for fall investigations and completion of the risk management tool. He stated that he and the DON then reviewed the falls to see what happened and to determine what caused the fall such as the resident tripped over something or had no socks on. The Administrator stated he and the DON should be making sure interventions were placed. The Administrator stated fall investigations and interventions were important to protect the resident and added that sometimes no matter how hard one tried to prevent falls, the falls continued. The Administrator stated it was his expectation for staff to investigate the fall to find the cause and to place interventions that would best protect the residents.	F 689		
F 690 SS=D	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	F 690	We at San Rafael Health and Rehabilitation are in compliance with Bowel/Bladder Incontinence, Catheter, UTI. Resident #24 currently resides in facility. Catheter was removed on 10/24/2024. Identification of Residents Potentially Affected: All residents current and future will be assessed for bowel and bladder program per clinical staff.	12/13/2024

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F 690	Continued From page 111 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 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 facility policy review, the facility failed to ensure an indwelling urinary catheter was secured to prevent potential pulling/trauma to the urethral meatus for 1 (Resident #24) of 1 sampled resident observed for indwelling urinary catheter care. Findings included: A facility policy titled, "Catheter Care, Urinary," revised 08/2022, indicated under "General Guidelines," to, "4. Ensure that the catheter	F 690	Measures of Prevent Recurrence: Nursing staff educated on facility protocols and requirements stated in protocol for bowel/bladder incontinence, catheter, uti dx. Doctor will document necessity of indwelling catheter. CNA's educated on importance of securing indwelling catheter in place as to protect resident from potential harm and maintain privacy to keep dignity in tact. Monitoring/Quality assurance: DON/ADON will audit for all new and current bladder training for residents. DON/ADON will audit bowel and bladder program within 72 hours of admission for all current and future residents until 100 % compliance x 60 days. Process/results to be incorporated into the Quality Assurance Performance Improvement process and monitored for 2 months to ensure this does not recur.	

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F 690	Continued From page 112 remains secured with a securement device to reduce friction and movement at the insertion site." The "State Operations Manual (SOM) Appendix PP - Guidance to Surveyors for Long Term Care Facilities" guidance at tag F690 specified additional care practices related to catheterization included, "Keeping the catheter anchored to prevent excessive tension on the catheter, which can lead to urethral tears or dislodging the catheter." An "Admission Record" revealed the facility initially admitted Resident #24 on 06/01/2022 and readmitted the resident on 01/06/2023. According to the Admission Record, the resident had a medical history that included diagnoses of unspecified obesity and chronic diastolic (congestive) heart failure. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/03/2024, revealed Resident # 24 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was always incontinent of bowel and bladder but had no indwelling urinary catheter. The MDS indicated Resident #24 was at risk of developing pressure ulcers but, at the time of the assessment, had no pressure ulcers. The MDS indicated Resident #24 did not have either a neurogenic bladder or obstructive uropathy. Resident #24's care plan included a focus area, revised 09/24/2024, that indicated the resident had frequent bladder incontinence related to	F 690		

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F 690	Continued From page 113	F 690		

impaired mobility. The care plan did not address the use of, or care required for, an indwelling urinary catheter.

Resident #24's "Order Summary Report," with active orders as of 10/16/2024, did not include a physician's order for the use of an indwelling urinary catheter, but did include a physician's order, dated 09/25/2024, for catheter care to be completed each shift and to ensure the catheter was patent and in a down draining position with no signs or symptoms of infection or other problems.

An observation of Resident #24's indwelling urinary catheter care, on 10/16/2024 at 9:25 AM with Registered Nurse (RN) #4 assisted by Nurse Aide (NA) #7, revealed the resident's urinary catheter was not secured. During a concurrent interview, RN #4 stated Resident #24 had a reaction to the adhesive on the catheter stabilization device, but she was unsure if there was documentation regarding the reaction since she had not been the one that placed the catheter. RN #4 stated that Resident #24's indwelling urinary catheter had been placed less than a month ago due to a red groin. An observation of Resident #24's skin revealed redness in the groin area but no pressure ulcers.

NA #7 was interviewed on 10/16/2024 at 9:43 AM. NA #7 stated she had previously seen a device used to secure Resident #24's indwelling urinary catheter, but one of the nurses had removed the device due to the resident's leg being red. NA #7 stated she had seen only one type of device used.

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F 690	Continued From page 114 RN #4 was interviewed on 10/16/2024 at 9:47 AM. RN #4 stated the indwelling urinary catheter had been placed due to Resident #24's fragile, sensitive skin. RN #4 stated that even with every two hour or hourly brief changes, Resident #24's skin remained painful, red, and raw. RN #4 stated there had been discussions with Resident #24's family member regarding the positives and negatives of using an indwelling urinary catheter, and the decision was made to use the catheter. RN #4 stated a stabilization device had been used to secure the indwelling urinary catheter, but Resident #24 had a reaction to the adhesive on the device. RN #4 stated she was unsure if any other type of securing device had been used. The Director of Nursing (DON) was interviewed on 10/16/2024 at 11:15 AM. The DON stated indwelling urinary catheters were used for residents who had issues with urination, chronic infections, or wounds that had not healed. The DON stated Resident #24 had a Stage 2 pressure ulcer that had not healed and had redness in the groin. The DON stated Resident #24 was allergic to the adhesive on the catheter stabilization devices that were usually used. The DON stated no other methods of securing the indwelling urinary catheter had been attempted and added that it was important to secure the indwelling urinary catheter to keep the catheter from being pulled out. The DON reviewed progress notes for Resident #24 and stated there was no documentation about the Resident #24's reaction to the adhesive on the stabilization device. The Administrator was interviewed on 10/17/2024 at 2:29 PM. The Administrator stated if Resident	F 690		

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F 690	Continued From page 115 #24 was allergic to the adhesive on the stabilization device, he expected another type of stabilization device to be tried.	F 690		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and	F 756	F756 Drug Regimen Review Corrective Action for Identified Residents: Resident 26: Currently resides in facility. Facility medical Director, pharmacist and DON reviewed, updated and corrected irregularities for resident on 12/05/2024. Identification of Residents Potential Affected: All residents with PRN antianxiety medications must have an end date. Measures to prevent Recurrence: Administrator and DON educated pharmacist consultant that all PRN medication must have an end date and must be reported to medical director and DON in writing. Monthly reviews will be done by both pharmacist consultant and DON to review all residents PRN medication to ensure end dates are in place/compliance. Nurses/DON to review medications upon admission for PRN's and ensure that end dates are in place and up to date. Nurse to notify MD of any irregularities found upon admit after reviewing new admission chart.	12/13/2024

