

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 314020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 9/14/2022
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NAME OF PROVIDER OR SUPPLIER MISSION POINT NSG & PHY REHAB CTR OF HANCOCK	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 POPLAR ST HANCOCK, MI 49930
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F0000 SS=	INITIAL COMMENTS Mission Point at Hancock was surveyed for an abbreviated survey on 9/14/22. Intakes: MI00130451, MI00130427, MI00130213, MI00129738, MI00130890, MI00130578, MI00130567, MI00129506, MI00130887, MI00129110, MI00131016, MI00131019 Census=42	F0000		
F0600 SS= L	Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: This deficient practice pertains to the following Intakes: #MI00130890, #MI00130578, #MI00130567, #MI00130451, #MI00130427, #MI00130213, #MI00129738, #MI00129110, AND #MI00131016. This citation has two deficient practice statements (DPS's): DPS A and DPS B. Deficient Practice Statement A: Based on observation, interview, and record	F0600		

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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	<p>review the facility failed to provide necessary structures to provide goods and services to meet the needs of all residents as evidenced by:</p> <ol style="list-style-type: none"> 1. Insufficient nursing staff to meet resident needs. 2. Failure to follow protocols related to turning and repositioning, checking and changing of briefs, showers, and basic supervision and care needs. 3. Failure to timely pay facility vendors to ensure supply chain fluidity. 4. Failure to maintain facility environmental safety, function, and order for all facility residents. <p>This deficient practice resulted in wide-spread neglect of all 42 facility residents at a level of immediate jeopardy.</p> <p>Findings include:</p> <p>Due to the critical content of the interviews and evidence provided during this survey with repeated verbalization of resident and staff concerns related to potential retaliation by the facility, all staff will be identified as "Staff" unless the position title is critical to deficiency understanding.</p> <p>Insufficient Staff for Resident Needs</p> <p>During a telephone interview on 9/6/22 at 5:22 p.m., Complainant "FF", a former resident of the facility who resided in the building for approximately five months said in June and July of 2022 the facility was very short of nursing staff, especially on the night shift. Complainant "FF" stated, "Once in a while there was only one</p>			

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	<p>nurse and one aide (all night)." Complainant "FF" said the concern was voiced to facility administration who said they were doing the best they could. Complainant "FF" said the Director of Nursing (DON) position was not filled promptly and stated, "Apparently nobody was in charge of the nursing things. I often had to wait for a respiratory treatment, and that made me short of breath and more anxious. I am incontinent and with one aide you may get changed once a night, and on afternoons you (I) had to wait over a half hour for a brief change with stool in it ... They had a couple of weeks where they had to cancel my appointment because the bus didn't work... They were forever running out of washcloths and face towels. With the showers, you never got the showers you were scheduled. I probably got a shower a month..." Complainant "FF" reported to staff wanting showers, but staff said they did not have time, and one of the resident shower rooms had been closed for repairs. "As far as I know the other bathroom (shower room) was still torn apart... With the food... I was supposed to be on a diabetic diet, and I would get half a plate of corn. They way over serve the starches and the mashed potatoes. They don't very often get fresh fruit and vegetables ..."</p> <p>During a telephone interview on 9/7/22 at 8:06 a.m., anonymous Complainant "EE", an advocacy organization employee, reported having been in the building approximately three to four weeks previous. Anonymous Complainant "EE" stated, "The day I was there many of the residents were fearful of the staffing situation (low staffing levels). One of the huge complaints I got was the (lack of) showering."</p> <p>Resident #59</p> <p>Review of Resident #59's Minimum Data Set (MDS) assessment, dated 3/22/22, revealed the</p>				

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	<p>Resident required extensive two-person assistance with bed mobility, dressing, toilet use, personal hygiene, and was totally dependent upon staff for bathing. Resident #59 scored 13 of 15 on the Bried Interview for Mental Status (BIMS) reflective of intact cognition.</p> <p>Review of Resident #59's Shower Task documentation in the Electronic Medical Record (EMR) for the last 30 days as of 9/12/22, revealed "Shower/Bathing/Bed Bath as Scheduled Monday & Thursday AM shift - use Ketoconazole 2% shampoo on Thursdays. Leave shampoo on for 3-5 minutes before rinsing". A shower was documented on 8/18/22 and 9/1/22, a bed bath on 8/25/22, with one "Resident Not Available" documented on 9/5/22.</p> <p>During an interview on 9/8/22 at 10:00 a.m., Emergency Staff "F" said she was working due to an emergency staffing crisis in the facility. Staff "F" said she felt emergency staff now working in the facility were like the last resort for a facility that is in a staffing crisis. Staff "F" said a Resident (Resident #59) died very recently while the emergency staffing aides were working in the building and noted Resident #59 had a pressure injury on her coccyx. Staff "F" said the emergency staffing aides would make sure to turn and reposition her when they were working, and when they left each day they would put a piece of paper underneath her, that would show if Resident #59 had been repositioned. Staff "F" said she did not believe Resident #59 was repositioned appropriately because they (emergency staffing aides) would come in and find the paper in the exact same place as they had placed it. Staff "F" said it was incredibly sad.</p> <p>Staff "N" stated in an interview on 9/8/22 at 3:20 p.m., "I was concerned Resident #59 was not getting the care she needed, and now she passed</p>			
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	<p>away".</p> <p>During a telephone interview on 9/11/22 at 2:00 p.m., Staff "N" confirmed the following concerns related to Resident #59, who was transferred out to the acute care hospital with emergency care needs:</p> <ol style="list-style-type: none"> 1. Prior to discharge to the hospital Resident #59 was observed to be dehydrated, with extremely dry oral mucosa, and was not observed to be offered sufficient oral hydration. 2. Resident #59 was not being timely changed and repositioned at nights, which was observed, reported, and education provided to the involved CNA's (Certified Nurse Aides) related to checking and changing briefs and repositioning of the resident. 3. Resident #59 was found wet, when she should have been checked and changed by inexperienced CNA staff. <p>Resident #62</p> <p>Review of Resident #62's EMR revealed she scored 15 of 15 on the BIMS reflective of intact cognition. Resident #62 required extensive two-person assistance with bed mobility, dressing, toilet use, personal hygiene, and was totally dependent upon staff for bathing. Resident #62 was always incontinent of urine, and frequently incontinent of stool. Active diagnoses included chronic kidney disease (Stage 4), and personal history of urinary (tract) infections.</p> <p>During an observation/interview on 9/8/22 at 2:58 p.m., when asked about care received in the facility, Resident #62 said she was not routinely receiving showers from the facility and had been left in a cold, wet brief for two and a half hours</p>			

