STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065241	A. BUILDING _____ B. WING _____	05/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE HEALTH SERVICES-DENVER	290 S MONACO PKWY DENVER, CO 80224

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** Based on observations and staff interviews, the facility failed to treat residents (Resident #1, Resident #4 - #18) who resided on the secure unit with respect and dignity. Specifically the facility failed to ensure: - Staff used resident names when referring to them; - Staff did not use labels for residents who needed assistance with dining; - Staff conversed with residents while assisting them; and - Staff spoke to residents when residents were asking them questions. Cross reference: F600: Failure to protect residents from abuse; F835: Failure to have sufficient administration oversight Findings include: I. Facility policy and procedure The undated Patient/Resident policy and procedure was provided by the quality assurance coordinator (QAC) on 5/22/2020 at 4:30 p.m. It documented in pertinent part: As a patient of the center you have the right to be treated courteously, fairly and with the fullest measure of dignity. II. Using resident names - observation and interview On 5/15/2020 at 10:25 a.m. registered nurse (RN) #1 was observed pushing a resident by the nurses' station and down the hallway toward the exit doors. When she came back up the hall she confirmed she was a nurse but was currently helping on the secure unit and was not acting as a nurse. She said, I'm providing one on one with residents. First I push this one then I push another one, then another one (down the hall) for a walk. She said, I guess her name is (resident name) regarding the resident she was currently pushing down the hall. III. Using labels for residents - observations and interviews CNA #3 was interviewed on 5/21/2020 at 5:43 p.m. CNA #3 pointed to a table in the dining room where four residents were sitting. He said, This is a feeder table so they sit them together at that table (so they know they need assistance with meals). RN #1 was interviewed on 5/21/2020 at 6:37 p.m. She said that it was difficult to keep residents separated in the secure memory unit. She said, Some of them are feeders and so they sit together. CNA #6 was interviewed on 5/22/2020 at 12:29 p.m. She said that a resident was seated at the feeder table because she required staff assistance and encouragement to eat. IV. Conversing with residents during cares - observations and interviews On 5/15/2020 at approximately 10:40 a.m. RN #1 was standing next to a male resident who was sitting at a dining room table in the communal dining room. He attempted to stand up. Without speaking to the resident, RN #1 took his arm and directed him back into a sitting position. On 5/22/2020 at 1:02 p.m., CNA #8 sat with her head in hands next to a female resident who, according to CNA #6, sat at a table with residents who required assistance with eating. At 1:06 p.m., CNA #8 got up and walked away from the resident. She did not speak to the resident during this time. On 5/22/2020 at 1:10 p.m., LPN #4 sat down next to a female resident in the dining room in the secured unit. The resident fed herself slowly while LPN #4 watched her. She did not greet the resident or speak to her as she sat next to her. At 1:14 p.m., LPN #4 got up and walked away without ever speaking to the resident. V. Resident interaction - observations On 5/22/2020 at 3:08 p.m. CNA #3 was observed standing next to a resident who was talking to him, looking at his face and touching his arm. The resident did this for approximately 45 seconds. During this time CNA #3 did not acknowledge the resident. After the 45 seconds, while the resident was still talking, CNA #3 walked away. VI. Staff interviews On 5/15/2020 at approximately 2:15 p.m. the assistant nursing home administrator (ANHA) was notified of the observed interactions with RN #1 (see above) and residents who resided on the secure unit. The ANHA agreed those interactions did not promote dignity and respect to residents. On 5/22/2020 at 3:05 p.m. the hospitality aide (HA) was interviewed. He said examples of dignity included smiling politely, trying to not make residents feel bad, use the resident ' s name and laugh with the resident if they were laughing. CNA #9 was interviewed on 5/22/2020 at 3:12 p.m. She said if a resident was getting into harm's way you would offer cues to help them but a resident should never be grabbed. She said she would also use distraction and have activities. She said it was important to use the resident ' s name. She said she called the resident ' s feeders so other staff knew those were the residents that needed help eating. LPN #2 was interviewed on 5/22/2020 at 3:04 p.m. She said that she addressed residents by their preferred names. She said they should be addressed by whatever their preference was and if the resident was unable to voice their preference, she would refer to them as Mr. or Miss with their last name. She said residents should be treated as individuals and cared for by their individual needs. She said she would not refer to residents as feeders because it is disrespectful to generalize residents based on their needs. She said she would refer to them on an individual basis, Mr. or Miss and their last name has difficulty with swallowing and required assistance. RN #2 was interviewed on 5/22/2020 at 3:09 p.m. She said how she addressed residents was dependent on their choice. She said she called them Miss or Mr. with their last name or by their first name. She said it was the resident ' s choice how they wanted to be addressed by staff and that she would ask what their preference was. She said she would say residents who need assistance with eating. She said she would never refer to residents as feeders as this did not portray any respect. RN #3 was interviewed on 5/22/2020 at 3:18 p.m. She said providing dignity for residents included making sure they were clean and their brief was changed frequently. She said it was important to use resident names and to never use the term feeders. She said it was not dignified towards residents. The activities director (AD) was interviewed on 5/22/2020 at 3:39 p.m. She said examples of dignity included addressing residents respectfully, using their names, never talking to the residents like they are children and never using the term feeder. She said if she heard staff use that term she would correct them. The nursing home administrator (NHA), ANHA, and director of nursing (DON) were interviewed on 5/27/2020 at 9:03 a.m. The NHA said examples of treating residents with dignity included using a respectful tone, treating residents as adults, using their name and never putting hands on them without asking first. The DON said dignity included providing privacy during care and never using the term feeders. The ANHA said by not providing dignity to residents, residents are depersonalized. She said when she had been made aware of the observations of RN #1 on the secure unit on 5/15/2020, she had not provided any education or addressed these concerns with RN #.