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F 756	Continued From page 116 maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility document review, and facility policy review, the facility failed to ensure pharmacy recommendations were addressed for 1 (Resident #26) of 5 residents reviewed for unnecessary medications. Findings included: A facility policy titled, "Pharmacy Services Committee," revised 12/2009, indicated, "Duties and responsibilities of the Pharmacy Services Committee include, but are not limited to:" "12. Reviewing the reports of the Consultant/Supervising Pharmacist." An "Admission Record" indicated the facility admitted Resident #26 on 04/03/2022. According to the Admission Record, the resident had a medical history that included diagnoses of schizophrenia and paranoid personality disorder. A significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/14/2024, revealed Resident #26 had moderate impairment in cognitive skills for daily decision-making and had a short-term memory problem per a Staff Assessment of Mental Status (SAMS). The MDS revealed the resident received an antipsychotic, antianxiety,	F 756	Educate nurses on how to put in orders correctly with end dates on 14, 30, and 90 day cycles for PRN medication. Monitoring/Quality Assurance: Process to be incorporated into the Quality Assurance process to begin 12/06/2024 and monitored monthly x 3 months to ensure this deficient practice does not recur.	

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F 756	Continued From page 117	F 756		

antidepressant, an opioid, and a hypoglycemic medication during the assessment period.

Resident #26's "Order Summary Report," with active orders as of 10/15/2024, contained an order dated 07/22/2024 for lorazepam 2 milligrams (mg) one tablet by mouth every 12 hours as needed for anxiety. Further review revealed the order did not indicate an end date. The Order Summary Report also contained an order dated 09/25/2024 for lorazepam injection 2 mg per one milliliter (ml) with instructions to inject 1 ml intramuscularly every 24 hours as needed for severe anxiety. Further review revealed the order did not indicate an end date.

Resident #26's "July Pharmacy Consulting Report," dated 08/08/2024, indicated PRN (pro re nata, as needed) lorazepam must have a 14-90 day auto-stop date.

Resident #26's "Medication Administration Record [MAR]" for the timeframe from 10/01/2024 through 10/15/2024, contained a transcription of an order for lorazepam 2 mg one tablet by mouth every 12 hours as needed with a start date of 07/22/2024. The MAR revealed that staff documented the medication had been administered to the resident eight times during the month.

During an interview on 10/16/2024 at 8:29 AM, Registered Nurse (RN) #12 stated the Director of Nursing (DON) handled all the pharmacy recommendations.

During an interview on 10/16/2024 at 8:40 AM, RN #4 stated a stop date was required on PRN

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F 756	Continued From page 118	F 756		

psychotropic medications so the medication could be reviewed for effectiveness. RN #4 stated she was not familiar with pharmacy recommendations, but the pharmacist did a monthly review and discussed it with the DON.

During a telephone interview on 10/16/2024 at 1:02 PM, the Consultant Pharmacist stated he remotely conducted pharmacy reviews for two months then came to the facility every third month to participate in the psychotropic medication review meeting. The Consultant Pharmacist stated the pharmacy report was sent to the DON and the Medical Director. The Consultant Pharmacist stated the DON was always present in the psychotropic review meeting. The Consultant Pharmacist stated the facility did not follow the recommendations on the report, and if the report read there were no new irregularities or no new concerns it was because he had already pointed out the need for a stop date.

During an interview on 10/17/2024 at 8:42 AM, the DON stated PRN psychotropic medications were evaluated every month by the pharmacist. The DON stated the Medical Director, the Consultant Pharmacist, and she met quarterly to review psychotropic medications. The DON stated she was responsible for the monthly medication reviews. The DON stated she missed the recommendation on the 08/08/2024 pharmacy review for Resident #26. The DON stated she expected for the monthly medication reviews to be reviewed and recommendations for PRN psychotropic medication stop dates completed.

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F 756	Continued From page 119 During an interview on 10/18/2024 at 11:28 AM, the Administrator stated a 14-day stop date was needed to reassess psychotropic medications. The Administrator stated the Medical Director, and the DON were responsible for the pharmacy reviews. The Administrator state he expected the DON and Medical Director to communicate and discuss the need for the residents.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive	F 758	We, San Rafael Health and Rehabilitation are in compliance with Free from Unnecessary Psychotropic Meds/PRN use CFR. Corrective Action for Identified Residents: Resident #26 was identified and still resides in facility. Reviewed residents chart and use of psychotropic medication, accurate and up to date dose with complete and factual diagnosis included. Any PRN medication will be reviewed within 14 days by medical director/DON. Identification of residents potentially affected: All current and future residents who have medications including psychotropic and PRN. Measures to prevent recurrence: Nursing staff and MDS coordinator was educated on 12/10/2024 regarding administration of psych medications, stop/end dates, review dates and nursing job descriptions.	12/13/2024

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F 758	Continued From page 120 psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility document review, and facility policy review, the facility failed to ensure an as-needed (PRN, pro re nata) psychotropic medication order specified the duration of use for 1 (Resident #26) of 5 residents reviewed for unnecessary medications. Findings included: A facility policy titled, "Psychotropic Medication Use," dated 07/2022, specified, "12. Psychotropic medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. a. PRN orders for psychotropic medications are limited to 14 days."	F 758	MD will review, upon admission and prior to day 14 of medication initiation and determine ongoing need or D/C medication based on behavioral charting and diagnoses and make notation in residents chart according to need if medication is ongoing. DON/ADON reviewed with nursing staff policy and procedure on 12/10/2024 psychotropic 14 day review. The six rights of medication administration. Electronic health record is up to date with documentation of correct medication administration monitoring side effects, intervention, and behaviors specific to medication category. Monitoring/Quality Assurance: DON/ADON or designee will monitor and audit current residents and new admits medications within 72 hours of admit or PRN psychotropic medications until 100% compliance x two months. Process/results to be incorporated into the Quality Assurance Performance Improvement process and monitored until 100 % compliant x two months.	

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F 758	Continued From page 121 An "Admission Record" indicated the facility admitted Resident #26 on 04/03/2022. According to the Admission Record, the resident had a medical history that included diagnoses of schizophrenia and paranoid personality disorder. A significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/14/2024, revealed Resident #26 had moderate impairment in cognitive skills for daily decision-making and had a short-term memory problem per a Staff Assessment of Mental Status (SAMS). The MDS revealed the resident received an antipsychotic, antianxiety, antidepressant, an opioid, and a hypoglycemic medication during the assessment period. Resident #26's "Order Summary Report," with active orders as of 10/15/2024, contained an order dated 07/22/2024 for lorazepam 2 milligrams (mg) one tablet by mouth every 12 hours as needed for anxiety. Further review revealed the order did not indicate an end date. The Order Summary Report also contained an order dated 09/25/2024 for lorazepam injection 2 mg per one milliliter (ml) with instructions to inject 1 ml intramuscularly every 24 hours as needed for severe anxiety. Further review revealed the order did not indicate an end date. During an interview on 10/16/2024 at 8:29 AM, Registered Nurse (RN) #12 stated Resident #26 took PRN lorazepam every one or two days. RN #12 stated PRN psychotropic medications should have a stop date on the physician order. RN #12 stated Resident #26's physician order for the PRN lorazepam did not have a stop date and	F 758		

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F 758	Continued From page 122	F 758		

should have had one.