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	<p>one night. Resident #62 said she has a problem with recurrent urinary tract infections, so sitting in a wet brief was a concern to her. Resident #62 was observed in bed wearing a hospital gown. Resident #62 said she had to be relocated from a different room because the previous room roof was leaking directly onto her bed. The Resident reported half of her personal belongs were still back in the other room, and she had not been moved back to that room (Room 109). She was unsure if the roof had been repaired.</p> <p>Review of Resident #62's care plans revealed, in part:</p> <p>"BRIEF USE: I use disposable incontinence products. Change daily, when soiled and PRN (as needed) ... Revision on 6/18/21."</p> <p>"INCONTINENT: Check me every 2 hours and as needed for episodes of incontinence ... Revision on: 6/18/2021."</p> <p>No shower interventions were documented in Resident #62's care plan.</p> <p>Review of the "Master Bath List" provided by the NHA of Record/Regional Director of Operations revealed Resident #62 was scheduled for twice-weekly showers on Tuesday PM and Saturday AM.</p> <p>Review of Resident #62's Shower Task documentation in the EMR revealed showers were performed three times in the last 30 days as of 9/12/22, on: 8/20 (Tuesday), 8/30 (Friday), and 9/3 (Monday).</p> <p>Review of Resident #62's Turning and Reposition Task Documentation in the EMR revealed not all shifts were documenting repositioning of this Resident, and on 8/14, 8/16, 8/20, 8/23, and 9/2</p>			

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	<p>documentation checked revealed Resident #62 was turned and repositioned "two times" during the shifts documented. Checks for "not applicable" were noted on 9/4, 9/5, and 9/10.</p> <p>Resident #51</p> <p>Review of Resident #51's Shower/Bathing/Bed Bath Schedule revealed the following: "I prefer to let staff know when I would like to shower. No alcohol gel for hand washing. Use only Dove/Ivory soap." POC Response History (staff documentation software) revealed Resident #51 only had one shower on 8/20/22. The form was absent any other staff documentation.</p> <p>Resident #52</p> <p>Review of Resident #52's complete EMR revealed a BIMS score of 15, reflective of intact cognition. Resident #52 MDS assessment documented extensive two-person assistance with bed mobility, transfers, dressing, toilet use, personal hygiene and "Bathing" was documented as "Physical help in part of bathing activity with one-person assistance". Resident #52 had active diagnoses that included urinary tract infections in the last 30 days.</p> <p>During an observation and interview on 9/9/22 at 3:48 p.m., Resident #52 self-propelled up to this Surveyor in his wheelchair and stated, loudly, "I really, really need a shower. I have been sick and had diarrhea, and I need to get cleaned up, but even the new aides say they don't have time to give me a shower. I get really mad when I have to ask and ask, and I need a shower and I don't get one." Resident #52 said several aides who had recently quit would get his showers done. Resident #52 stated, "Now, they don't get done."</p> <p>Review of Resident #52's Shower Task</p>			

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	<p>documentation in the EMR revealed a "Shower/Bathing Scheduled Wednesday & Saturday shift". During the previous 30 days, as of 9/12/22, Resident #52 received one shower on 8/27/22, one bed bath on 8/31, and was documented with three "not applicable" dates checked on 8/17, 8/20, and 9/3/22.</p> <p>Resident #53</p> <p>Review of Resident #53's complete EMR revealed a BIMS score of 15, reflective of intact cognition. Resident #53 MDS assessment documented extensive, two-person assistance with bed mobility, transfers, dressing, toilet use, and "Bathing" was documented as "Activity itself did not occur". Resident #53 had active diagnoses that included: end stage renal disease and urinary tract infections in the last 30 days.</p> <p>Review of Resident #53's Shower Task documentation in the EMR revealed a "Shower/Bathing Scheduled Monday & Friday AM shift". During the previous 30 days reviewed, Resident #53 received no showers, one bed bath on 9/5, and was documented as "refusing" on 8/15 and 9/2, with two "not applicable" dates checked on 8/12 and 9/9/22.</p> <p>Resident #54</p> <p>Review of Resident #54's complete EMR revealed a BIMS score of zero, indicative of severe cognitive impairment. Resident #54's MDS assessment, dated 8/2/22, revealed Resident #54 required extensive, two-person assistance with bed mobility, transfers, and toilet use. "Bathing" was documented as "Activity itself did not occur". Active diagnoses included Alzheimer's disease and non-Alzheimer's dementia.</p> <p>On 9/14/22 at 8:44 a.m., Resident #54 was in bed</p>			

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	<p>yelling out, "Help, help, help" repeatedly. No facility staff came and after 20 minutes the Resident gave up. The Resident was unable to/did not use her call light. There was an office just down from the room with management staff who did not come out of the office.</p> <p>Review of Resident #54's Shower Task documentation in the EMR for the last 30 days revealed one shower was given on 8/23, three bed baths, on 8/25, 9/1, and 9/4. "Resident Refused" was documented on 8/11, 8/14, 8/21, and 8/28. The Task was identified as "Shower/Bathing/Bed Bath as scheduled Sunday & Thursday AM Shift - I require physical help with part of bathing and sometimes total assistance".</p> <p>Resident #55</p> <p>Review of Resident #55's MDS assessment, dated 7/5/22, revealed the Resident required extensive two-person assistance with bed mobility, transfers, toilet use, and one-person physical help in part of bathing. Resident #55 scored 15 of 15 on the BIMS assessment reflective of intact cognition.</p> <p>During an interview on 9/7/22 at 3:01 p.m., when asked about showers in the facility, Resident #55 stated, "Sometimes I go two weeks without a shower. I (had) a shower day on Monday, and that was the first shower I had in 21 days." Resident #55 denied ever refusing a shower and said staff would tell him they did not have time to give him a shower. When asked about call light response times, Resident #55 said he would be on the toilet and press the call light for assistance. Someone would come and said they would find someone to help him right away. Nobody came, and he had to use the call light again. Resident #55 stated, "It is sometimes horrible at night here. Sometimes it is just the nurse here, and there is no</p>			
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	<p>aide." When asked about food, Resident #55 said the facility ran out of eggs, both fresh and hard boiled, they hardly ever had cottage cheese, and they ran out of brown sugar packets and oatmeal. Resident #55 stated, "The good aides quit now. They were getting sick of being mandated. They quit and went somewhere else." Resident #55 said the facility was still short staffed, and no one come for months to mow the lawn. Resident #55 stated, "The lawn was almost three feet long. It looked horrible."</p> <p>Review of Resident #55's Shower Task documentation in the EMR for the last 30 days as of 9/7/22, revealed a shower was provided on 8/11, 8/15, and 9/5/22, with "Shower/Bathing/Bed Bath as Scheduled Monday & Thursday AM Shift" noted on the POC Response History.</p> <p>Resident #56</p> <p>Review of Resident #56's MDS assessment, dated 5/31/22, revealed the Resident required one person assistance with physical help in part of bathing activity, and scored 15 of 15 on the BIMS assessment reflective of intact cognition.</p> <p>Review of Resident #56's Shower Task documentation in the EMR for the last 30 days as of 9/12/22, revealed no showers or bed baths were provided by facility staff with the "Task" of "Shower/Bathing/Bed Bath as Scheduled Monday AM & Thursday PM Shift" noted on the POC Response History.</p> <p>Resident #57</p> <p>Review of Resident #57's MDS assessment, dated 8/1/22, revealed the Resident required extensive two-person assistance with bed mobility, dressing, toilet use, personal hygiene. "Bathing"</p>			