F 0600 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to protect 18 residents (Residents #1, Resident #4 - #21) residing in the secure unit from abuse. Resident #1 was severely cognitively impaired and resided on the secure unit with 17 other cognitively impaired residents. A certified nurse aide/activities assistant (AA) reported on 3/25/2020 that on 3/24/2020, she observed a staff member yank Resident #1 out of his chair, which was located back from the table where the activity was underway and a distance from other residents. Then, using two hands, the staff pulled on the resident's left arm, causing the resident to yell out, that hurts, stop. Yet, the staff member did not stop, and continued to pull the resident up out of his chair, sitting him down in a chair across the room. The facility failed to address the 3/25/2020

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

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

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) report of abuse by the AA in a comprehensive manner until 5/22/2020, during survey and almost two months after the incident. This failure made it likely the 18 cognitively impaired residents residing in the secure unit were at risk for abuse if immediate action was not taken. Cross-reference F550E, F610E, F726E and F835E Findings include: I. IMMEDIATE JEOPARDY A. Findings of immediate jeopardy Resident #1 was severely cognitively impaired and resided on the secure unit with 17 other cognitively impaired residents. A certified nurse aide/activities assistant (AA) reported on 3/25/20 that on 3/24/20, she observed a staff member yank Resident #1 out of his chair which was located back from the table where the activity was underway and a distance from other residents. Then, using two hands, the staff pulled on the resident's left arm, causing the resident to yell out, that hurts, stop. Yet, the staff member did not stop; she continued to pull the resident up out of his chair, sitting him down him in a chair across the room. The facility failed to address, in a comprehensive manner, the 3/25/2020 report of abuse by the AA until 5/22/2020, during survey and almost two months after the incident. Specifically, the facility failed to identify and interview staff and residents present at the activity on 3/24/2020. Moreover, the staff identified, Licensed Practical Nurse (LPN) #1 and registered nurse (RN) #1, continued to work on the secure unit. The facility's failure to address the AA's report in a comprehensive manner prior to survey resulted in a failure by the facility to take steps to protect residents in the secure unit, all of whom are cognitively impaired, from potential abuse by staff. On 5/21/2020 at 4:12 p.m., the nursing home administrator (NHA) was notified the failures above created an immediate jeopardy situation that placed all residents in the secure unit at risk for serious harm (abuse by staff). B. Facility plan to remove immediate jeopardy On 5/22/2020, the facility submitted a plan to abate the immediate jeopardy. The abatement plan read: Request to remove Immediate Jeopardy as of May 22, 2020 F-600 This serves as (the facility's) response to the Immediate Jeopardy Notification that the center received on May 21, 2020 The submission of this plan does not constitute agreement or an admission on the part of (the facility) as to the accuracy of the statements or conclusions contained in the notification. The facility took immediate action through Quality Assessment Performance Improvement relative to Resident # I incident upon identification of the issue on 5/21/2020. Immediate Actions: Resident # I no longer resides in the center Employee involved in investigation was suspended Nursing Home Administrator and Assistant Nursing Home Assistant Administrator were educated on The Patient Protection Guideline to include how to conduct an investigation and Special Consideration: Abuse, Neglect, Exploitation or Misappropriation Investigation by the Regional Director of Operations. Staff working in the center were educated on The Patient Protection Guideline on May 21, 2020 by the Director of Nursing and Staff Development Coordinator. Like Residents: Residents who reside on the (secure) Unit were identified as like residents. Interviewable residents were queried related to abuse with the attached questionnaire by social services on May 22, 2020. Non-interviewable residents will have a body assessment completed for any injuries of unknown origin by Staff Development Coordinator and licensed nurses by May 22, 2020. Any Trends and concerns from review of like residents will be addressed a??d then discussed with QIPI May 22, 2020. System Revisions: Immediate education of 100% of facility staff on patient protection expectations Including but not limited to the training for prevention; protection, identification, and investigation of all allegations of abuse, neglect, mistreatment and misappropriation of property. And the reporting and responding to the appropriate individuals and agencies will be completed by NHA or ANHA. No employee will be allowed to work until they have completed the education. This education was started on May 21, 2020 and will be completed by May 28, 2020 The NHA and ANHA were educated on May 21, 2020 Any allegations of abuse or neglect will be reported immediately via phone to NHA/ANHA 24 hours per day, 7 days per week. NHA/ANHA will direct staff with next steps of investigation, including resident protection and reporting. As of 5/22/2020 there remain 97 of 146 staff requiring education on abuse which will be completed prior to the start of their next scheduled shift. Ongoing Monitoring Random weekly interviews and body assessments will be completed of three patients regarding abuse beginning May 26, 2020 and continuing for four weeks. Results will be reviewed at QAPI meeting on June 24th to determine next steps for ongoing monitoring. Each investigation will be reviewed to ensure a comprehensive abuse investigation has been completed by the NHA. The facility QAPI committee through Ad Hoc or full QAPI shall monitor weekly for 4 weeks to review