During an interview on 10/16/2024 at 8:40 AM, RN #4 stated a stop date was required on PRN psychotropic medications so the medication could be reviewed for effectiveness. RN #4 indicated she did not see a stop date on the physician's order for Resident #26's PRN lorazepam.

Resident #26's "July Pharmacy Consulting Report," dated 08/08/2024, indicated PRN lorazepam must have a 14-90 day auto-stop date.

During a telephone interview on 10/16/2024 at 1:02 PM, the Consultant Pharmacist state he came to the facility every third month to participate in a psychotropic medication review meeting. The Consultant Pharmacist stated the Director of Nursing (DON) was always present in the psychotropic review meeting. The Consultant Pharmacist stated that in the meeting he would sit with his laptop and go over each psychotropic medication and tell the facility if it needed a stop date. The Consultant Pharmacist stated the facility had a hard time placing stop dates on physician orders. The Consultant Pharmacist stated the facility did not follow the recommendations on the pharmacy consulting report, and if the report read there were no new irregularities or no new concerns it was because he had already pointed out the need for a stop date.

During an interview on 10/17/2024 at 8:42 AM, the DON stated the first physician order for a

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F 758	Continued From page 123 resident's psychotropic medication should have a 14-day stop date, then after, the physician reviewed the need for the medication. The DON stated after the physician's review the stop date should be 90 days and should be reflected on the physician order. The DON reviewed Resident #26's physician order then indicated it did not have a stop date. The DON stated she expected for any PRN psychotropic medication to have a stop date. During an interview on 10/18/2024 at 11:28 AM, the Administrator stated a 14-day stop date was needed to reassess psychotropic medications. The Administrator stated he expected for there to be a stop date on PRN psychotropic medications.	F 758		
F 812 SS=F	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	F 812		

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F 812	Continued From page 124 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility document review, and facility policy review, the facility failed to maintain a clean and sanitary kitchen. These failures had the potential to affect 39 of 39 residents who received meals from the dietary department. Findings included: A facility policy titled, "Cleaning Schedules," updated 03/2014, revealed, "The Dietary staff shall maintain the sanitation of the Dietary Department through compliance with written, comprehensive cleaning schedules developed for the community by the Dietary Manager." The policy revealed, "7. Under the days of the week or the weeks the Dietary Manager or designee can check off assignments completed or the employee can initial." A facility policy titled, "Operation and Sanitation," revised 11/01/2011, revealed, "Operating instructions are made available and cleaning procedures are developed for all Dietary Department equipment." Observations during the initial tour of the kitchen on 10/14/1024 beginning at 8:50 AM, revealed the appliances, including the commercial oven, convection oven, grill, and steamer, were dirty with grease and splatters. An observation on 10/16/2024 at 10:53 AM revealed the appliances remained dirty. Further observation revealed the top of the microwave	F 812	Kitchen has been deep cleaned to make sure there are no fuzz or grease on any of the cooking appliances. Education of Dietary Manager was done on proper cleaning and keeping the kitchen area clean. Dietary Manager had also done and in-service with her staff on keeping a sanitary kitchen and cooking area and training on how to properly clean. Monitoring/ Quality Assurance: Dietary Manager reviewed policy and procedures and education was given on keeping a sanitary kitchen. A walk through the kitchen will be done weekly by Administrator and Dietary manager to make sure that cleaning is being done properly. Any findings will be reported to the QAPI. Process/results to be incorporated into the Quality Assurance Performance improvement process and monitored for the next 2 months to 100% compliance to ensure this does not recur.	12/13/2024

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had a layer of fuzz and dirt that could be removed with a finger sweep. Observations also revealed that crumbs covered the counter behind the toaster and the microwave, which sat on the food preparation table, next to the steamtable in the center of the kitchen.

Observations of the kitchen on 10/16/2024 at 10:59 AM revealed the following:
- A thick layer of dirt and food splatters covered the front of the grill, which could be scraped off with a fingernail;
- The side of the steamer was covered with food splatters;
- The sides (about half-way down) and the top of the back side of the conventional stove top/oven combination were covered with splatters and felt sticky to the touch; and
- The front of the convection oven was covered with a large thick area of dust along the bottom of the appliance that could be pulled off with two fingers, leaving dust and fuzz sticking out from the door.
- The handles of the convection oven were covered with grease that left smudges when a finger was rubbed over them.

Observation of the kitchen on 10/16/2024 at 11:49 AM revealed the following:
- The knobs on the steamer were dirty and the dirt scraped off with a fingernail.
- There was fuzz and dirt hanging between the convection oven and the steamer.
- There was fuzz that was approximately two inches long on the wheel of the convection oven that blew in the breeze created by the fan.
- The fronts of two stainless steel drawers under the grill were covered with splatters and the vent

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located to the side of the drawers was covered with dirt and fuzz that could be removed by rubbing with a finger.

The "AM [morning shift] Cook's Daily Cleaning Schedule" for the week of 10/07/2024 through 10/13/2024 revealed the AM Cook was required to clean the grill, range top, and drip pans. The schedule revealed no one signed that the task was completed on 10/12/2024 or 10/13/2024. The cleaning schedule for the week of 10/14/2024 revealed the Cook had initialed the schedule on 10/14/2024 and 10/15/2024, indicating that the items had been cleaned.

During an interview on 10/16/2024 at 10:59 AM, the Cook stated staff wiped the appliances down every day and staff deep cleaned them once a week.

The "PM [evening shift] Cook's Daily Cleaning Schedule" for the week of 10/07/2024 through 10/13/2024 revealed that the PM Cook was required to clean the preparation counter/back splash, clean the range and drip pan, clean the toaster, and clean the microwave. The cleaning schedule revealed the DM had initialed the form indicating that she cleaned the items on 10/07/2024 and 10/10/2024. The cleaning schedule revealed no one initialed the form to indicate the items were cleaned on 10/11/2024, 10/12/2024, and 10/13/2024.