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	<p>was documented as "Activity itself did not occur". Resident #57 scored 11 of 15 on the BIMS assessment reflective of moderate cognitive impairment.</p> <p>During an observation and interview on 9/9/22 at 3:45 p.m., Resident #57 was observed sitting in her wheelchair in the hallway with long (approximately 1 inch in length) facial hairs on her chin. When asked how she felt about grooming in the facility, especially the long chin hairs, Resident #57 stated, "I want them to shave that, but they only do that when I get a shower, and I am not getting showers like I am supposed to." Resident #57 said the nurse aides were not nice and said the nurse aides did not have time to give her a shower. When asked about bed repositioning, Resident #57 said she could do that independently, but stated, "There are not enough staff, and you have to wait a long time for them to respond if you need them ... I want to get my hair cut ..." but said there had not been a hairdresser in the building for a long time. Resident #57's hair was long and unkempt.</p> <p>Review of Resident #57's Shower Task documentation in the EMR for the last 30 days as of 9/12/22, revealed "Shower/Bathing/Bed Bath as Scheduled Tuesday & Friday PM shift". A shower was documented on 9/2/22, and a bed bath on 8/25/22. Refusals were noted on 8/23 and 9/6/22.</p> <p>Resident #58</p> <p>Review of Resident #58's MDS assessment, dated 7/21/22, revealed the Resident required extensive one-person assistance with bed mobility, dressing, toilet use, personal hygiene, and bathing. Resident #58 scored 14 of 15 on the BIMS reflective of intact cognition.</p>			

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	<p>During an interview on 9/7/22 at 12:30 p.m., when asked about facility staffing, Resident #58 stated, "They do not have enough staff", and noted staffing was less at night. Resident #58 stated, "On night shift I have to wait a long time for call light assistance and have had to wait wet and in BM (bowel movement/stool) for a long time." Resident #58 said showers were not received twice a week, as they were supposed to be given. Resident #58 stated, "The main thing is they are short of help ..."</p> <p>Review of Resident #58's Shower Task documentation in the EMR for the last 30 days as of 9/12/22, revealed "Shower/Bathing/Bed Bath as Scheduled Monday & Wednesday AM shift". A shower was documented on 8/24/22, and bed baths on 8/17/22 and 8/31/22, with one Refusal documented on 9/5/22.</p> <p>Resident #60</p> <p>Review of Resident #60's MDS assessment, dated 8/11/22, revealed the Resident required extensive two-person assistance with bed mobility, toilet use, and personal hygiene. "Bathing" was documented as "Activity itself did not occur". Resident #60 scored 15 of 15 on the BIMS reflective of intact cognition.</p> <p>Review of Resident #60's Shower Task documentation in the EMR for the last 30 days as of 9/7/22, revealed "Shower/Bathing/Bed Bath as Scheduled Tuesday & Friday PM shift". A shower was documented on 8/18/22 and 8/23/22, with "Not Applicable" documented on 8/9/22 and 8/19/22.</p> <p>Resident #61</p> <p>Review of Resident #61's MDS assessment, dated 7/12/2022, revealed the Resident required</p>			

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	<p>extensive two-person assistance with bed mobility, transfers, dressing, toilet use, and was totally dependent upon staff for "Bathing". Resident #61 scored zero on the BIMS reflective of severely impaired cognition.</p> <p>Review of Resident #61's Shower Task documentation in the EMR for the last 30 days as of 9/12/22, revealed "Shower/Bathing/Bed Bath as Scheduled Sunday & Wednesday PM shift". A shower was documented on 8/17/22, bed baths on 8/14/22 and 8/24/22, with "Not Applicable" documented on 8/21/22.</p> <p>Resident #63</p> <p>Review of Resident #63's MDS assessment, dated 8/8/2, revealed the Resident required extensive two-person assistance with bed mobility, and dressing. "Bathing" was documented as "Activity itself did not occur". Resident #63 scored zero (0) on the BIMS reflective of severely impaired cognition.</p> <p>During an observation and interview on 9/9/22 at 5:00 p.m., Resident #63 was observed crying out for "help" while lying in her bed, flat on her back. Resident #63 was dressed only in a hospital gown and incontinence brief. Resident #63 had tears in her eyes as she cried, "I hardly have any help anymore. I am not able to get the help I need. I don't want to be here anymore, I want to go somewhere else. They don't hardly come and see me (staff). I am so lonely, with nobody to talk to." Resident #63 confirmed she had not been getting her showers/bathing consistently as scheduled, and that she was not repositioned every two hours like she should be.</p> <p>Observation of Resident #63's positioning, with Staff "V", at this same time, found Resident #63's left heel positioned directly on the bed, with a</p>			

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	<p>pillow under her right knee only, to keep the right heel floating in bed.</p> <p>Review of Resident #63's care plan revealed the following, in part: "Assist me to turn &/or reposition routinely during CNA rounds while in bed and frequently redistribute my weight ... Date Initiated: 4/13/22" and "Assist/encourage me to elevate my heels off the bed. Date Initiated: 4/13/22."</p> <p>Review of Resident #63's Shower Task documentation in the EMR for the last 30 days as of 9/19/22, revealed "Shower/Bathing/Bed Bath as Scheduled Sunday PM Shift & Tuesday AM shift". No showers were provided to this Resident, bed baths were given on 8/13, 8/17, 8/24, 9/3, and 9/7/22. "Not Applicable" was documented on 8/20/22.</p> <p>Resident #64</p> <p>Review of Resident #64's MDS assessment, dated 6/7/2022, revealed the Resident required extensive two-person assistance with transfers and bathing, and extensive one-person assistance with bed mobility, locomotion, dressing, toilet use, and personal hygiene. Resident #64 was always incontinent of urine, and frequently incontinent of bowel. Resident #64 was documented as "Severely Impaired" on the "Cognitive Skills for Daily Decision Making"</p> <p>Review of Resident #64's Shower Task documentation in the EMR for the last 30 days as of 9/12/22, revealed "Shower/Bathing/Bed Bath as Scheduled Wednesday & Saturday PM shift". No showers were provided, one bed bath on 8/24/22, with "Not Applicable" documented on 8/17/22, 8/20/22, and 8/27/22.</p> <p>Staff documentation on the "Turning and</p>			

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	<p>Repositioning" and "Bed Mobility" POC Response Histories in the previous 30 days were inconsistently completed by staff on various shifts, with not all shifts recording task completion on the above residents.</p> <p>Review of Resident Council Meeting Minute concerns, March through July 2022, revealed the following, in part:</p> <p>"New Business: 3/9/22</p> <ol style="list-style-type: none"> 1. Too many residents yelling in hallway. 2. CNA's getting mouthy with residents ... 3. Getting left on toilet because EZ stand dies ... 4. Want haircuts ... <p>4/13/22</p> <ol style="list-style-type: none"> 1. Nurses don't always know how to answer lites (call lights) ... 2. Someone to keep an eye on people by the nurses' station (staff education/behavior intervention) ... <p>5/11/22</p> <ol style="list-style-type: none"> 1. CNA's ignoring people ... 2. Changing shower assignments ... <p>6/8/22</p> <ol style="list-style-type: none"> 1. Showers still not being offered ... <p>New Business</p>			

