STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035250	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IMMANUEL CAMPUS OF CARE	**11301 NORTH 99TH AVENUE PEORIA, AZ 85345**

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 0578 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility to ensure one resident's (#136) advanced directive was consistent in the clinical record. The deficient practice could result in the residents not receiving emergent services which would be against the residents' wishes. Findings include: Resident #136 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The nursing note dated February 17, 2020 revealed the resident was alert and oriented. The note also revealed information received from the hospital included the resident was a Do Not Resuscitate (DNR). The note included the code status was not obtained because the resident was now thinking of changing her code status from a DNR. The note also included the resident was informed that she will be treated as a full code until she provided a written consent of her decision. However, the physician order [REDACTED]. The baseline care plan dated February 17, 2020 included the resident was alert and cognitively intact and had a code status of full code. Review of the Advance Directive Acknowledgement form signed by the resident on February 18, 2020 revealed the resident circled the box for No as a response for the section on Do Not Resuscitate (DNR) order. The electronic resident profile on March 9, 2020 at 12:52 p.m. included a code status of DNR. A nursing note dated March 9, 2020 at 1:16 p.m. revealed the resident now wants to have a code status of partial DNR; that she does not want life support. The note included it was explained to the resident that they do not have a partial DNR. The note also included the physician was notified the resident requests full code status and an order was obtained. A physician order [REDACTED]. In an interview conducted with a licensed practical nurse (LPN/staff #37) on March 9, 2020 at 12:44 p.m., she stated the resident was a full code status unless the resident had changed her mind after the most recent hospitalization . After reviewing the clinical record, staff #37 stated once the resident signed the Advance Directive Acknowledgement form on February 18, 2020, the code status in the clinical record should reflect the resident was a full code. An interview was conducted with the Director of Nursing (DON/staff #) on March 11, 2020 at 10:58 a.m. The Executive Director and the assistant DON (ADON/staff #94) were present during the interview. The DON stated the social services staff is responsible for ensuring Advance Directives are completed and signed by the resident upon admission. She further stated that the clinical record should be consistent regarding the resident's choice for code status. The ADON stated a physician order [REDACTED]. The facilty's policy titled Advance Directives revised December 2016 revealed Advance Directives will be respected in accordance with State law and facility policy. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive.
F 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 staff interviews, facility documentation, clinical record review, and policy review, the facility failed to ensure one of five sampled residents (#116) was free from verbal abuse by staff. The deficient practice could result in residents being verbally abused by staff. Findings include: Resident #116 was admitted on [DATE] and readmitted on [DATE], with [DIAGNOSES REDACTED]. Review of the care plan revised May 31, 2018 revealed the resident required extensive assistance with many activities of daily living. The goal was that the resident would maintain current level of function in all activities of daily living. Interventions included the resident required extensive assistance by staff for toileting and incontinence care and encouraging the resident to participate to the fullest extent possible with each interaction. The care plan revised on June 16, 2018 revealed the resident was at risk for falls related to unsteady balance with transfers, needing extensive hands-on assistance from staff for transfers from one surface to another, history of falls, generalized weakness and limited mobility. The goal was that the resident risk for falls will be minimized. Interventions included anticipating and meeting the resident's needs. Continued review of the care plan revised on August 30, 2018 revealed the resident wished to return home with family. The goal was that the resident would communicate an understanding of the discharge plan and describe the desired outcome. Interventions included monitoring for and addressing episodes of anxiety, fear, and distress. A quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 14 which indicated the resident was cognitively intact. The MDS assessment included the resident had adequate hearing, was incontinent of bowel, and required extensive assistance of 2 persons for toileting. Review of a behavior note written by an LPN (Licensed Practical Nurse/staff #207) dated December 24, 2019 at 10:47 a.m., revealed resident #116 was non-compliant with dietary orders and that staff continues to educate the resident. The note included the resident continues to eat junk food and dairy on a daily basis. The note also revealed the resident did not want to go to [MEDICAL TREATMENT], and that a unit manager convinced the resident to get up for [MEDICAL TREATMENT]. Another behavior note written by staff #207 dated December 24, 2019 at 11:12 a.m., revealed the resident had 2 loose stools and one soft