An observation of the kitchen on 10/16/2024 at 12:10 PM revealed the "PM Cook's Daily Cleaning Schedule" for the week of 10/14/2024 through 10/20/2024, was hanging on a wall in the kitchen; however, no one had documented that

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F 812	Continued From page 127 the required cleaning had been completed for 10/14/2024 and 10/15/2024. The facility's September 2024 "Chore List" revealed the "PM" (evening shift) cook was required to "wipe inside and out of the oven, stove and steamer (that includes the top)" on Mondays. The chore list revealed no one signed off on the task, indicating it was completed for September 2024. The Chore List for October 2024 revealed a line through task for 10/01/2024, and no one signed off on the task on 10/14/2024, indicating the items were cleaned. During an interview on 10/16/2024 at 2:15 PM, the Dietary Manager (DM) stated the staff were supposed to wipe the appliances down every day and do a deep cleaning of the appliances weekly. She stated she had monitored in the past to ensure all the things on the lists were completed, but she had not been monitoring lately as the kitchen had been short staffed recently and she had been working shifts in the kitchen. She stated she knew the appliances were dirty. She stated she was usually the one who did the deep cleaning and tried to do it three to four times a year but had not been able to in a while. The DM stated when she cleaned, she had to use a putty knife to clean the appliances. According to the DM, if staff were wiping the appliances down daily, they may not be as bad. During an interview on 10/18/2024 at 9:42 AM, the Director of Nursing (DON) stated she thought the kitchen should be cleaned daily. The DON stated the kitchen should be cleaned and sanitized before every meal.	F 812		

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F 812	Continued From page 128 During an interview on 10/18/2024 at 11:28 AM, the Administrator stated he expected the kitchen to be clean. He stated the kitchen had always been in top shape when they had previous inspections. The Administrator stated he was in the kitchen often but did not look at everything while he was in there.	F 812	F842 San Rafael Health and Rehabilitation is in compliance with Resident Records Identifiable Information.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;	F 842	Resident #190 was identified and no longer resides in building. Corrective Action for Identified resident: Education/in service given to admit nursing staff and MDS coordinator about having accurate dates of service, updating in the EMR. Measures to prevent Recurrence: Education given to all nursing staff, CNAs, and MDS coordinator regarding accuracy of documenting and timelines. Monitoring/Quality Assurance: DON/ADON or designee will monitor current resident and future residents for accurate dates of admission for correct documentation in the electronic health record weekly, until 100% compliance, for 2 months. Process/Results to be incorporated into the Quality Assurance Performance Improvement process and monitored until 100% compliance x 2 months.	12/13/2024

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F 842	Continued From page 129 (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced	F 842		

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by:
Based on interview, record review, facility document review, and facility policy review, the facility failed to maintain accurate medical records for 1 (Resident #190) of 19 sampled residents.

Findings included:

A facility policy titled, "Record of Admission," revised December 2006, revealed, "A record of admissions will be maintained for each resident admitted to the facility." The policy revealed, "1. At the time of the resident's admission, a resident identification and summary record is completed. 2. A copy of this record must be placed on the resident's chart, and a copy must be provided to the medical records department. 3. Our identification and summary record includes, but is not limited to: a. the resident's full name and social security number; b. the date and time of this admission."

An "Admission Record" revealed the facility admitted Resident #190 on 08/04/2023. According to the Admission Record, the resident had a medical history that included Alzheimer's disease, insomnia, dementia with agitation, and bipolar disorder.

An admission Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 08/14/2023, revealed Resident #190 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. The MDS revealed the facility admitted the resident on 08/04/2023.

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Resident #190's "Care Plan," included a diagnosis area initiated 08/22/2023, that indicated the resident was an elopement risk and wanderer related to a history of attempts to leave the facility unattended, and the resident wandered aimlessly. Interventions directed staff to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. Interventions also directed staff to provide structure activities such as toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes. Interventions also indicated that the resident usually triggered for wandering/eloping in the afternoon.

Resident #190's "Progress Notes" revealed an "Admission Summary" dated 08/05/2023 at 1:43 PM written by Registered Nurse (RN) #5 that indicated Resident #190 had arrived at the facility with their family.

An "Admission Agreement" revealed the resident's date of admission was 08/04/2023. The agreement revealed the financial responsible party and witness signatures were dated 08/05/2023.

During an interview on 11/11/2024 at 3:04 PM, the MDS Coordinator reviewed the electronic health record for Resident #190 and stated the resident's entry MDS indicated an admission date of 08/04/2023, the resident's admission document also indicated an admission date of 08/04/2023, and the resident's admission summary indicated an admission date of 08/05/2023.

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F 842	Continued From page 132 During an interview on 11/11/2024 at 3:22 PM, the Business Office Manager (BOM) stated the resident was admitted on 08/04/2023. The BOM provided a copy of the resident's baseline care plan that had an admission date of 08/04/2023, and a referral note from the hospital dated 08/04/2023. The BOM stated she had billed the resident for 08/04/2023. During an interview on 11/11/2024 at 3:41 PM, the Director of Nursing (DON) stated that she remembered talking back and forth with the hospital on 08/04/2023 about transportation for Resident #190. The DON stated the hospital felt the resident would not be comfortable going with the facility's transportation, so a decision was made that the resident's family member would bring them to the facility on 08/05/2023. During a follow-up interview on 11/12/2024 at 8:10 AM, the DON stated that on 08/04/2023, Resident #190's family member had taken the resident to the clinic at the hospital hoping they could admit the resident. The DON stated the hospital told the family that the resident could not be admitted for dementia. The DON stated that was when the clinic did a referral for the resident to be in long term care. The DON stated the resident's family member did not bring the resident to the facility until 08/05/2023. During an interview on 11/12/2024 at 8:35 AM, RN #5 stated she documented the admission summary progress note on the day that Resident #190 was admitted to the facility. RN #5 stated they would always document a progress note on the same day a resident was admitted. RN #5 stated there was some back and forth with the	F 842		

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F 842	Continued From page 133 family on the resident being at the facility, so there may have been an issue with the date based on that. During an interview on 11/12/2024 at 9:18 AM, the Administrator stated he felt what happened with Resident #190's admission date was that the resident was supposed to come to the facility on the fourth (08/04/2023) and that was when everything was started in the electronic health record system, but the family did not bring the resident to the facility until the fifth (08/05/2023). During an interview on 11/12/2024 at 9:58 AM, the MDS Coordinator stated she received residents' admission dates for the MDS from the BOM because she was the one that would verify the resident was qualified to be at the facility. The MDS coordinator stated new admissions were discussed in the morning meetings. The MDS coordinator stated she was not present on the day Resident #190 was admitted to the facility. The MDS coordinator stated there could have been a mix up on the paperwork that the BOM received, but she was not sure. During an interview on 11/12/2024 at 10:04 AM, the DON stated her expectation was that dates were correct in the electronic health record. The DON stated Resident #190's paperwork should have reflected the admission date of 08/05/2023 and not 08/04/2023. The DON stated when they found out the resident was not coming on 08/04/2023, they should have taken the resident out of electronic health record system and then entered the resident back in when they came in on 08/05/2023.	F 842		