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	<p>1. CNA's being mean ...</p> <p>2. Showers not being served ...</p> <p>6/24/22</p> <p>Old Business</p> <p>1. Not getting showers - unhappy with follow up ...</p> <p>New Business</p> <p>1. Not getting showers ...</p> <p>2. Never want the fish from today again ...</p> <p>7/1/22</p> <p>New Business</p> <p>1. Sidewalks by the patio very broken, do not want to do activities out there.</p> <p>2. Residents want to use area behind activity room.</p> <p>Note: Down to one shower room. Residents still do not have resident council present.</p> <p>7/13/22</p> <p>New Business:</p> <p>1. Residents want trust money. Stated they have been waiting for over a week and that they do not want to wait any longer ...</p> <p>7/18/22</p> <p>1. Old Business - shower repair - will be getting</p>			

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	<p>bids ..."</p> <p>During an interview on 9/7/22 at 12:02 p.m., Staff "L" stated, "Corporate flies here on their private jet, and staffing has been absolutely horrible. When corporate comes, they don't fix anything, even though they know the condition of the facility." Staff "L" said they were terribly short on Certified Nurse Aides (CNA's), with three CNA's working day shift that day. Staff "L" said normally there would be five, and stated, " ...but we are short today."</p> <p>During an interview on 9/7/22 at 1:17 p.m., when asked about staffing levels, Staff "E" stated, "Our Corporate (management) doesn't care. They say we have adequate staff, but we don't ... We have been begging and pleading with corporate. Out of a five-day week, staff are working four 16 hours shifts (because of mandated overtime)".</p> <p>During an interview on 9/7/22 at 3:25 p.m., Staff "H" confirmed the facility was very short of staff, particularly CNA's. Staff "H" stated, "Staffing has been terrible. There are some days I leave here (at approximately 10:00 p.m.) and there is nobody to work for nights ... There are always two nurses if there are no aides, but there may be no aides. I am sure they (residents) don't get changed as often as they should be on night shift. The nurse can't pass pills and do all the medical things, and make sure everyone is checked and changed. Showers do not get done often, unless we have a shower aide ... It is hard enough to take care of 16 people and make sure they are clean, dry, and safe. The "with-it" (cognitively intact) residents say, 'I haven't had a shower in weeks', and you feel sorry for them (residents), but you just don't have the time. Half the time I get the BM's and food charted, but to get the rest, I don't have time." Staff "H" said there was only one shower room for resident use. Staff were told it was being renovated, but Staff</p>				

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	<p>"H" said she had not seen anyone working on it. When asked about residents being left for extended periods of time in wet and/or soiled briefs, Staff "H" said that was a possibility because staff were so short.</p> <p>During an interview on 9/7/22 at 3:35 p.m., when asked about staffing levels, Staff "I" stated, "It has been terrible. Everyone is getting mandated (required overtime) over and over and over. Everyone is exhausted ... Showers do not get done ... I get mandated into nights, and one night it was one nurse and me ... The residents are complaining about care not being provided ..."</p> <p>During an interview on 9/8/22 at 9:30 a.m., when asked about staffing, Staff "J" stated "It is horrible. I think we only have five people that are full-time. We had two of our best employees quit because they were getting nailed for four 16-hour shifts when mandated. It is insane here - because we don't have enough staff. It is insane because we don't have the right management here. What does corporate do for you? Nothing. We tell them and tell them, and they don't do nothing ... Showers are not getting done. There is no staff time to do them. They got used to saying, 'I don't have time to do it'. They got into that rut, and we were really short, and we didn't have time. They are not getting done. I think there are pressure ulcers because people are not getting turned. They are not getting out of bed, because there is no time to get them out of bed. Elders (residents) will be left in their bed because it is easier. They are not getting checked and changed as frequently as they should"</p> <p>During an interview on 9/8/22 at 10:50 a.m., when asked about facility functioning, including staffing, Staff "D" stated, "Staffing is terrible, they have been begging for help forever. Last time we had this meeting with corporate, (it was</p>			

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	<p>all about how to build a tree from its roots." Staff "D" said it had nothing to do with the living conditions in the facility and the lack of staff for resident care needs. Staff "D" said two CNA's recently quit because they worked four 16 hour shifts in a row. "The wound care nurse quit too, because she worried she was going to have to go (work) on the floor. We had several people quit. They were good workers too. They didn't want to do all those shifts".</p> <p>During an interview on 9/14/22 at 9:55 a.m., the new NHA confirmed Social Service Designee "C" resigned on Monday (9/12/22) morning via email, with no notice provided.</p> <p>During an interview on 9/8/22 at 10:24 a.m., Administrative Staff (Staff) "A" and Administrative Staff (Staff) "B" confirmed new admissions were being planned; one for that day, and one on 9/9/22. When asked if the facility had adequate staff to provide for current resident care needs, Staff "A" stated, "Absolutely not, I do not have enough staff to provide care for the residents we have without the emergency staff that we currently have." Staff "B" stated, "Corporate is pushing for us to take admissions." Staff "A" agreed and stated, "Personally my thoughts, and I have had communication with [the NHA of Record] regarding my concerns - I personally don't feel we should be admitting right now ... Corporate has asked us and told us to take admissions ... It is crazy here. I didn't know that coming in."</p> <p>During an interview on 9/8/22 at 12:09 p.m., Administrative Staff "B" requested to speak with this Surveyor because "Corporate instructs us on what to say about admissions and I didn't want to say anything in front of [Administrative Staff "A"] ... I agree that our residents are not being taken care of with the staff that we have, and it is</p>				

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	<p>irresponsible for us to take more new admissions. That is not in the best interest of the residents or our staff."</p> <p>During an interview on 9/13/22 at 10:39 a.m., Staff "T" was asked for Nursing Competency Evaluations for five CNA's and three nurses. Staff "T" stated, "I don't have any competencies for any of the CNA's or the nurses. I presented the list of all the nurses and CNA's that needed to be done. They could be in the DON's office, but I know that she would have them, and she would have given them to me."</p> <p>During an interview on 9/14/22 at 8:30 a.m., CNA and Nursing Competency Evaluations were requested from the new NHA for five CNA's and three facility nurses. The new NHA said that Staff "T" would have copies of those competencies, which Staff "T" had previously said the competencies were not found.</p> <p>During an interview on 9/14/22 at 11:52 a.m., the new NHA, regarding nurse competency evaluations, stated, "I do not have any nurse aide, or nursing competencies to provide to you." No policy, or job descriptions detailed the requirement for annual competencies, but blank competency checklist forms were provided by the facility to show what information should have been completed.</p> <p>During an interview on 9/8/22 at 3:20 p.m., Staff "N" said right before the Emergency CNA's started, a night shift was staffed with two nurses. Staff "N" stated, "We also had a weekend and a few other night shifts where it was one nurse and one CNA. The CNA had just graduated high school. [A Resident] said 'Nobody came in and offered to change and turn me.' It happened a second time, and it was each time it was just the one CNA working at night. I don't think we can</p>			