any trends and findings, issues or concerns-and develop plan of action for follow up and resolution. The document was signed by the nursing home administrator (NHA) C. Removal of immediate jeopardy On 5/22/2020 at 1:10 p.m., the nursing home administrator was notified that its abatement plan had been accepted and the immediate jeopardy removed. However, based on record review and interviews, deficient practice remained at an E level, potential for more than minimal harm at a pattern. II. Policy and procedure When requested, the nursing home administrator (NHA) provided the policy titled, Patient Protection Abuse, Neglect, Exploitation, Mistreatment & Misappropriation Prevention. The NHA reported on 5/2/6/2020 this was the only abuse policy. The document read, The facility must develop and implement written policies and procedures that: prohibit and prevent abuse, establish policies and procedures to investigate allegation, include training and establish coordination with the QAPI (quality assurance performance improvement) program. However, the NHA did not produce additional policies and procedures to investigate allegations and establish coordination with QAPI when further policies and procedures were requested. III. Report of abuse involving Resident #1 and failures in facility response A. Resident #1 Resident #1, age 91, admitted [DATE] and passed away on 5/5/2020. According to the May 2020 computerized physician's orders [REDACTED]. The resident resided on the secure unit until his death. According to the 4/1/2020 minimum data set (MDS) assessment, the resident was severely cognitively impaired and was unable to complete the brief interview for mental status (BIMS). Staff documented the resident had short and long-term memory problems and was severely impaired regarding decision-making. The MDS documented the resident had no behaviors during the review period. He required supervision with ambulation and transfers and extensive assistance with grooming and dressing. The resident was unable to complete a pain assessment with staff; however, staff documented the resident would complain of pain one to two days during the review period. Care plan review revealed the following issues had been identified: -Left arm pain, plan created 10/31/17 for which he received pain medication. Although staff interviews (5/15/20) indicated the resident always complained of pain, there was no documentation indicating the resident frequently called out in pain, -History of verbal aggression towards others (curse or threaten to punch caregiver during attempts to redirect) related to cognitive impairment, hard of hearing, misinterpretation of environment/actions of others. -Inappropriate sexual behavior asking whose lap he can sit on. Interventions included explain effects of behavior on others, set limits for acceptable behavior, avoid conversations that could initiate or encourage inappropriate behavior, provide supervision in social gatherings/recreation programs and redirect resident to available empty chair in room. B. Facility report of abuse 3/24/2020 1. Record review Review of the facility abuse investigations on 5/15/2020 revealed a report of abuse involving Resident #1 on 3/24/2020. The facility interviewed the AA on 3/25/2020 at 4:36 p.m., the day she reported the incident. Her report read in pertinent part: -I was sitting doing an activity with residents and (Resident #1) asked if he could sit in a chair, he joined us about 8 ft. (feet) away and was participating. About 5 minutes into the activity the nurse (nurses' name/ RN #1 crossed out and error written above) comes in and says to Resident #1, you can't sit there. She walked over to him and yanked him out of the chair and using 2 hands . pulled on his left arm, and he yelled out and said stop but she continued to pull him up. -(The nurse) walks over to another table and sits him down by himself. Today (3/25) during lunch, Resident #1 said my arm hurts, rubbing his left arm. I told his sitter and she told the nurse. The nurse came to check him out and he stopped complaining. I didn't say anything to the nurse at the time, because the nurse has a reputation of being intimidating and I was afraid. I didn't tell anyone else. 2. AA interview The AA, who no longer worked at the facility, was interviewed on 6/5/2020 at 2:04 p.m. She said the date of the incident (3/24/2020) she was doing an activity with approximately five residents in the common area in the secure unit while sitting at a table. She said Resident #1 wandered in and said, Hey I'm still alive. He sat down in a chair which was located back from the table where the activity was underway and nowhere near other residents, and began participating in the activity with the other residents. RN #1, who was working as a CNA that day, came into the room and looked at Resident #1 and grabbed his arm and yanked him up out of his chair and said, you can't sit there. Resident #1 said, that hurts, stop, and RN #1 moved the resident to another chair across the room. She said RN #1 sat down next to him and did not say a word but began to look at her phone. The AA said the next day she returned to work and UNK #1 (Resident #1's sitter) asked the AA what had happened because Resident #1 was complaining of pain in his shoulder. The AA said she told UNK #1 what had happened, then went to LPN #1 and told her that the resident was complaining of pain. She said LPN #1 was watching something on her phone and said she would take care of it. The AA said in about 20 to 30 minutes LPN #1 went into the resident's room to give him medicine. The AA said she was nervous about reporting the incident and had heard that RN #1 had threatened people in the past. She said she also knew there were two other CNAs in the room, although she could not remember their names, who had witnessed the incident and thought they would tell someone. She said at that time, she was nervous and thought they would shrug it off. The AA said