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F 842	Continued From page 134 During a follow-up interview on 11/12/2024 at 11:46 AM, the Administrator stated his expectation was that medical records were accurate.	F 842	San Rafael Health and Rehabilitation is in compliance with Infection Prevention and Control.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880	Corrective action for Identified Residents: Resident #24 identified and currently resides in building. Residents catheter was discontinued on 10/24/2024. The care plan for resident has been reviewed and updated to reflect measurable goals and interventions to keep resident safe. Identification of residents Potentially Affected: All current and future residents have the potential to be affected. Measures to prevent recurrence: Education given to all nursing staff, medical director, MDS coordinator and infection prevention nurse of the importance of accurately documenting necessity of indwelling catheters and putting in appropriate orders, managing them and keeping them up to date. Education given to all staff regarding Enhanced Barrier Precautions and the requirements for indwelling catheters on 12/10/2024 as well as other infection prevention precautions. Educated Infection Prevention nurse on the requirement to teach every employee, current and further, about infection prevention requirements.	12/13/2024

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F 880	Continued From page 135 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to	F 880	Monitor/Quality Assurance: DON/ADON will audit weekly on the use of Enhanced Barrier Precautions to assure measurable goals are put into place and followed appropriately x 2 months to 100% compliance. Any variance will be resolved as soon as possible. The results of these audits will be reported to Quality Assurance Performance Improvement Committee in regularly scheduled monthly or until it is determined that staff education has reached implementation of interventions appropriately.	

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F 880	Continued From page 136 implement infection control and prevention policies. Specifically, the facility failed to ensure staff followed enhanced barrier precautions (EBP) when completing indwelling urinary catheter care for 1 (Resident #24) of 1 resident reviewed for indwelling urinary catheter care. Additionally, the facility failed to conduct annual tuberculosis (TB) risk screenings for 4 (Residents #1, #3, #4, and #27) of 5 residents whose immunization histories were reviewed. Findings included: 1. A facility policy titled, "Enhanced Barrier Precautions Policy and Procedure," revised 03/27/2024, indicated, "Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MOROS) [sic - MDROs] in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MORO as well as those at increased risk of MORO acquisition (e.g. [exempli gratia, for example], residents with wounds or indwelling medical devices). High-contact resident activities include: - Dressing - Bathing/showering - Transferring - Providing hygiene - Changing linens - Changing briefs or assisting with toileting - Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator - Wound care: any skin opening requiring a dressing."	F 880		

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F 880	Continued From page 137 An "Admission Record" revealed the facility initially admitted Resident #24 on 06/01/2022 and readmitted the resident on 01/06/2023. According to the Admission Record, the resident had a medical history that included diagnoses of unspecified obesity and chronic diastolic (congestive) heart failure. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/03/2024, revealed Resident #24 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was always incontinent of bowel and bladder but had no indwelling urinary catheter. The MDS indicated Resident #24 was at risk of developing pressure ulcers but, at the time of the assessment, had no pressure ulcers. The MDS indicated Resident #24 did not have either a neurogenic bladder or obstructive uropathy. Resident #24's care plan included a focus area, revised 09/24/2024, that indicated the resident had frequent bladder incontinence related to impaired mobility. The care plan did not address the use of, or care required for, an indwelling urinary catheter. Resident #24's "Order Summary Report," with active orders as of 10/16/2024, did not include a physician's order for the use of an indwelling urinary catheter, but did include a physician's order, dated 09/25/2024, for catheter care to be completed each shift and to ensure the catheter was patent and in a down draining position with no signs or symptoms of infection or other problems.	F 880		

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F 880	Continued From page 138 An observation of care provided to Resident #24's on 10/16/2024 at 9:25 AM revealed Registered Nurse (RN) #4 providing indwelling urinary catheter care and personal hygiene care with the assistance of Nurse Aide (NA) #7, after Resident #24 had a bowel movement. RN #4 and the NA #7 both donned gloves, but neither staff member donned a gown while providing care to the resident. RN #4 was interviewed on 10/16/2024 at 9:47 AM. RN #4 stated she was unaware of the term "enhanced barrier precautions" and had not been educated to wear a gown or mask while providing catheter care. She did state that EBP was used for residents with wounds. NA #7 was interviewed on 10/16/2024 at 11:12 AM. NA #7 stated she had not heard the term "enhanced barrier precautions" and had not been taught to wear a gown and gloves when providing care for Resident #24, who had an indwelling urinary catheter. The Director of Nursing (DON) was interviewed on 10/16/2024 at 11:15 AM. The DON stated the facility policy instructed EBP usage with any task dealing with fluids. The DON stated there was the potential to come in contact with fluids when caring for an indwelling urinary catheter. The DON stated EBP training had been provided. She indicated EBP training was not provided to nursing staff during orientation, but the use of personal protective equipment (PPE) was discussed. The Infection Preventionist (IP) was interviewed	F 880		

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F 880	Continued From page 139 on 10/16/2024 at 1:30 PM. The IP stated she had not heard about EBP until she started her employment with the facility and had no idea what staff had been taught. The IP stated any resident with catheters and wounds should be placed on EBP. The IP stated she knew there were a few residents in the facility with wounds. Certified Nurse Aide (CNA) #2 was interviewed on 10/17/2024 at 9:22 AM. CNA #2 stated she had not heard the term EBP. CNA #2 stated she had not received any instruction to wear a gown when providing care to Resident #24. The MDS Coordinator was interviewed on 10/17/2024 at 12:09 PM. The MDS Coordinator stated there were no residents in the facility on EBP. The MDS Coordinator stated she had not been trained on EBP and, therefore, did not think there were any residents who required EBP and had not care planned EBP for Resident #24. Registered Nurse (RN) #6 was interviewed on 10/17/2024 at 10:53 AM. RN #6 stated he had received education on EBP, but then said he was unaware of the term EBP. RN #6 stated he thought it was mandatory to wear a gown when taking care of residents with indwelling urinary catheters due to the potential of disease and added that, at the very least, gloves were worn. RN #6 stated he was unable to recall CNAs wearing gowns when emptying a urine collection bag but stated the CNAs did wear gloves. RN #6 stated that when providing treatments to pressure ulcers, the personal protective equipment (PPE) worn depended on the type of dressing change and added that most of the wound care in the facility for pressure ulcers only	F 880		