stool. The note included staff continues educating the resident on dietary choices and that the resident remains non-compliant. The facility's Reportable Event Record/Report dated January 2, 2020 revealed that on December 24, 2019 at 11:00 a.m., resident #116 stated she was not going to [MEDICAL TREATMENT] after having a second bowel movement. Staff #207 stated that she began educating the resident on dietary choices and that she sent a text message to the Unit Manager (staff #79) that the resident was refusing to go to [MEDICAL TREATMENT]. The report included that when staff #79 arrived to the resident's room, she overheard staff #207 scolding the resident, who was defending her choice to refuse going to the [MEDICAL TREATMENT] appointment. The report included staff #79 asked the resident if she was going to her appointment and that the resident replied no. Staff #207 left the room. The report included staff #79 then asked the resident what was wrong and that the resident expressed concern regarding having another bowel movement. Staff #79 reassured the resident that they would make sure the resident was clean and changed before she left. The report revealed the resident then stated that she was afraid of staff #207. Staff #79 consoled the resident who then agreed to go to [MEDICAL TREATMENT] if staff #79 would stay with her. The report included staff #79 stayed with the resident until she left for her appointment. Staff #79 met with staff #207 and informed staff #207 that she was not happy with what she overheard and that the resident was afraid of her because of the way she had spoken to the resident. Staff #207 defended her statements by stating the resident

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** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) always behaves this way and admitted that she might have been a little loud but that the resident does not always hear her. Staff #79 reported the incident to the Director of Nursing (DON/staff #72). The report included that staff #207 was removed from duty, and the facility investigator substantiated the allegation of abuse. The report included a statement from staff #79 dated December 24, 2019. Staff #79 stated that on December 24th at approximately 10:45 a.m., she received a text from staff #207 that the resident decided not to go to [MEDICAL TREATMENT]. As she was approaching the resident's room, she saw staff #207 facing the resident, yelling at the resident and that staff #207's tone was very harsh. The statement included that when staff #207 saw staff #79, staff #207 continued in a lower tone of voice. The statement also included that after staff #207 left, the resident stated that she would appreciate it if staff #79 would stay with her because she was very afraid of staff #207. Continued review of the report included a statement dated December 24, 2019 from staff #207. Staff #207 stated that after having a second bowel movement, the resident stated that she was not going to [MEDICAL TREATMENT]. Staff #207 stated that she began educating the resident on dietary choices and that she was talking a little loudly because sometimes the resident hears her and sometimes the resident does not hear her. The statement included that when asked if she felt her tone was harsh with the resident, staff #207 replied yes. Review of the personnel record for staff #207 revealed a disciplinary report dated January 9, 2020 that staff #207 was witnessed by her supervisor scolding a resident in a manner which was inappropriate in both tone and volume. The report included staff #207 was terminated from employment. An interview was conducted with staff #79 on March 6, 2020 at 1:30 p.m. She stated that while she was doing rounds on the unit she stopped outside of the resident's room due to shouting in the room that could be heard in the hallway. Staff #79 stated that when she looked into the room she observed staff #207 leaning over the resident's bed talking with her hands and shouting at the resident. Staff #79 stated that staff #207 was saying You always ask for things, you always eat junk food then you refuse [MEDICAL TREATMENT]! in a loud angry manner to the resident. Staff #79 stated when staff #207 turned around and saw her standing in the doorway; she stopped shouting at the resident and stepped outside of the room. Staff #79 stated she asked staff #207 why she was yelling at the resident and that staff #207 stated, in a very loud voice audible to the resident, that she told the resident about not following her diet and refusing [MEDICAL TREATMENT]. Staff #79 stated that when she interviewed the resident, the resident stated she was scared and afraid of staff #207. Staff #79 stated the resident said all she wanted to do was to go to the bathroom before [MEDICAL TREATMENT], or else she did not want to go to [MEDICAL TREATMENT]. Staff #79 stated that the resident's roommate was not in the room, and no other staff was in the room at the time of the incident. During an interview conducted on March 6, 2020 at 2:15 p.m. with staff #207, she stated that when the incident occurred on December 24, 2019 at 11:00 a.m. she had already been in the resident's room [ROOM NUMBER]-5 times that day and that the resident kept changing her mind about whether or not she was going to [MEDICAL TREATMENT]. Staff #207 stated the resident had been educated by the nurse and by dietary multiple times but that the resident kept making bad decisions regarding her diet and eating junk food which was causing diarrhea. Staff #207 stated she was aware a nurse had accused her of speaking loudly to the resident but that it was