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) she asked the director of nurses (DON) to whom she could report abuse and the DON told her she could tell her. The AA told the DON, who said she would let the Assistant NHA (ANHA) know and then the ANHA came and interviewed her. C. The facility failed to investigate the incident on 3/24/2020 in a comprehensive manner and as a result, failed to take timely and appropriate measures to protect residents in the secure unit, all of whom are cognitively impaired, from potential abuse by staff. Cross-reference F610. The ANHA and the NHA acknowledged the facility investigation of the events on 3/24/2020, completed 3/31/2020, was incomplete and re-opened the investigation 5/22/2020 after immediate jeopardy was called during survey. Record review and interview of the facility's 3/31/2020 abuse investigation revealed the 3/24/2020 incident was reported to the police and the state agency, the resident's chart was reviewed, and a skin evaluation was conducted. The nurse on duty (LPN #1) was suspended upon administration receiving the AA's report on 3/25/2020, and she returned to work the next day, although the investigation was not signed as completed until 3/31/2020. Record review, confirmed by interview with the ANHA and NHA, revealed only three interviews were obtained during the 3/31/2020 abuse investigation; interview with the AA (see above), Resident #1 and LPN #1 the nurse on duty 3/24/2020. -In his interview, Resident #1, who had severe cognitive impairment (see 4/21/2020 MDS above), said his arm was better now and he broke it playing tennis. -In her interview, LPN #1 said she did not recall any incident with Resident #1 on 3/24/2020. The investigation concluded the allegation of abuse was unsubstantiated. The CNA (activities assistant) believed she had witnessed rough handling of Resident #1 on the afternoon of 3/24/2020 by the nurse . no other witnesses to the encounter. Resident #1's skin check revealed no signs of rough treatment and there have been no outward changes in his behaviors towards staff or fell ow residents. Yet, the facility investigation did not explain how it was determined that there were no other witnesses to the incident, based on the limited interviews obtained. Per the AA interview on 6/5/2020 (see above), there were other staff in the room as well as other residents attending the activity who she thought might report the incident. In summary, the facility completed its investigation on 3/31/2020 without attempting to identify the staff member who could have been involved in the incident described by the AA. The AA, in her interview on 3/25/2020, identified RN #1, but the RN's name was crossed out and no other name was inserted. When LPN #1 reported she did not recall any incident with Resident #1 on 3/24/2020, there was no evidence the facility attempted to interview RN #1 or other staff who worked on the unit that day until almost two months later, after being informed of immediate jeopardy during survey. At that time, the investigation of the incident was reopened. This placed residents on the secure unit at risk for serious harm (abuse). LPN #1 and RN #1 were interviewed on 5/15/2020 at 1:45 p.m. -LPN #1 said she kind of remember something but didn't hear about it for a few days and then asked Resident #1 if he was in pain. That was all she remembered; she said she did not remember hearing anything about the resident getting pulled or bruising. She said the resident always complained of pain and no one had told her anything about the incident, although per the ANHA she was suspended for the day and interviewed the next morning before returned to work. -RN #1 said she did not know anything about the incident and agreed Resident #1 always complained of pain, even when no one touched him. But see the resident's care plan above, lacking any reference to the resident frequently calling out in pain. The re-opened abuse investigation of the 3/24/2020 incident on 5/22/2020 involved interviews with the AA, LPN #1, and RN #1 as well as a number of other staff and residents. LPN #1 and RN #1 were suspended pending outcome of the investigation, which revealed RN #1 had not worked on 3/24/2020, per review of the punch detail, although, per the AA, RN #1 had worked that day as a CNA (see interview above). The investigation concluded on 5/27/2020 and again, the allegation was determined to be unsubstantiated. However, due to the nature of the allegation and the observations made during the investigation, staff were to receive additional education regarding the provision of care for individuals with dementia, including dignity and alternative methods of communicating to promote the highest level care and wellbeing for the residents. Interview with the NHA and the ANHA revealed no staff education on abuse, neglect or mistreatment (other than education of the AA on timely reporting) was conducted upon completion of the abuse investigation on 3/31/2020. D. Current observations of staff interactions with residents in the secure unit. The AA, in an interview on 6/5/2020, stated she had seen RN #1 do other things to residents on the secure unit such, as yell at them, ignore them and belittle them. She said she had never reported anything that she had witnessed until 3/25/2020, as RN #1 intimidated her. Review of the staffing schedules revealed LPN #1 and RN #1 have continued to work in the secure unit since 3/24/2020. Review of their files revealed no training in abuse recognition or prevention or management of residents with dementia and/or difficult behaviors from 3/31/2020 and until 5/7/2020, a training that was conducted in response to a different allegation of abuse. Observations in the secure unit on 5/15/2020 at approximately 10:40 a.m., revealed RN #1 standing next to a male resident who was sitting at a dining room table in the communal dining room. He attempted to stand up. Without speaking to the resident, RN #1 took his arm and directed him back into a sitting position. Further observations and staff interviews on 5/15/2020 and 5/22/2020 revealed staff in the secure unit failed to not know or use residents' names, referred to residents as feeders, and failed to acknowledge or speak to the residents they were assisting. (Cross-reference F550).