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F 880	Continued From page 140 required gloves be worn. A telephone interview was held with RN #16 on 10/17/2024 at 11:07 AM. RN #16 stated she no longer worked at the facility but was previously employed as the facility's IP. RN #16 stated she had received education on IP and EBP when she attended a conference in Salt Lake City. RN #16 stated, upon return to the facility, she shared the education she had received with the DON, the Assistant Director of Nursing (ADON), and the Administrator. RN #16 stated she felt dismissed about the information she tried to share and was told by the DON there was no need to go to extreme measures with infection control and no need to initiate EBP. RN #17 was interviewed on 10/17/2024 at 11:39 AM. RN #17 stated no residents in the facility required EBP. RN #17 stated she had been taught about EBP in nursing school. RN #17 stated if a resident required EBP, there would be a sign on the resident's room door alerting her to the precautions that were to be taken. RN #17 stated the facility had residents with pressure ulcers and with catheters, but she had not been instructed to wear gowns, gloves, or eye protection when providing care to those residents. RN #17 confirmed Resident #24 had an indwelling urinary catheter and stated she had not been told the resident was on EBP or that she needed to wear any type of PPE. The DON was interviewed on 10/17/2024 at 2:08 PM and stated she did not have a good reason for EBP not having been initiated for residents with catheters and those that required wound care.	F 880		

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F 880	Continued From page 141 The Administrator was interviewed on 10/17/2024 at 2:13 PM. The Administrator stated he was unaware staff were not following EBP but expected EBP to be followed. 2. A facility policy titled, "Tuberculosis, Screening Residents for," revised 07/2016, indicated, "Policy Statement - This facility shall screen all residents for tuberculosis infection and disease (TB)." The policy also indicated under the section, "Serial Testing of Residents," that, "1. The facility will conduct an annual risk assessment to determine TB risk classification (low or medium). 2. If the risk classification is identified as 'low risk' for transmission of TB the facility shall screen residents for TB if the develop symptoms of active TB disease or if there has been an incident of known exposure to a person with active TB. Otherwise, annual screening is not routine. 3. If the risk classification is identified as 'medium risk' for transmission of TB, residents will receive an annual TST [tuberculin skin test], with the exception of known 'converters' (those whose previous skin tests are positive)." A review of the immunization record for Resident #1 revealed the resident had their last tuberculosis (TB) testing on 08/01/2021. The record did not specify whether annual risk assessments had been completed since that date. A review of the immunization record for Resident #27 revealed the resident had their last TB testing on 03/14/2023. The record did not specify whether annual risk assessments had been completed since that date.	F 880		

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F 880	Continued From page 142 A review of the immunization record for Resident #3 revealed the resident had their last TB testing on 03/19/2020. The record did not specify whether annual risk assessments had been completed since that date. A review of the immunization record for Resident #4 revealed the resident had their last TB testing on 10/14/2019. The record did not specify whether annual risk assessments had been completed since that date. The Infection Preventionist (IP) was interviewed on 10/16/2024 at 1:30 PM. The IP stated TB testing was completed on admission or a break in care, such as when a resident went home, but not after a hospitalization. During an interview with the Administrator on 10/16/2024 at 2:48 PM, the Administrator stated either the Director of Nursing (DON) or the IP would know where to find the annual TB risk assessments. The DON was interviewed on 10/17/2024 at 2:08 PM and stated there had been no annual TB risk assessments completed for residents. The DON stated there had recently been a couple of different IPs and added that may be the reason the risk assessments had not been completed. The Administrator was interviewed on 10/17/2024 at 2:13 PM. The Administrator stated the yearly risk assessments were done for staff, but he was not aware the assessments had not been completed for residents.	F 880		
F 943	Abuse, Neglect, and Exploitation Training	F 943		

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F 943 SS=F	Continued From page 143 CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview, document review, and facility policy review, the facility failed to provide annual and periodic training in accordance with facility policy, to educate staff on activities that constitute abuse and procedures for reporting incidents of abuse for 2 (Certified Nurse Aide [CNA] #8 and Registered Nurse [RN] #6) of 4 staff reviewed. Findings included: A facility policy titled, "Policy and Procedure for Prohibiting Abuse," dated 02/2017, indicated, "2. Training All employees will be trained through orientation and ongoing inservices on issues related to the prohibition of abuse including: - Appropriate behavioral interventions to deal with aggressive and/or catastrophic reactions of	F 943	1:1 trainings were conducted on 11/14/2024 by CEO to all staff on proper identification of abuse and reporting of abuse timely. Each staff was given a copy of the abuse policy and will be required to sign that they received this training from the CEO prior to them coming on shift. All staff was made aware of where to find the Administrator and DON's numbers, which are located behind the nurses' station, so they will be able to contact them if an incident needs to be reported. Monthly in services are scheduled to continue training on abuse, when and who to report to. Relias has been added as well and will be monitored for compliance. Monitoring/Quality Assurance: All staff have been trained on policy and procedure on how to recognize and how to report abuse. At least Quarterly along with scheduled trainings abuse policies will be reviewed and documentation will be kept on all staff when they received this training. Process/results to be incorporated into the Quality Assurance Performance Improvement process and monitored quarterly to 10% compliance to ensure this does not recur.	12/13/2024

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F 943	Continued From page 144 residents - How to report allegations without fear of reprisal - Signs of burnout, frustration and stress that may lead to abuse - What constitutes abuse, neglect and misappropriation of resident property. 3. Prevention of abuse This facility carefully screens potential employees. Initial orientation and periodic inservices at least twice a year regarding abuse prevention and reporting, activities that constitute abuse, neglect, exploitation and misappropriation of resident's property. Education will include procedures for reporting, prevention of resident abuse and dementia management." The policy also specified, "4. Identification of possible abuse events: Facility will offer annual and periodic inservices educating staff to identify potential signs and symptoms of abuse including behavior changes and injuries of unknown origin and to identify events and trends which may constitute abuse." A "DLBC [Division of Licensing and Background] - Form 358: Facility Reported Incidents" document revealed that on 11/28/2023 at 2:30 PM, the Administrator reported an allegation to the state agency that Registered Nurse (RN) #6 physically and mentally/verbally abused Resident #38. The report revealed that staff became aware of the incident on 11/24/2023 in the "Early Morning," and Certified Nurse Aides (CNAs), including CNA #8, notified administration of the alleged incident on 11/28/2023 at 2:00 PM, four days after the incident. According to the report, RN #6 went into Resident #38's room, yelled in the resident's face that the resident needed to get into bed, grabbed the resident's arms and wrist,	F 943		

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F 943	Continued From page 145	F 943		

and shook the resident. Per the document, the nurse gave the resident a choice to either let the aides put the resident in bed or he would do it, then counted down from five. The document indicated that the nurse then grabbed the resident by their arms and legs and moved the resident to the bed. The document indicated that the resident told the nurse to stop hurting them. Per the report, the facility unsubstantiated the abuse allegations and indicated they would "educate again" on the "policies on abuse." (Refer to F600, F609, and F610).