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	<p>provide the care that the residents need. [Resident #59] was also a bed bound resident who was not turned and repositioned and her bottom developed a coccyx wound which was previously healed and then she wasn't turned, and she developed a Stage III pressure injury to her coccyx." Staff "N" said Resident #59's urine was thick. "We had been leaving one nurse (LPN) who had just graduated from LPN school a month ago, and the one CNA in the building at night ... I have lost all hope and heart in this place."</p> <p>Staff "N" said management would rarely show up on Fridays and that is when she would get all the collection calls: [Paint Store], [hospitals], [internet provider], Medical Director sent faxes that we had outstanding bills. They were hand-written faxes, and I saw them saying she had not been paid ... The wheelchair van bill had not been paid so they would not transport. [The Hospital] paid the wheelchair van so we could get our Resident (#53) back." Staff "N" was present when bill collectors dropped of envelopes for collection at the facility door.</p> <p>Staff "N" said permission had been given to not have a manager on weekends. Staff "N" stated, "We have had just an LPN and a CNA. Staff "V" became the interim DON two days ago. Two days ago, she was told she was that role. We did not even have Staff "V"'s telephone number". Staff "N" said Staff "V" was not reachable over the weekends and was not reachable when she was not here. "We had no group communication - some things got taped to the desk." Staff "N" said there was no Director of Nursing (DON) between the last DON and yesterday when the new DON started. "We were never able to communicate with Staff "V" as the DON. If there was an incident - I called the Administrator ... No residents can get their Resident Trust Fund money - it is incredibly difficult. It is embarrassing ..."</p>			

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	<p>Review of emails provided between facility staff and corporate officers revealed the following, in part:</p> <p>8/26/22 9:46 a.m. - FROM: NHA of Record/Regional Director of Operations: " ..With the annual survey cleared and behind us, it is time to get the word out to the hospitals and actively engage in new admissions. Thank you all for your efforts with the survey process so that we can now 'get back to normal' ..."</p> <p>8/26/22 10:28 a.m. - FROM: Facility Staff "V" to NHA of Record/Regional Director of Operations: "I was not under the impression that we cleared our annual survey. During exit the surveyor stated that she "cannot clear us" in regard to the incident due to unvaccinated staff not following the policy/guidelines during the revisit ... She did say our timeline will continue and we will still be in denial of payment. Along with our current critical CNA staffing shortage I do not believe it is ethical to begin taking admissions as our current residents are not receiving the care that they deserve at this time. We do have 5 CNA's coming from emergency staffing on Monday but, this is not a solution to the crisis we are in. Plus, they will only be giving us 250 hours over 2 weeks which is only 25 hours over 2 weeks per CNA. It does not help enough to consider taking admissions. We currently have 2 CNA's today for day shift and both will be mandated to work 16 hours. This message is not meant to be negative but ... I need to advocate for all the staff and the residents."</p> <p>8/30/22 4:47 p.m. - FROM: NHA of Record/Regional Director of Operations: "How many open rooms do you have that are not closed due to the flooring or leaking windows? I think three are out of commission due to those reasons,</p>			

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	<p>but we can admit into others. Correct me if I am wrong ..."</p> <p>8/30/22 1:51 p.m. - FROM: Regional Director of Marketing "XXX": "How many admits can you take this week?"</p> <p>8/30/22 1:45 p.m. - FROM: NHA of Record/Regional Director of Operations: "...We need to let the hospitals know that we can take admissions ..."</p> <p>8/31/22 9:07 a.m., - FROM Facility Staff: "We have 3 rooms closed due to leaking windows and have 2 rooms closed for carpeting issues. A total of 8 beds down."</p> <p>8/31/22 9:09 a.m. - FROM NHA of Record/Regional Director of Operations: "So 5 rooms out of commission due to carpet and leaks, leaving 8 available beds to move residents in?"</p> <p>8/31/22 9:51 a.m. - FROM Facility Staff: "Correct. We have 4 female beds available and 4 observation beds."</p> <p>8/31/22 10:22 a.m. - FROM NHA of Record/Regional Director of Operations: "Yahoo! Let's get some admissions!"</p> <p>9/3/22 10:51 a.m. - FROM Facility Administrative Staff to NHA of Record/Regional Director of Operations: "...One of the day shift nurses called in for today due to a family emergency out of state and there is no one who is willing to pick it up at this point. Does not help that there is no incentive to do so. Also, they should have two licensed nurses on nights, and they are running with one. Unfortunately, I was led to believe by both Administrative Staff "Y" and Staff "E" that "the nurse(s) are pretty well covered." This is absolutely not the case. The</p>				

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	<p>Registered Nurse (RN) staff are burnt, and many have left ..."</p> <p>9/5/22 2:53 p.m. - FROM Administrative Staff to NHA of Record/Regional Director of Operations: "...If we cannot secure adequate staffing, in all honesty, the corporation should be considering all options. To ensure the safety of the residents and whether it would not be in their best interest to close this facility. Obviously not what anyone wants to hear. What are our realistic options IMO (In my opinion):</p> <p>-Hire Agency Staff: This should be implemented immediately as the Grant is due to expired (9.30.2022) And week to week renewal IS NOT guaranteed. Literally, they could be working only up to 9.10.2022 and gone 9.11.2022.</p> <p>-If this is not an option, then we need to consider closing beds and phasing out our current resident population.</p> <p>I realize that the aforementioned option of closing the facility is not what anyone really wants to pursue; however, realistically and from a patient / resident safety standpoint it may and perhaps should be given serious consideration ...Your thoughts and some insight on a realistic compassionate approach to this situation which Imo is critical, is needed."</p> <p>Review of the Facility Assessment, updated July 1, 2022, revealed the following, in part: "Staffing is maintained at a level to meet the needs of the resident population. Mandatory overtime is utilized to maintain levels and increased efforts have been made to recruit and retain staffing ... The facility assesses the resident population through review of documentation from referral source (i.e., hospital, family, physician, homecare agency) prior to admission, assessments</p>				

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	<p>conducted upon admission into facility by IDT, initial care planning meeting held with resident and/or their family or responsible party, and ongoing assessments completed per policy. The facility determines the acuity of residents following review of above documentation and assessments. The facility determines staffing levels upon review of acuity and availability and will adjust staff as needed."</p> <p>Activities of Daily Living documentation in the Facility Assessment included the following numbers for "Assist of 1 or 2" which included 30-55 residents for transfers, dressing, and toileting, and "Dependent" which included 5-10 for transfers, and 0-10 for Mobility." No data was present showing the level of staffing that would be provided based on the resident acuity level for the facility.</p> <p>Vendor and Environmental</p> <p>On 9/7/22 at 10:15 a.m., this Surveyor walked down the hallway along the laundry room to find water flooding the carpeted hallway, from under the laundry room doors. It was not known if the water was contaminated, electrified or otherwise unsafe. This Surveyor was aware of a 220-volt electric cord laying on the floor inside the laundry room and was immediately alarmed for the safety of the flooding water. An unidentified resident was wheeling toward the water with only socks on their feet and a urinary drainage bag hanging no more than one half inch above the floor from the underside of the wheelchair. No staff were in the vicinity. This Surveyor called out for help three times before facility staff arrived. This Surveyor then had to assume command of the situation and instruct arriving staff to keep residents away from the area as more residents arrived to the area. This Surveyor then entered the laundry room to find hot water spraying from a</p>			