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to have evidence all alleged violations of potential abuse were thoroughly investigated and failed to ensure residents were protected from further potential abuse and/or mistreatment after allegations of abuse and/or mistreatment were known, involving one (#1) out of three sample residents. Specifically, the facility failed to: -Identify a potential abuse incident and conduct a thorough investigation of alleged staff to resident abuse; and -Protect Resident #1 and all other residents who resided on the secure unit from additional potential abuse. Cross reference: F600 Failure to protect residents from abuse; F835 - Failure to administer the facility effectively. Findings include: I. Facility policy and procedure When requested, the NHA provided the Patient Protection Abuse, Neglect, Exploitation, Mistreatment & Misappropriation Prevention policy. The NHA reported on [DATE]/2020 this was the only abuse policy. The document included: The facility must develop and implement written policies and procedures that: prohibit and prevent abuse, establish policies and procedures to investigate allegations, include training and establish coordination with the QAPI (quality assurance performance improvement) program. II.Abuse Allegation A.Resident #1 1.Resident status Resident #1, age 91, was admitted on [DATE] and deceased on [DATE]. According to the [DATE] computerized physician's orders [REDACTED]. The resident resided on the secure unit until his death. According to the [DATE] minimum data set (MDS) assessment, he was severely cognitively impaired and was unable to complete the brief interview for mental status (BIMS). Staff documented the resident had short and long term memory problems and was severely impaired regarding decision making. The MDS documented the resident had no behaviors during the review period. He required supervision with ambulation and transfers and extensive assistance with grooming and dressing. The resident was unable to complete a pain assessment with staff; however, staff documented the resident would complain of pain one to two days during the review period. 2. Record review a. Care plan Upon review of the resident's care plan there was no documentation indicating the resident frequently called out in pain (see LPN #1 interview below). b. Abuse investigation The investigation report signed [DATE] (seven days after the incident) by the assistant nursing home administrator (ANHA) documented, in pertinent part: Staff member stated she witnessed resident being handled roughly by his arm by a fell ow staff member, that the resident complained of arm pain the following day and that the staff member who evaluated the resident for pain was the same who had handled him roughly. The documents reviewed included the resident's chart and the skin evaluation. A comprehensive pain assessment was not completed. Three people were interviewed (the activities assistant, LPN #1 and the resident). A police report was made, a report to the state agency was made, and the resident was placed on alert charting for mood/behavior changes related to the incident. The conclusion read, in pertinent part: (Resident #1), a [AGE] year old male resident with advanced dementia, chronic shoulder and leg pain, who is extremely hard of hearing and who requires physical guidance ([DATE] MDS documents supervision with transfers and ambulation) when attempting to perform a task and often has a 1:1 sitter with him during day shift. The CNA (activities assistant) believed she had witnessed rough handling of (Resident #1) on the afternoon of [DATE] by the nurse who evaluated his pain on [DATE] with no other witnesses to the encounter. (Resident #1's) skin check revealed no signs of rough treatment and there have been no outward changes in his behaviors towards staff or fell ow residents. The allegation of abuse is unsubstantiated. The activities assistant was interviewed on [DATE] at 4:36 p.m. The interview read in pertinent part: I was sitting doing an activity with residents and (Resident #1) asked if he could sit in a chair, he joined us about 8 ft. (feet) away and was participating. About 5 minutes into the activity the nurse (nurse's name crossed out and error written above) comes in and says to (Resident #1), you can't sit there. She walked over to him and yanked him out of the chair and using 2 hands and pulled on his left arm, and he yelled out and said stop but she continued to pull him up. She walks over to another table

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) and sits him down by himself. Today (,[DATE]) during lunch, (Resident #1) said my arm hurts, rubbing his left arm. I told his sitter and she told the nurse. The nurse came to check him out and he stopped complaining. I didn't say anything to the nurse at the time, because the nurse has a reputation of being intimidating and I was afraid. I didn't tell anyone else. The resident was interviewed on [DATE]; he said his arm was better now and he broke it playing tennis. The document read: Resident takes this nurses hand with his left hand and walks down hall holding her hand for guidance and support. Resident shows no guarding or signs of being fearful. Licensed practical nurse (LPN) #1 was interviewed on [DATE] at 8:00 a.m. She said, in pertinent part: I do not recall any incident with (Resident #1) on Tuesday. There was a CNA that was a sitter with (Resident #1) on Tuesday during day shift. I did assess him for shoulder pain on Wednesday around lunch time, this is pretty normal for him: Shoulder and leg pain and he has routine Tylenol ordered and I gave it to him. He gets it every 4 hours. Resident has been his normal self the past week. 3.Staff interviews The ANHA was interviewed on [DATE] at 12:12 p.m. She said the incident had occurred on [DATE] but had not been reported by the activities assistant until [DATE]. She said after it was reported the nurse was suspended immediately. She said there were no other interviews completed except the resident, LPN #1 and the activities assistant. She said she only had completed part of the investigation and then passed it off to the NHA. She agreed the investigation was incomplete (missing education and other interviews from staff) and had only completed education with the activities assistant regarding reporting abuse timely. -On [DATE], the ANHA said she had notified LPN #1 telephonically that she was suspended on [DATE] and when the LPN #1 returned to work on [DATE] at 6:00 a.m. she was interviewed by the ANHA and returned to the floor after the 8:00 a.m. interview (see above). LPN #1 and registered nurse (RN) #1 were interviewed on [DATE] at 1:45 p.m. LPN #1 said she kind of remembered something but didn't hear about it for a few days and then asked if the resident was in pain; that was all I remembered. LPN #1 said she did not remember hearing anything about the resident getting pulled or bruising. She said the resident always complained of pain and no one had told her anything about the incident. She said the resident would complain about pain even when no one touched him. RN #1 said she did not know anything about it but agreed Resident #1 always complained of pain even when no one touched him. CNA #1 was interviewed on [DATE] at 1:50 p.m. She said she remembered being called but she had been working the night shift when it had occurred so she did not remember anything. She said that Resident #1 complained of pain all the time. The staff development coordinator (SDC) was interviewed on [DATE] at 3:46 p.m. She said she used to be the director of nursing (DON) but had stepped down from this position, and was currently the SDC until they found a replacement. She said when she was the DON she was heavily involved in the abuse investigation process. She said she would identify what had happened, determine what staff were involved and determine if the incident was reportable. She said her intent was to attempt to establish what happened by interviewing the living at this time. She said she would work on completing the investigation at this time since the DON was not in the facility. She said the facility was currently completing a lot of education related to abuse because of their last survey. The NHA and ANHA were interviewed telephonically on [DATE] at 10:00 a.m. The NHA said he was the abuse coordinator. Both the NHA and the ANHA agreed that the investigation was incomplete. The NHA said normally they would interview staff and residents if interviewable. The NHA said they would ask open ended questions and ask whether residents were happy with their care. He said the ANHA took over the investigation and he did not review it when he returned to the facility. He said they determined it was not abuse and he needed to move on to other things. The NHA said that Resident #1's sitter should have been interviewed and the two CNAs that worked during that shift. He said he had talked with his nurse management team about working with LPN #1 as sometimes she comes across as loud. He said his nurse management team said the allegation could not have happened so he was not concerned. He said, I reminded my nurse management team yesterday to talk with LPN #1 because of her approach. Both the NHA and the ANHA confirmed LPN #1 had not received any education. He said there were no other indications that the incident had occurred and two nurses examined the resident and found nothing unusual. The ANHA said that they had LPN #1 complete the routine pain evaluation (documented on the MARs) because they did not know she was the alleged perpetrator (she was the assigned nurse on the day shift for the secure unit where Resident #1 resided) until the next day. The ANHA confirmed, even though they received the report from the activities assistant on [DATE], a comprehensive pain assessment had not been completed until [DATE], and the pain assessment prior to that had been completed on [DATE]. The NHA, ANHA and DON were interviewed on [DATE] at 9:03 a.m. All agreed that the first investigation was incomplete and the investigation completed on [DATE] was more thorough and included all of the components of a comprehensive investigation.
F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to ensure one (#3) of three sample residents received adequate assistance to prevent accidents. Specifically the facility failed to ensure Resident #3 received the required assistance of two staff members during cares. Resident #3 was admitted to the facility with a known history of muscle weakness and [MEDICAL CONDITION]. She required extensive assistance with all activities of daily living (ADL) care and two person assistance with mechanical lift for transfers. On 5/12/2020 she was transferred out of her bed with a mechanical lift, received a shower and transferred back into her bed with a mechanical lift all with the assistance of one certified nurse aide (CNA). Once Resident #3 was in bed this CNA provided cares without the assistance of another staff member and as she rolled the resident to one side Resident #3 slid out of bed onto the floor landing on her knees. This action by the CNA, not following the residents prescribed plan of care, contributed to the harm of Resident #3. Resident #3 sustained a left distal femur fracture and was sent to the hospital. Cross reference: F835-Failure to administer facility effectively. Findings include: I.Resident status A. Resident #3 1. Resident status Resident #3, under [AGE] years old, admitted to the facility on [DATE]. According to the face sheet resident [DIAGNOSES REDACTED]. According to the 5/8/2020 minimum data set (MDS) assessment the resident had no cognitive impairment with a brief interview of mental status (BIMS) of 15 out of 15. The resident had no behaviors documented in the MDS. She required extensive assistance with all ADLs. 2. Record review a. Care plan The care plan, revised on 3/17/2020, documented the resident required transfers to be completed with a total mechanical lift with assistance of two people. The goal was for the resident to receive assistance to meet ADL needs. Interventions included two person assistance with bed mobility, assist with shower as needed and transfer using mechanical lift with assistance of two staff. b. Progress note The 5/12/2020 nursing progress note documented at 12:30 p.m. documented the nurse was called into the resident's room at 11:50 a.m. where Resident #3 was found on the floor; CNA #5 was in the room. The CNA said while changing the resident, Resident #3 rolled out of bed onto the floor. Resident #3 landed on both of her knees, but did not complain of pain and the nurse who assessed the resident did not identify neuro issues, redness or bruising to knees or feet. The nurse practitioner ordered bilateral knee two view x-rays and a left ankle x-ray. Resident #3's family was contacted. The 5/12/2020 nursing progress note documented at 4:19 p.m. documented the nurse contacted the resident's family to provide the results of the x-ray after the fall. The x-ray revealed a left-distal femur fracture. 