During an interview on 10/16/2024 at 6:15 PM, CNA #8 stated she worked at the facility for almost two years as a CNA. She stated she did not remember receiving any training regarding abuse prohibition or reporting while she worked at the facility. CNA #8 also stated that she did not receive any retraining after she did not immediately report the abuse allegation for Resident #38 in November 2023.

During an interview on 10/17/2024 at 9:41 AM, RN #6 stated he had worked at the facility for a little over two years. RN #6 stated he worked night shift and made it to some required trainings, but not all of them. He stated he recalled completing computer trainings for abuse prohibition and resident rights. RN #6 stated he was suspended for three days after the November 2023 abuse allegation but did not recall receiving abuse prohibition training after that.

RN #6's "RELIAS Certificate of Completion," revealed RN #6 successfully completed 0.50 training hours for "Preventing, Recognizing, and

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SAN RAFAEL HEALTH AND REHABILITATION	455 WEST MILL ROAD FERRON, UT 84523

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F 943	Continued From page 146 Reporting Abuse" on 02/01/2023. CNA #8's "RELIAS Certificate of Completion" revealed CNA #8 successfully completed 0.50 training hours for "Preventing, Recognizing, and Reporting Abuse" on 02/03/2023. A document titled, "2024 Inservices" indicated the facility provided training on vital signs and "abuse: kinds reporting and prevention" on 03/06/2024. The Administrator was asked for a copy of the sign-in sheet for this in-service on 10/18/2024 at 9:07 AM and provided a document titled, "Staff Meeting 3/13/24 [03/13/2024]" that listed 20 typed staff members' names. Some were only first names while others were first and last names. The list of names did not include RN #6 and CNA #8. This document did not specify the topics that were discussed during the 03/13/2024 staff meeting, and no other sign-in sheet was provided for the 03/06/2024 abuse training. An undated "Abuse Policy" found in several employees' personnel records specified, "All employees of [the facility] must immediately report any incidents of abuse or misappropriation of patient property. Patient abuse is defined as the willful infliction of a patient with resulting physical harm or pain, mental anguish, deprivation of goods or services that are necessary to attain or maintain physical, mental or psychosocial well-being. Abuse may consist of verbal abuse, sexual abuse, physical abuse, involuntary seclusion, mental abuse, neglect and/or misappropriation of patient property. Abuse of any kind will not be tolerated at [the facility] and will result in termination of	F 943		

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F 943	Continued From page 147 employment." Personnel records for RN #6 and CNAs #2, #10, #8 and #9 all contained a copy of this undated policy that had been signed by the employee as follows: - CNA #2's personnel record revealed that she signed the undated "Abuse Policy" on 07/23/2023. CNA #2's personnel record did not include any other evidence of abuse training. - CNA #10's personnel record revealed that she signed the undated "Abuse Policy" on 10/24/2023. CNA #10's personnel record did not include any other evidence of abuse training. - CNA #8's personnel record revealed that she signed the undated "Abuse Policy" on 08/30/2022. CNA #8's personnel record did not include any other evidence of abuse training. - RN #6's personnel record revealed that he signed the undated "Abuse Policy" on 07/17/2022. RN #6's personnel record did not include any other evidence of abuse training. - CNA #9's personnel record revealed that she signed the undated "Abuse Policy" on 08/03/2022. CNA #9's personnel record did not include any other evidence of abuse training. During an interview on 10/18/2024 at 9:42 AM, the Director of Nursing (DON) stated that the Administrator monitored the required computer training for staff. She stated if someone missed a training, the Administrator notified her, and she notified the staff member that they needed to complete the missing training. Per the DON, staff signed in when they attended an in-service, and	F 943		

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F 943	Continued From page 148 they reviewed the training with the staff who did not attend; however, the DON stated they did not document the individual training. The DON also stated they should have staff repeat abuse prohibition trainings if there were allegations of abuse against them. During an interview on 10/18/2024 at 11:28 AM, the Administrator stated the facility provided abuse prohibition training to the staff involved in an abuse allegation, just not right away. The Administrator stated he had no documentation of these trainings but had provided an in-service for the CNAs. The Administrator stated the facility also provided yearly abuse prohibition trainings. During a telephone interview on 11/13/2024 at 12:12 PM, the facility's corporate Chief Operating Officer (CEO) stated he knew the facility conducted annual training on abuse and reporting allegations of abuse and did so at least annually. He believed they had conducted more than one training. He indicated there should be sign-in sheets for each training, and if a staff member did not attend, they needed to come in and the facility needed to provide individual training and have the staff member sign that they received the training. He did not know why there was no sign-in sheet for the abuse training in March 2024. He stated he attended a training a couple of months ago where the facility did their annual emergency preparedness training, and he had to sign in that he attended. During a telephone interview on 11/14/2024 at 2:23 PM, the previous Assistant Director of Nursing (ADON) stated she did not remember the March 2024 training, why there were no	F 943		

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F 943	Continued From page 149 sign-in sheets, or who attended. She indicated it had been almost a year ago and she no longer worked at the facility, so her memories had faded. During an interview on 11/15/2024 at 9:57 AM, the Business Office Manager (BOM) stated the previous ADON had provided the typed list for the March 2024 training/in-service, and she did not know if there were any sign-in sheets; she just knew that the previous ADON kept track of who attended. She indicated the previous ADON was in charge of tracking the CNAs' trainings and that the current ADON would be taking over that piece of the training. She stated when she first started working in the business office, she noticed that the personnel files were a mess. Since she had been working in the office, they had developed a new system where health records were kept in a red folder, and Human Resources (HR) took care of the onboarding and maintained the new hire personnel paperwork. She indicated HR did not start this process until June 2024, so she was not sure who maintained the onboarding paperwork prior to that. She stated she believed it was all in the blue folders that were provided to the survey team for the four CNAs and RN #6. According to the BOM, the Administrator was the only one who had access to look at the overall Relias training and pull up those training records. She indicated she did not believe the facility had any other documentation of abuse training for the four CNAs and for RN #6 if there was no other documentation found in their blue personnel files. During an interview on 11/15/2024 at 10:52 AM, the Administrator provided a printout of his own	F 943		