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	<p>fixture on the opposite wall. There was approximately two inches of hot water covering 90% of the laundry room floor and spilling out into the hall. There was an overhead page for a staff person to come to the laundry room. No staff reported the emergency to the Nursing Home Administrator (NHA). This Surveyor, then reported the emergency to the NHA. As of the survey exit on 9/14/22 at 2:30 p.m., no qualified professional performed a water system analysis to determine safety of the system.</p> <p>Observation of the south shower room on 9/7/22 at 12:12 p.m., found the door posted with the following signage: "Shower room and restroom are closed under-construction. ABSOLUTELY ZERO ENTRY OTHER THAN MAINTENANCE PERSONNEL. CLOSED DATE 6/28/22." Observation of the closed room found that the linoleum and tile over the top of the linoleum had been partially removed. Shovels were present in the room, dirt and debris were on the floor, and the coded door lock that had been removed from the shower room door was on a shelf in the closed shower room.</p> <p>During an interview on 9/7/22 at 12:15 p.m., the south shower room was observed with Regional Clinical Coordinator "JJ", who was unaware of the condition of the shower room. Upon viewing the unrenovated shower room Regional Clinical Coordinator "JJ" stated, "What is taking so long?"</p> <p>Review of a "Quote: Quartz Epoxy Base and Flooring System," dated July 11, 2022, and noted as "Proposal valid for 30 days", detailed the work to be completed by the flooring contractor for an amount of \$2450.00. The "Scope of Work" included: "Prep floor by grinding to profile concrete (ALL TILE MUST BE REMOVED PRIOR TO ARRIVAL) ..."</p>				

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	<p>During an interview on 9/7/22 at 1:17 p.m. Staff "E" stated, "They (Corporation) owe(d) everybody money so nobody wants to do any work here ... They (residents) are not getting the care they need. [medical supply vendor], we don't use them anymore, because they (Corporation) haven't paid their bill ... [medical supply vendor], (the facility) cannot buy things from there anymore. The lawn had not been done for most of the summer (due to non-payment of past invoices). Code Alerts, for the last three months (have been on order) ... but they had an outstanding bill so they cannot service us until the bill has been paid. Plowing (snow), we had a hard time with them (coming to plow snow because they didn't get paid) ... [NHA of Record] is running around and acting like everything is wonderful. I have seen the [NHA of Record] in the building about five times. They (Corporate Administration) come in around 10:00 a.m., and usually they are still here around 3:00 p.m. We are in a crisis for staffing. I am scared (about) staffing ..." Staff "E" said they had been without a biller for months, a maintenance person was not employed in the facility at the time of the survey, and that the bill collectors called non-stop. "... There is nobody ... There is no DON ..." Staff "E" said staff who received a paper paycheck received them late in the beginning of September. Staff "E" stated, "This is the third time this happened with [the Corporation]."</p> <p>During interview on 9/11/22 at 1:48 p.m. and 2:00 p.m., Staff "CCC" and Staff "N", respectively confirmed paychecks had been received on 9/8/22 and 9/9/22, when other staff had received direct deposit of their paycheck on 9/2/22. Staff "N" said Staff "KK" had also received her paycheck late in September. Both staff said they had received their paychecks late previously, but the delay was much shorter with only a one-to-two-day delay in receipt of their paychecks.</p>				

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	<p>During an interview on 9/12/22 at 10:59 a.m., Staff "T" confirmed paper paychecks were late following the holiday in the beginning of September. Staff "T" stated, "From what I was told, these checks were sent out fed ex on the first and were expected to arrive on the second, but didn't come here until the 7th ...It has happened when they were a day late ... This is the longest it ever came out ... I expected the checks no later than the third." Staff "T" acknowledged the staff involved were Staff "N", Staff "KK", and was unsure about Staff "CCC".</p> <p>During an interview on 9/7/22 at 3:41 p.m., Staff "Q" confirmed she had worked at the facility beginning March 2021 and had not started her training for becoming a Certified Dietary Manager (CDM) until June of 2022. When asked why there was such a long delay in beginning the CDM training, Staff "Q" said the Facility Corporation had agreed to pay for the CDM training when she was hired in March of 2021. Staff "Q" stated, "I had been submitting the expense reports for it to be paid for months and months ... Eventually we tried to charge the credit card (for the training) and that (was) declined for several months. Then I was told I would have to pay for it (CDM training) out of pocket. The [Corporate Dietitian] paid for the schooling (for CDM training) out of her pocket (personally) and then was reimbursed."</p> <p>Staff "Q" confirmed they ran out of eggs, cottage cheese, oatmeal, and milk. Over the previous weekend Consultant Registered Dietitian (RD) "S" went to the grocery store and purchased 5-6 gallons of milk with her own personal money because there was no petty cash in the facility. Staff "Q" stated, "The corporation doesn't pay for anything, and if I have to go to the store, I pay for it myself. I try my best to not run out of things. I am working so much in the kitchen I am not</p>				

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	<p>spending as much time doing my own job as I should be." Staff "Q" said sometimes there were multiple carbohydrate choices on the menu, and that was brought to the corporate dietitian's attention. Staff "Q" said their department was short three staff members, which required both Consultant RD "S" and Staff "Q" to cook as well as perform their other designated responsibilities.</p> <p>During an interview on 9/7/22 at 4:14 p.m., Consultant RD "S" confirmed she had been cooking in the facility and had purchased milk for the facility with personal funds. Consultant RD "S" stated, "I know we have had some supply chain issues ... I know Staff "Q" asked repeatedly to get the CDM training, and I did the same thing (asked to get [Staff "Q] trained) ..." Consultant RD "S" confirmed dietary staff were working short-staffed by at least three staff.</p> <p>During an interview on 9/8/22 at 7:17 p.m., when asked about kitchen operations, Staff "ZZ" stated, "I hear 'it is out of stock' a lot. Either with lids, or food, or condiments. The ordering (of food) may have been wrong ... We are not consistent with the menu." Staff "ZZ" said Consultant RD "S" did not come to the building once a week consistently. Staff "ZZ" stated, "She is taking care of two other buildings." When asked about menu changes, Staff "ZZ" said if the food items were not available in the kitchen, something else was prepared with the food that was available in the kitchen. Staff "ZZ" stated, "We can't run to the store and get anything."</p> <p>During a telephone interview with [Grocery Vendor] on 9/8/22 at 1:05 p.m., Store Manager "UU" reported when ownership changed for the facility the [Grocery Vendor] was left with a \$2,000 dollar balance that never got paid, and the lady ended up hanging up on our bookkeeper. Store Manager "UU" stated, "We closed the</p>			