that nurse's opinion. She stated that she did not yell at the resident. In an interview conducted with the DON on March 6, 2020 at 3:00 p.m., the DON stated staff #207 had been expressing frustration at the resident without intentionally trying to harm the resident. The DON further stated they substantiated abuse had occurred and that is why staff #207 was terminated from employment. The facility's policy and procedure titled Abuse Program Policy and Procedure revealed the residents have the right to be free from abuse, the facility will not condone any form of resident abuse and residents must not be subjected to abuse by anyone including but not limited to facility staff. The policy included that verbal abuse is defined as the use of oral, written or gestured language that willfully uses disparaging and derogatory terms to residents within their hearing distance regardless of their age, ability to comprehend, or disability. The policy also included examples of verbal abuse include but are not limited to saying things to frighten a resident.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and the RAI (Resident Assessment Instrument) manual, the facility failed to ensure MDS (Minimum Data Set) assessments were accurate for one resident (#9) regarding limitation in range of motion (ROM). The deficient practice could affect continuity of care and result in data that is not accurate for quality monitoring. Findings include: Resident #9 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the clinical record revealed an OT (occupational therapy) evaluation for SOC (start of care) dated December 17, 2018. The musculoskeletal assessment included the resident had impaired ROM of the right and left upper extremity; and that the functional limitation present was due to contracture. The evaluation included the resident was at risk for decreased participation with functional tasks and further decline in function. However, review of the quarterly MDS assessments dated March 9, 2019 and June 9, 2019 revealed the assessment was coded for no functional limitation in ROM to the bilateral upper extremity which includes the shoulder, elbow, wrist and hand. The assessment dated [DATE] included the resident required extensive assistance with bed mobility, dressing and eating and was totally dependent for transfers, toilet use and personal hygiene. The assessment dated [DATE] revealed the resident was totally dependent for bed mobility, transfers, dressing, toilet use and personal hygiene and required extensive assistance with eating. Another OT Plan of Care for SOC date of June 18, 2019 revealed the resident was referred to skilled OT evaluation for bilateral hand contractures, bilateral upper extremity tone and decreased functional use with self-care activities, weakness and contracture prevention. The baseline care plan dated [DATE], 2019 included the resident was cognitively intact and had OT orders for bilateral hand contractures. A health status note dated July 10, 2019 included an order was received for an OT evaluation and treatment for [REDACTED]. Review of the Braden/Clinical Risk Progress Note dated December 3, 2019 revealed the resident was at risk for skin integrity occurrence and that contractures was among the risk factors identified. However, review of the quarterly MDS assessment dated [DATE] and the annual MDS assessment dated [DATE] revealed the resident had no impairment in functional limitation in ROM of the bilateral upper extremity. The assessment dated [DATE] revealed the resident was totally dependent for bed mobility, transfers, dressing, toilet use and personal hygiene and required extensive assistance with eating. The assessment dated [DATE] revealed the resident was totally dependent for transfers, dressing, toilet use and personal hygiene and required extensive assistance with eating and bed mobility. The quarterly MDS assessment dated [DATE] revealed the assessment was coded for impairment in functional limitation in ROM of the bilateral upper extremity. An interview was conducted with the MDS coordinator (staff #24) on March 11, 2020 at 10:11 a.m. Staff #24 stated that she reviews and obtains information from the hospital records and the clinical record to code MDS assessments. She also stated that she utilizes information obtained from the resident and staff interviews she conducts. She further stated she uses the RAI manual for guidance in coding MDS assessments. Staff #24 stated contractures that interferes with daily function or places the resident at risk for injury are coded under the functional limitation in ROM. Staff #24 further stated that she could not speak to resident #9's MDS assessments before January 2020, because she was hired at the end of January 2020. During an interview conducted with the administrator (staff #19) on March 11, 2020 at 12:15 p.m., he stated the residents' limitation in ROM should be coded accurately on the MDS assessments. The RAI manual revealed that if a resident is observed to have limitation of the upper and/or lower extremity ROM, review the section of the MDS assessment for Activities of Daily Living (ADL) assistance and/or directly observe the resident to determine if the limitation interferes with function or places the resident at risk for injury. The RAI manual instructs to code the MDS assessment if the resident has impairment in ROM that interferes with daily functioning or places the resident at risk of injury. The RAI manual also included it is required that the assessment accurately reflects the resident's status and that the importance of accurately completing and submitting the MDS assessment cannot be over emphasized.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews and policies and procedures, the facility failed to ensure that a comprehensive person-centered care plan with interventions was developed for one resident (#9), with contractures and limited range of motion. The deficient practice could result in resident needs not being identified and interventions implemented. Findings include: Resident #9 was readmitted to the facility on [DATE] and on [DATE], 2019, with [DIAGNOSES REDACTED]. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had moderate cognitive impairment and required total dependence with bed mobility and transfers, and extensive assistance with