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F 943	Continued From page 150 Relias trainings completed since 2020, which indicated he completed abuse training every year. He stated that what he was providing for himself was what it should look like in each staff member's file on Relias. He confirmed again that there were no training records in the Relias system for RN #6 and CNAs #2, #8, #9, and #10, other than the abuse training in 2023 that he had provided for CNA #9 and RN #6. He indicated he had no other documentation to provide for those staff members' trainings. He stated he was currently in charge of tracking staff trainings, but he could see now what was lacking. He revealed he had been behind this year but knew that was not an excuse. He stated the facility had been working to make improvements on several of the systems, and he could see they still had some things to work on. During an interview on 11/15/2024 at 11:15 AM, the HR employee stated that when a new employee started, she gave them the new hire packet, which included a lot of policies, what forms of identification they were required to bring in, I-9s, W-4s, education, employee vaccinations and the consents/declinations for those, and the employee handbook. She stated she did not do any trainings with the staff and, once she had all the information and had the background checks, she turned the files over to whatever supervisor the employee would have. She stated again that she provided no training to new hires and did not enter the new employees into the Relias system when they were hired. When asked about the Relias system, she stated, "I don't even know what that is." According to the HR employee, she started her employment with the facility in June 2024.	F 943		

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F 943	Continued From page 151 During an interview on 11/15/2024 at 6:16 PM, the Administrator stated hey needed to keep better track of sign-in sheets, track the Relias training, make sure everyone was doing the training, and document to make sure they had the documentation to show the trainings had been done.	F 943		

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K 000	INITIAL COMMENTS Emergency preparedness E-000 Initial Comments: Statutory and regulatory authority for this Emergency preparedness survey that was conducted on 10-22-2024 in the presence of the facility manager are found in 42 Code of Federal Regulations, Section 483.73 The facility was found to be in compliance with the requirements for participation in Medicare and Medicaid. No deficiencies were cited for emergency preparedness during this survey.	K 000	Cole Julian Approved: 11-12-2024 POC date: 11-30-2024	
K 100 SS=D	General Requirements - Other CFR(s): NFPA 101 General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: K-100 Based on observations made in the presence of the facility manager on 10-22-2024 it was determined that the facility did not maintain Cooking Facilities in accordance with NFPA 101 Section 19.3.2.5.1, 9.2.3; 2011 NFPA 96 Section 6.2.3.3 This deficiency affected 3 areas of the exhaust grease filters bank. Findings include: The grease filters in the dietary exhaust hood were not arranged so that all exhaust air passes	K 100	**Corrective Action:** Plant manager aligned the grease filters correctly to assure that there is no gap. **Measure to Prevent Recurrence:** On 10/24/24 plant manager talked with dietary manager and dietary manager educated dietary staff on how to keep gaps from occurring and why it is important to not have gaps. Staff will put that part of their cleaning and maintenance list for the kitchen equipment. This will be to assure everything is in working order. **Monitoring/Quality Assurance:** The plant manager will monitor and report findings to scheduled QAPI meetings, including findings and documentation 3x quarterly.	10/24/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	11/7/24

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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K 100	Continued From page 1 through the grease filter, the filter bank had 3 gaps of approximately ½ to1 inch or greater allowing grease to be vented out into the exhaust duct. Ref: 2012 NFPA 101 Section 19.3.2.5.1, 9.2.3; 2011 NFPA 96 Section 6.2.3.3	K 100		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments	K 363	**Corrective Action:** Plant Manager adjusted the door hardware so that the door would latch upon closing. **Measure to Prevent Recurrence:** A annual door inspection performed by the maintenance supervisor, has been incorporated into the checklist to monitor that the doors are latching upon closing. Incorporating this will help monitor any issues that may arise and will then be able to report any findings. **Monitoring/Quality Assurance:** Plant manager will monitor annually and report in next QAPI meeting his findings, this will include documentation and checklists and continue quarterly and follow up annually.	10/24/2024

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K 363	Continued From page 2 there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: K-363 Based upon observations made in the presence of the facility manager on 10-22-2024, it was determined that the facility did not maintain the door openings in smoke barriers to have at least a 20-minute fire protective rating. The doors shall be self-closing or automatic closing in accordance with 19.3.7.6. This deficiency affected 1 Fire/smoke compartments. Findings include: 1-During the facility tour the east hallway fire rated dual egress exit door failed to close to a latching position in accordance with NFPA 19.3.7.3, 8.5, 8.3.3.1, NFPA 80 5.2.4.2.	K 363		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	K 511	**Corrective Action:** The plant manager installed a GFCI outlet in laundry sorting room and tested to assure it was functioning properly. **Measures to Prevent Recurrence:** The plant manager while doing his GFI checklist will make sure that all outlets are working properly with current codes and regulations.	10/24/2024

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K 511	Continued From page 3 This REQUIREMENT is not met as evidenced by: K-0511 Based upon observations made in the presence of facility manager on 10-22-2024, it was determined that the facility did not maintain electrical equipment in accordance with NFPA 101 19.5.1 and 9.1.2. This deficiency affected one of the GFIC outlets. Findings include 1-During the facility tour it was observed that the outlet in the laundry sorting room was not GFCI protected at the hopper sink and was observed to be within 6ft of the sink. GFCI outlets are required where the receptacles are installed to serve the countertop surfaces and are located within 6 ft. (1.83 m) of the outside edge of the sink. NFPA 101 Section 19.5.1, 9.1.2; 1999 NFPA 70 Article 210-8(7). The facility manager confirmed these findings.	K 511	**Monitoring/Quality Assurance:** The plant manager will monitor and report his findings in scheduled QAPI meetings that include findings and documentation and will continue quarterly. **Correct Action:**	
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several	K 921	The plant manager has ordered the testing equipment to perform the leak current testing on all patient related care electrical equipment. The administrator and plant manager have started to gather the necessary electrical manuals for the equipment in patient care areas. Testing has begun and continues on all patient related care equipment and will document all data and assuring all equipment is compliant. All testing will be completed by November 30, 2024	11/30/2024

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K 921	Continued From page 4 electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: K-921 Based on records review, observation, and an interview with the Facility Manager on 10-22-2024 the facility failed to maintain documentation of the inspections for the Patient-Care Related Electrical equipment (PCREE). This deficiency affected all residents. Findings include: During the record review it was discovered that the PCREE testing had been started but had not been completed for all of the required facility equipment, and was lacking documentation for the inspections of the Patient Care Related Electrical Equipment in use throughout the facility as required by section 10.5.6.2 of NFPA 99,	K 921	**Measures to Prevent Recurrence:** The plant manager and administrator will test all patient related care electrical equipment and will test annually all equipment in the patient related care electrical category, and will test all new equipment brought into the building that will be used for patient use. Documentation will be completed upon testing all electrical equipment. The electrical equipment manuals will also be kept on a computer file for easy access for all electrical equipment used. Education of staff will be done so that staff will be able to easily find manuals on computer when needed. **Monitoring/Quality Assurance:** The plant manager will monitor monthly and report findings in regularly scheduled QAPI meetings including findings and documentation, and continue 3x quarterly.	

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K 921	Continued From page 5 Health Care Facility Code 2012. 3.3.137. NFPA 99 10.3 through 10.5.8.	K 921		