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	<p>account, and there was a girl that came to re-open the account because they had new owners again. We reopened the account. They filled out new paperwork, used it a few times and never made a payment. There has not been one payment made since they reopened the account in February 2022. The last time they charged was in April (2022). We send a monthly statement, and then wrote a more in depth note that the account was going to be closed ... They (facility) still haven't paid anything and there is a \$400 dollar balance that was owed."</p> <p>During an interview on 9/8/22 at 9:30 a.m., Staff "J" stated, "Since about July 15th, the facility bus lift went totally out, and it had to be hand pumped. The bracket on the hand pump would break, and we had to drill a couple of holes. The bracket for the hand pump is still not replaced. We took it to [a local automatic repair shop] to fix it so the power lift works now." Staff "J" said the former Corporate Administrator used her personal credit card to pay for the facility repair of the lift and had to use her personal credit card to get gas for the facility bus. Staff "J" stated, "I paid for gas a couple of times myself, but it took so long to get repaid for the gas. It is hard to get any gas for the bus. I used to have a Fleet (credit) card, but they didn't pay the bill, so now we don't have a Fleet card. I have been complaining about the air conditioning since last summer, and every time this summer when the people are hot in the van. I won't go any farther than [hospital a few miles away], because it is too hot for them, and the air conditioner still doesn't work." Staff "J" said there were two spots to hook up wheelchairs in the back of the van, but only one could be accommodated because one seat belt was broken, and the metal bracket on the floor that locks the wheelchair in place does not work, so only one wheelchair could go on the van at a time. Staff "J" said she had complained about that (wheelchair limitations) to anybody that would listen. Staff</p>			
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	<p>"J" stated, "I can only do so much, and they yell at me because I am only taking one person (in a wheelchair), and we may have to call transit, and then we have to take a person off the floor to go with them, and we can't take anyone off the floor because we don't have enough staff to do that."</p> <p>During an interview on 9/8/22 at 10:57 a.m., Administrative Staff "A" reported they had a Resident who needed to return from the hospital on the evening of 9/8/22. Administrative Staff "A" was called by the night nurse who reported a problem with a resident who needed transportation back from the hospital. I tried to call [Ambulance Service] to transfer the resident back from the hospital for us. Dispatch refused to transport the resident back from the hospital, so the owner of the [Ambulance Service] was contacted directly. The owner said that he had been working with [Facility Corporation Name] but he would not continue to transport residents because they had not been paid by Corporate. The [Ambulance Service] reported the bill had not been paid since the [Ambulance Service] began servicing [Facility Corporation Name]. The ambulance service refused and did not transfer that resident back to the facility. Administrative Staff "A" stated, "They (Corporate) don't realize that in a small community you have to pay your bills."</p> <p>During an interview on 9/8/22 at 1:16 p.m., when asked about the provision of non-emergent wheelchair van service from the Ambulance Service, Chief Executive Officer (CEO) "VV" stated, "The wheelchair van is not available from [Ambulance Service] ... Because they have not paid any of the invoices since we started providing services (in) May of 2021. It is right around \$1400.00 (balance owed) ... We were not paid for a year and a half."</p>				

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	<p>During an interview on 9/8/22 at 10:50 a.m., Staff "D" said the [Medical Director] had not been paid, the ambulance company would not talk to her and a medical appointment for Resident #65 needed to be rescheduled for another day because there was no transportation for the resident. Staff "D" said they could no longer get anything from a local pharmacy, and stated, "We just got our lawn mowed. It was appalling ... In the kitchen the garbage disposal was broken ... we have had so many (collection) calls from [internet provider] and I worry that our electronic medical record (EMR) is going to be (shut) down. They [internet provider] were calling all the time. When you tried to fax anybody, it said your provider has discontinued your access to this system. It was about two weeks (we couldn't use the fax machine), so we had to fax the document through the [Rehab Agency's] fax machine that did work." Staff "D" said an email had been sent to corporate to advise them of the emergent concerns in the building and directed this Surveyor to the person who emailed the letter(s) to the Corporate Officers.</p> <p>During a telephone interview on 9/9/22 at 10:08 a.m., Medical Director "NN" confirmed the facility had significant staffing issues and said payment for the Medical Director services for the building had not been paid in months. Medical Director "NN" stated, "I remind them every month that I haven't been paid," and when on to list the numerous other vendors for services and necessary expenses including mechanical repair, private transportation, van licensing, deferred maintenance, flooring contractors, and garbage removal. Medical Director "NN" said \$8000 was the current amount owed for the Medical Director services provided to the facility, and stated, "I keep reminding them that I need to get paid." When asked how long these conditions in the facility had been present, Medical Director "NN" stated, "It has been really bad since October or</p>			

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	<p>November of last year (2021)."</p> <p>During a telephone interview on 9/8/22 at 12:48 p.m., when asked about any accounts receivable from [Facility Corporation Name], Head of Retail Pharmacy (Pharmacist) "SS" stated, "They do have a corporate account with us, and they are delinquent. They are no longer able to charge to that charge account because we had to send it to collections. After going through several routes, we were just not able to get the account paid. The account is frozen ... \$611.61 was owed, and this was over a year period ... They don't pay the total bill. They pay only a portion of it ... We worked with them extensively. My poor biller had to send the bills to corporate over and over. We did talk to local people, but they didn't have much control over it locally ..."</p> <p>During a telephone interview on 9/8/22 at 7:48 p.m., [Lawn Care Vendor] "QQ" was interviewed regarding staff and resident reports of the grounds being unkempt. [Lawn Care Vendor] "QQ" confirmed they had not cut the facility lawn between July 6th, 2022, and August 26th, 2022. [Lawn Care Vendor] "QQ" stated, "I felt so bad (that we did not cut the lawn) ... patients' families are coming in and they are seeing it so horrible ... We went through this before with them. It was about \$2300 that they owed us this time, and we told them we needed the balance paid, and we needed this cut paid, and going into the fall cleanup and lawncare for them ... it is coming to that we have them pay in advance ... (We) had been in communication with the office and called the DON, and it was kind of like pass(ing) the buck. We looked at each other and said we can't keep going back (to provide lawn care) ... even though I felt so bad for the residents having to be outside with it looking like that (very bad) ..."</p> <p>During a telephone interview on 9/12/22 at 9:30</p>				