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F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) eating. Per the MDS, the resident did not have limited range of motion (ROM) to upper or lower extremities. However, the OT (occupational therapy) Plan of Care with a start of care date of June 18, 2019, included the resident was referred to skilled OT for an evaluation for bilateral hand contractures, bilateral upper extremity tone and decreased functional use with self-care activities, weakness and contracture prevention. A nursing note dated [DATE] revealed the resident was sent to the hospital at 6:15 p.m. A nursing note dated [DATE], 2019 included the resident returned from the hospital. According to a baseline care plan dated [DATE], 2019, the resident was cognitively intact and had OT orders for bilateral hand contractures. A health status note dated July 10, 2019 included an order for [REDACTED]. Review of a comprehensive care plan revealed the resident required extensive assistance with many of her ADL's (activities of daily living) related to generalized weakness. A goal included the resident would maintain current level of functioning with ADL's. Interventions included extensive assistance with showers, turning and repositioning, dressing, personal hygiene and oral care and transfers. This care plan did not address that the resident had contractures or limited ROM. Further review of the resident's comprehensive care plans revealed that no care plan had been developed to address the resident's contracture or limitation in ROM, nor did they include any interventions related to contractures/limited ROM. During an observation conducted on March 4, 2020 at 9:05 a.m., the resident was sitting in a high back wheelchair and her right and left wrists and hands were contracted, and no rolled washcloths were in place. A later observation was conducted at 2:49 p.m., and the resident did not have any rolled washcloths in place to the right and left hands. On [DATE] at 10:27 a.m., the resident was observed sitting in a high back wheelchair by the nurse station. The resident's right hand was tucked underneath the blanket and her left hand was in a closed fist position, with her left wrist bent forward. There was no rolled washcloth in place to the left hand. In an interview conducted on [DATE] at 10:33 a.m. the resident stated therapy comes to her room and provides her treatment and exercises for her hand at least three times a week. She stated she has something to place in both of her hands, but she does not know where it is. An observation was conducted on [DATE] at 12:59 p.m. of the resident sitting in a high back wheelchair at the nurse's station. The resident had a rolled washcloth in the left hand and the right wrist was bent forward and fingers were extended. However, there was no rolled washcloth in place to the right hand. An interview with a licensed practical nurse (LPN/staff #33) and the unit manager (staff #89) was conducted on March 11, 2020 at 9:59 a.m. Both staff stated that when a resident is admitted , a care plan is created to reflect the needs of the resident. They stated once the care plan is developed, it can be revised if there are changes in the resident's condition by any nurse if needed. Both staff stated if a resident has limitation in ROM and/or the presence of contractures, this would definitely be care planned, with interventions. During an interview with the MDS Coordinator (staff #24) conducted on March 11, 2020 at 10:11 a.m., she stated that a care plan is based on what is triggered in the MDS assessment and that the areas are identified during the review of the clinical record. She stated limitation in ROM will be care planned if it triggered and/or was identified, and that the nurses can revise the care plan as needed. She stated she is responsible in developing the comprehensive care plan. During the interview, a review of the clinical record was conducted with staff #24. She said that the MDS assessments of resident #9 did not code the resident with limitations in ROM and as a result, it was not care planned. She said that she does not know why and that she has only worked at the facility since the end of January 2020. Review of a policy regarding Comprehensive Care Plans revealed that an individualized comprehensive care plan which includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to the MDS. The policy stated that each comprehensive care plan is designed to incorporate identified problem areas and risks factors associated with identified problems, reflect treatment goals, timetables and objectives in measurable outcomes, aid in preventing or reducing declines in the resident's functional status and/or functional levels and enhance the optimal functioning of the resident, by focusing on a rehabilitative program. Further, the policy included that assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change.