3. Investigation report 5/12/2020 Resident #3, statement dated 5/12/2020 at 4:30 p.m. documented I got back from my shower (CNA #5 name) put me back into my bed with the full lift. It was just me and her in the room during the incident. I was lying in the bed after the transfer wth (CNA #5) rolled me towards her in the bed to help me get dressed. I was too close to the edge. My right leg went off the bed and the rest of me went with. I told (CNA #5) that I was starting to slip off the bed. She tried to hold me up by my torso, but I outweigh her, and I went down. I landed on both of my knees and the rest of me fell to the floor as well. It was an accident. I felt pain in both of my knees, but my right leg hurts more than the left. CNA #5, statement dated 5/12/2020 documented, in pertinent part: After giving the resident a shower I placed her back in bed and began the dressing process for her. When I rolled her facing the door, her legs came off the bed and I could not control them. Her feet began to push me backwards and her upper body began to slip from the bed. I was trying to control her head and upper body, she was lowered to the floor onto her knees. I lowered her to the floor and called for help. I was alone in the room. I got her up to the shower with the full body lift alone. After her shower, I placed her back to bed with the full body lift, alone. Yes I am aware (the resident needs two person assistance). She is a large and heavy patient and I knew by the process of deduction that she would need 2 people to help. It was just a lack in judgment to get my work done. The investigation report signed by the ANHA documented: -Summary of alleged incident, in pertinent part: On 5/12/2020 the resident was on the floor landing on her knees and fracturing her left distal femur. Staff stated she knew the resident was a 2-person assist for bed mobility but she chose not to use a second person. -Conclusion: Failure on the part of staff to follow care plan or exercise good judgement in her duties resulted in major injury in the form of a

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F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 4) fracture to this resident. Neglect is substantiated. 4.Staff interview Licensed practical nurse (LPN) #5 was interviewed on 5/15/2020 at10:05 a.m. She said she was the nurse working the night Resident #3 fell . She said she immediately implemented that all CNAs must go in with another CNA regardless of the residents bed mobility. 5.Facility follow-up The Facility Past-Non-Compliance checklist dated 5/13/2020 documented the facility would complete the following: -Identify CNA's role in reviewing and following Kardex (CNA communication for residents); -Identify bed mobility procedure; -Education initiated with CNAs on Bed Mobility Procedure including obtaining additional assistance and needed equipment as indicated and following the Kardex and appropriate documentation; and -The facility will monitor residents who require assistance with bed mobility and audit that staff are following the Kardex and documenting appropriately.
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** Based on record review and interviews, the facility failed to establish certified nurse aides (CNAs) were able to demonstrate the skills and competencies needed to provide resident care for two out of five CNAs reviewed. Specifically, the facility failed to ensure that all CNAs working in the facility had completed required training and were oriented to the specific needs of the residents in the facility. Cross reference to F600: failure to create an environment that was free of abuse and neglect. Cross reference to F835: failure to have sufficient administrative oversight which led to deficient practice. Findings include: I. Facility policy and procedure The facility ' s Employee Development policy, revised 12/2019, from page 45 of the facility ' s employee handbook, was provided by the director of nursing (DON) on 5/22/2020 at 4:25 p.m. It read in pertinent part, Ongoing training is necessary to provide the highest level of quality care to our patients/residents. You (staff) will be responsible be responsible for participating in training related to your position. Your supervisor/ or the HR (human resources) designee will communicate those requirements to you. II. Record review Training records for CNA #1, #2, #3, #4 and #5 were provided by the nursing home administrator assistant (NHA) on 5/22/2020 at 4:48 p.m. All five CNAs reviewed were permanent facility staff that had worked at the facility for more than one year. The records revealed that CNA #1, CNA #4 and CNA #5 had not completed 12 hours of required annual training. CNA #4 had not received required annual training on abuse and neglect or dementia care. The records failed to include evidence the facility had a process to establish staff competencies in the performance of basic and specific skills in order to meet the needs of its residents. III. Staff interviews CNA #3 was interviewed on 5/21/2020 at 5:43 p.m. He said that, as a CNA, his responsibilities included meeting the individual care needs of each resident and assisting with activities of daily living (ADLs). He said he had completed annual training on resident care needs as required to do his work. The nursing home administrator (NHA), assistant nursing home administrator (ANHA) and DON were interviewed on 5/27/2020 at 9:03 a.m. The DON said that charge nurses, unit managers were responsible for CNA oversight and providing education on the units if there were identified issues with performance. She said the staff development coordinator (SDC) was responsible for staff education oversight and the human resources (HR) department was responsible for tracking nursing staff training. The NHA said that staff turnover and an HR personnel ' s leave of absence had created lapses in the oversight of staff training. The ANHA said that she was working in HR for interim support. She said that training was assigned quarterly and staff were provided with verbal reminders during staff meetings that training needed to be completed. She said if it was found that a staff member had not completed the required training, they would be taken off the floor until it was completed.