F 0688 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review and resident and staff interviews, the facility failed to ensure that one of two sampled residents (#9) with contractures and limited range of motion (ROM) received the necessary treatment and services. The deficient practice could result in residents experiencing decrease in ROM and functioning. Findings include: Resident #9 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The baseline care plan dated [DATE], 2019 included the resident was cognitively intact and was totally dependent with ADL's (activities of daily living). Per the care plan, the resident had OT (occupational therapy) orders for bilateral hand contractures. A health status note dated July 10, 2019 included that an order was received for an OT evaluation and treatment for [REDACTED]. According to the documentation, contracture was one of the risk factors identified. Review of the OT plan of care dated July 15, 2019 revealed the resident was referred to skilled OT for bilateral hand contractures, with bilateral upper extremity tone and decreased functional use with self-care activities, weakness and contracture prevention, indicating the need for OT for self-care skills and therapeutic exercises. The OT plan of care also included: -Right wrist slightly flexed but can get to neutral with stretch -Right hands and fingers with poor grip and extension -Left wrist flexed position -Left hand flexed and pointer finger extended. The OT evaluation further included that without therapy the patient was at risk for increased need of care and contractures. The current level of function included the resident demonstrates poor PROM (passive ROM) to both upper extremities, was at risk for bilateral hand contractures, and that there were no splints at this time. Goals included the resident would increase ROM to bilateral upper extremities to prevent contractures, achieve functional ROM for daily living and to fit for splints to bilateral hands as needed for contracture prevention to increase ROM and for staff to manage determined splint use. Review of the OT discharge summary dated August 22, 2019 revealed the resident was discharged because progress ceased. According to the documentation, goals were not met because resident chose not to participate in PROM and that the resident had not received any splints. The note stated that education was initiated with nursing focusing on rolled washcloth placement to bilateral hands to prevent further contractures and increase skin protection. Impacts on burden of care/daily life revealed contributing factors which included self-limiting behaviors prevent the resident from achieving all established goals. The OT discharge plan and instruction included continue hand protection with rolled washcloth. The quarterly MDS (Minimum Data Set) assessment dated [DATE] included a BI[CONDITION] (Brief Interview for Mental Status) score of 8, which indicated the resident had moderate cognitive impairment. Per the assessment, the resident did not have functional limitation in ROM to the upper extremity, which included the wrist and hand. Review of the resident's comprehensive care plans revealed that the resident was not care planned for any interventions related to contractures. There were also no care plans that identified that the resident was non compliant or refused care or treatments. In addition, there was no clinical record documentation regarding the placement of washcloths in the resident's hands, as recommended by OT from August 23, 2019 through [DATE]. There was also no evidence that the resident refused placement of the washcloths to her hands. Further, there was no documentation of the reason why the recommendation was not implemented and no documentation that the physician was notified. An observation was conducted on March 4, 2020 at 9:05 a.m., of the resident sitting in her high back wheelchair. The resident's right and left wrists and hands were contracted and there were no rolled washcloths in place. Another observation of the resident was conducted on March 4, 2020 at 2:49 p.m., and there were no rolled washcloths in place to the right and left hands. An observation was conducted on [DATE] at 10:27 a.m. of the resident sitting in a high back wheelchair, by the nurse's station. The resident's right hand was tucked underneath a blanket, however, her left hand was in a closed fist position with her left wrist bent forward. There was no rolled washcloth in place to the left hand. In an interview conducted on [DATE] at 10:33 a.m., the resident stated that therapy comes to her room and provides treatment and exercises for her hand at least three times a week. She stated there is something to place in both hands, but she does not know where it is. An observation was conducted on [DATE] at 12:59 p.m. of the resident sitting in a high back wheelchair at the nurse's station. The resident had a rolled washcloth in the left hand and the right wrist was bent forward and fingers were extended. However, there was no rolled washcloth in place to the right hand. An interview with a CNA (staff #87) was conducted on March 11, 2020 at 9:06 a.m. Staff #87 said the resident was alert and oriented, can tell staff her needs and wants and has behaviors of yelling or screaming. She stated sometimes when the resident screams or yells, it is because she is in pain which is usually from her

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) hands. She stated the resident is a total assist with all ADL's and is assisted with feeding, because the resident cannot do it on her own. She stated the resident is on and off of therapy and for awhile therapy recommended a rolled washcloth in the resident's hand, but it did not work. She stated therapy also tried a tube that was placed in her hands and then inflated; however, this also did not work. She stated the resident is not on any RNA (restorative nursing assistant) program or therapy. She said the resident cannot move both wrists and fingers. She said that she tries to put a rolled washcloth in the resident's hands and keep it there all day, but this task is not something that she needs to do on a daily basis. She further stated that she did not think the placement of rolled washcloths has been documented in the clinical record in the past. An interview with the Director of Nursing (DON/staff #72) and a RNA (staff #11) was conducted on March 11, 2020 at 11:33 a.m. Staff #11 stated the resident is not under RNA and if there's an order for [REDACTED]. The DON stated the placement of rolled washcloth does not require a physician's orders [REDACTED]. The DON said that the use of rolled washcloths to the resident's bilateral hands was recommended by OT. However, she stated that it was also documented that the resident had self-limiting behaviors which prevented the resident from achieving goals. She stated the resident refused to have the rolled washcloths be placed in her hands and that the placement of the rolled washcloths were not documented anywhere in the clinical record. The DON was unable to provide any additional documentation that the resident refused to have the washcloths in her hands. A request was made for CNA and RNA documentation of tasks provided to this resident. However, on March 11, 2020 at 12:20 p.m., the medical record supervisor (staff #8) stated she was unable to print this documentation, due to a software issue. On March 11, 2020 at 11:34 a.m., a request was made for policies regarding the facility's RNA program to include implementation and documentation, treatment of [REDACTED]. However, at 12:25 p.m. the assistant DON (staff #94) stated the facility does not have policies on these topics.
F 0925 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.** Based on observations, staff interviews, review of facility records and policies and procedures, the facility failed to maintain an effective pest control program to ensure the facility was free of rodents. The deficient practice could result in ongoing rodent problems. Findings include: Review of the facility pest control log dated December 21, 2019 through March 3, 2020 revealed the following entries: -On December 22: Rm 432 Rats and the room had been sprayed. -On December 30: Rodents were found in the kitchen, rodent traps were checked and dead rodents removed. Glue boards were placed and traps were reset. -On January 3, 2020: Glue boards were placed under counters and a Nest was located in ceiling. -On January 9: Rm 432 Rats and the room had been sprayed. -On January 17: Kitchen Rats and that 6 dead rodents had been removed from the ceiling. -On January 22: Rats in Hallway and that the pest control specialist had spoken with maintenance staff about possible entry points. -On February 9: Rats seen in Hallway. -On February 10: Entries included Rm 218 Rat Rats in Ceiling and Activities Lounge Rats. The entries included that 4 rodents had been removed. -On February 12: Staff reported that Rats sound like (they are) falling through Ceiling and that this was at a nurses station. -On February 17: Entries included 432 Rats and that dead rats were removed from above a nurses station. -On March 1: hear rats above unit. -On March 2: Med Room Rat. During an interview conducted on March 5, 2020 at 8:20 a.m. with the Maintenance Director (staff #206), he stated that rats had nested in a tree located between two resident buildings in December 2019 and in January 2020. He said when the tree was trimmed, staff noticed the rats had moved inside of the facility. Staff #206 stated that they have been working closely with a pest control company since December 2019 to eradicate the rats, and that the pest control comes at least weekly to remove dead rats and to set more traps. Staff #206 stated the pest control problem persisted but has improved, and that resident's had not come into contact with any rats. An observation was conducted on March 5, 2020 at 8:25 a.m., with staff #206 of a section of the hallway ceiling space located in an area adjacent to the Human Resources and Business offices. During the observation, staff #206 removed a large ceiling tile. A flashlight was used to illuminate the ceiling space, which revealed numerous rodent droppings covering the top-side of the ceiling tiles. In addition, there were numerous small yellow spots among the droppings, with an odor of urine. During this observation, a surveyor located in a conference room down the hallway from the ceiling observation area, heard noises in the ceiling located above the Board Room, indicating that a small animal was running across the ceiling, followed by a squeaking noise emanating from a vent in the conference room ceiling. A kitchen observation was conducted on March 6, 2020 at 9:10 a.m. During the observation, numerous rodent droppings were observed on the main kitchen floor in high traffic areas. There were also clusters of rodent droppings on the floor of the dry storage room in the corners and underneath the food storage shelves. During an interview conducted on March 6, 2020 at 9:25 a.m. with the Dietary Director (staff #208), she stated that rats had been caught in the ceiling over the kitchen area, but none had been caught or actually seen in the kitchen. Staff #208 stated that she was not aware that there were rodent droppings on the kitchen floor, under the steam table and on the floor in the dry storage room. Review of a policy and procedure titled, Pest Control revealed a statement that the facility shall maintain an effective pest control program. A policy and procedure titled, Food Storage included that staff are to check for pest infestation regularly. The policy stated that there should be a monthly pest control program in place with documentation that services were provided. If there was a pest infestation problem, steps for eradicating the problem should be in place. The policy included that the walls, ceiling and floor should be maintained in good repair and regularly cleaned.