F 0835 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** Based on observation, record review, and interview, the facility was not administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the facility failed to provide sufficient leadership to address and/or avoid significant concerns. Findings include: I. Freedom from abuse Cross-reference F600: Facility administration failed to protect residents from abuse which included physical staff-to-resident abuse. Cross-reference F610: Facility administration failed to thoroughly investigate an allegation of abuse. II. Resident Rights Cross-reference F550: Facility administration failed to ensure residents who resided on the secure unit were treated with dignity and respect. III. Quality of Care Cross reference F689: Facility administration failed to ensure residents were free from accidents which caused major injury. IV. Nursing services Cross-reference F726: Facility administration failed to ensure CNAs working in the facility had completed required training and were oriented to the specific needs of the residents in the facility. V. Infection control Cross-reference F880: Facility administration failed to ensure that social distancing was maintained amongst residents who resided in the secure unit; and residents wore face coverings when outside of their rooms who reside in the secure unit. VI. Leadership interview The regional director of operations (RDO) was interviewed on 5/28/2020 at 3:30 p.m. She said the facility had been through several nursing home administrators (NHAs) and currently had a director of nursing (DON) who was new in her role. She also said they were still working on their plan of correction for their last recertification survey in March 2020. She said the ANHA was also new and very inexperienced. She said that they had just posted a permanent NHA position and hoped they were able to get back on track.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on observation and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of Coronavirus disease (COVID-19) and infection. Specifically the facility failed to: -Maintain social distancing amongst residents who reside in the secure unit; and -Ensure that residents wore face coverings when outside of their rooms who reside in the secure unit. Findings include: I. Improper resident social distancing, mask use and hand hygiene A. Professional standards The Centers for Disease and Prevention (CDC) Hand Hygiene in Healthcare Settings, last updated 4/15/2020, retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-strategies.html included the guidance that long term care facilities ensure all residents wear a cloth face covering for source control whenever they leave their room or are around others, including whenever they leave the facility for essential medical appointments. Additional measures included that facilities should cancel communal dining and all group activities. Residents should be reminded to practice social distancing. The CDC Hand Hygiene in Healthcare Settings, last up updated 4/15/2020, retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-strategies.html included additional the measure that facilities should remind residents to perform frequent hand hygiene B. Observations and staff interviews 1. 5/15/2020 on the secure unit -At 10:22 a.m. observations were made of the dining room/common area in the secure unit; four of the six tables were occupied by residents. One table had two residents, approximately two feet apart. Another table had three residents, two approximately two feet apart and a third resident three feet from the resident. The third table had five residents sitting approximately one foot apart; three of the residents were sleeping. The final table had two residents, two feet apart. -At 1:45 p.m. in the television room there were three residents facing the television sitting approximately one foot apart. -None of the residents during either observation were wearing masks. -Licensed practical nurse (LPN) #1 was interviewed at 10:22 a.m. and said they had never offered masks to the residents because they wouldn ' t keep the mask on. She said they did not encourage social distancing on the secure unit because they are a very different population (residents of the secure unit) and they would just get up and sit back together. She said, as staff we provide the social distancing with residents by staying six feet away from them. LPN #1 agreed many of the residents were currently sleeping and perhaps would not notice if they were moved. RN #1walked by at this time and agreed with LPN #1 and said because the residents on the secure unit are such a different population they would not keep masks on or stay at a certain table if they were encouraged to move. -Certified nurse aide (CNA) #6 was interviewed at 10:30 a.m. She said all of the residents who reside on the secure unit do not keep masks on, which was why they did not have masks on. 2. 5/21/2020 on the secure unit -At 5:24 p.m. 16 residents were observed dining in the dining room. None of the residents wore masks. Six tables were pushed together to form three larger tables, which allowed for more residents to sit together. At the first table there were four residents sitting with three staff who were providing meal assistance. At the other tables there were four

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) residents who sat together, a table with five residents, a table with two residents and one male resident sat alone at a table. -At 5:36 residents began getting up the tables in the dining room and staff provided assistance to get up to go to their rooms or the television room. Staff did not provide support to the residents to perform hand sanitization after they finished their meals and moved to other areas of the unit. -At 5:48 p.m. three residents sat together in the television room less than six feet apart from one another. The chairs in which the residents sat were positioned so that they were less than six feet apart. None of the residents wore masks. 3. 5/22/2020 on the secure unit -At 9:49 a.m. eight residents were seated in the dining room. None of the residents wore masks. Three residents sat with two staff at one table, four residents sat together at another table and at another table two residents sat together. -At 12:32 p.m. eighteen residents were eating in the dining room. None of the residents wore masks. One table had four residents seated together while the other tables had two residents at each table. -At 1:16 p.m. staff assisted residents from the dining room to the television room where three residents were seated next to each other less than six feet apart. None of the residents wore masks. C. Staff interviews The nursing home administrator (NHA), director of nursing (DON) and assistant nursing home administrator (ANHA) were interviewed on 5/27/2020 at 9:03 a.m. The NHA said he had found some guidance from the state health department ' s website on how to approach infection control on secured memory units and he planned to enact this guidance at the facility, however, had not yet done so. He said the facility followed the CDC ' s guidance but said the facility had struggled to enact infection control measures such as social distancing on their secured unit. He said that adjusting the placement of furniture where residents sat was a measure they planned to make immediately. The DON said that she did not think the residents on the unit would move chairs or furniture if it was repositioned to promote distancing. She said that more specialized dementia training for staff working on the unit would help staff to redirect residents and promote social distancing.