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	<p>a.m., [Flooring Vendor] President "ZZZ" was asked about a flooring contract not yet completed in the facility. President "ZZZ" said he had requested a down payment for the scheduled work on 8/15/22 and had not yet received that from the Corporation. President "ZZZ" stated, "We are supposed to repair the carpet and put vinyl flooring in with four-inch base ... The material is in my warehouse. As soon as I get my down payment, I will start working on it. I have had trouble with reimbursement from them in the past ... It has always been a pain in the ... to get paid from them."</p> <p>Review of the [Flooring Vendor] Quote, dated 7/19/22 for rooms 103 and 105, revealed the following information related to the repair: "Comment: Our quote to install vinyl flooring ... with 4" (inch) cove base in the above referenced rooms is for the total sum of \$4,944.00. Quote does include minor subfloor preparation, but no removal of existing floor coverings, mastic (adhesive), toilets or furnishings ..."</p> <p>During a telephone interview on 9/12/22 at 10:40 a.m., [Mechanical Vendor] Accountant "YYY" confirmed the facility had outstanding balanced that included, in part:</p> <ol style="list-style-type: none"> 1. 12/14/21 outstanding balance, paid 6/20/22, \$7343. 2. 12/30/21 outstanding balance, paid 6/27/22 \$7562. <p>Accountant "YYY" stated, "All of the payments are months out and they will not pay interest, so we are giving them loans basically ... Some of the checks were made out but sat on for a while. The last time I sent an email back, I have acknowledged that we are willing to go 45 days out (on outstanding balances), (and) we hadn't</p>			

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	<p>heard from them since. They made it sound like they can't pay ... They don't get their funding for 90 days or something like that."</p> <p>During an interview on 9/14/22 at 9:00 p.m., Resident #55 was observed sitting alone in the dining room. Resident #55 stated, "The dining room gets SO hot in here, and the maintenance man (who quit) and [Administrative Staff "Y"] were looking into the replacement of the air conditioning, but I don't think it ever got done. I am not sure that anyone has even gone up on the roof and looked at the filters that can get clogged with pollen." When asked about ventilation in the dining room, Resident #55 said the residents used to be able to get a nice breeze through the bottom part of the windows, and now they don't even open, so they don't get a breeze at all. Resident #55 stated, "Now they don't even have a Social Worker ... Social Workers keep coming and going ...The Social Workers start planning a discharge, working on how I can go home, and then everyone quits. At this rate, I am never going to get home." Resident #55 said it was extremely discouraging, because all he wanted to do was go home.</p> <p>During an interview on 9/7/22 at 2:17 p.m., Staff "T" confirmed no accounts payable are paid out of the facility, and said the corporate office paid all of the bills. Staff "T" stated, "It is all on the corporate end." Staff "T" confirmed the current NHA of Record was also the Corporate Regional Director of Operations. When asked about staffing, Staff "T" said it was horrible before the State Emergency Staff arrived the previous week. Staff "T" stated, "Regional (Corporate) kept saying it was fine and there was not an issue. We see them (CNA's) working 16-hour shifts - you cannot do that (to staff). I see the payroll. I see the four 16 hour shifts back-to-back sometimes ...It is day to day right now on staffing ... We can't lose anybody else. We cannot get more</p>				

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	<p>admissions if we don't have the staff to take care of them. Corporate is supposed to pay all of our bills. This is a small community, and you cannot burn bridges with one vendor and just go on to the next ..."</p> <p>Review of an email dated 8/15/22 at 7:41 a.m., sent by Staff "E" to facility Owner "Z", Chief Operating Officer "AA", Nursing Home Administrator (NHA) of Record/Regional Director of Operations, NHA of another [Corporate Name] facility "Y" and "W". Regional Director of Operations "DD" revealed the following: "Non-payment: I am not sure whom to go to anymore, our facility is failing. We had calls over the weekend from [Internet Provider], our computer/internet, non-payment, they are going to turn us off. The hospital did not want to transport a resident back as we owe them money. We cannot rent from [Medical Supply Vendor] anymore, Non-payment. We cannot rent from [Medical Supply Vendor], wander guard monitors, non-payment. After August 24th we have 4 full-time CNA's (sic) left in this facility. Our lawn looks like a jungle. We have a handful of loyal employees sticking it out, what is happening with [Corporation Name]. We have been begging for help."</p> <p>Review of an email dated 8/18/22 at 3:55 p.m., from Staff "E" to facility Owner "Z", Chief Operating Officer "AA", Nursing Home Administrator (NHA) of Record/Regional Director of Operations, NHA of another [Corporate Name] facility "Y", Regional HR (human resources) Director "BB" and VP (Vice President), Clinical Operations "CC", revealed the following:</p> <p>"Emergent need of help.</p> <p>[Corporate Owner],</p>			

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	<p>I am still awaiting your assistance requested on Monday in which you replied: 'I'll take care of this today'. We are still waiting on a reply from a travel CNA agency. Our staffing is at a critical level as of Tuesday, August 22, 2022. We have been begging for help for months now. We have been mandating staff for 16 hrs. (hours) a day 4 days a week and have lost many good CNA's due to the excessive workload. They are feeling hopeless because corporate promises of help have not been met. We have numerous vendors complaining of non-payment. Most supply companies are on a 'credit hold'. Transportation is an issue because of non-payment. We are unable to transport residents to their specialized MD (doctor) appts. (appointments) and procedures that are scheduled. This is putting them at risk. We never had petty cash available for emergency use. Our fax machine is not faxing out making outside communication difficult. All our management staff are working in all departments. The first appearance of our building is appalling. Our lawn hasn't been mowed. Weeds are overgrown. Dead trees are still standing. We are unable to get lawn service due to non-payment. Shut off notices are coming in the mail. The staff are concerned that we are going to have to close. This is a small community, and everyone talks. We have little to no suppliers that will deal with us due to our reputation. Our medical director was not paid since February (2022). Our kitchen, housekeeping, and several manager positions are open. We are at our wits end up here. PLEASE give us some help or direction as this building is at a critical level right now."</p> <p>Review of facility policies, including: "Routine Resident Checks", dated July 2013, "Incontinence", revised 12/20, "Bathing", Revised 4/22, and "Positioning and Transfer", dated 12/2018, revealed the following, in part:</p>			

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	<p>1. "Incontinence" policy: "...Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services ..." No reference to standard of practice time requirements for checking and changing of incontinent residents was identified in this policy.</p> <p>2. "Routine Resident Checks" policy: "To ensure the safety and well-being of our residents, nursing staff shall make a routine resident check on each unit at least once per each 8-hour shift." During interview with Staff "P" and the new NHA, on 9/14/22 at 10:35 a.m., regarding this policy, Staff "P" stated, "Standard of Practice would be checking and changing as necessary every 2 hours." The new NHA stated, "That is not a good policy."</p> <p>3. "Bathing" policy: "...4. A complete tub or shower bath shall be taken, under staff supervision, by (or administered to) an ambulatory resident at least once a week ...5. A bedfast resident shall be assisted with bathing or bathed completely at least twice a week and shall be partially bathed daily and as required due to secretions, excretions, or odors."</p> <p>4. "Positioning and Transfer" policy: "Policy: The patient with limited mobility will be positioned and transferred in a safe manner ... 1. Any resident confined to bed should be repositioned at least every two (2) hours unless contraindicated ..."</p> <p>Review of the facility "Abuse, Neglect and Exploitation" policy, revised 6/22, revealed the following, in part: "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation</p>			

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	<p>and misappropriation of resident property ...Definitions: "Neglect" means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress ... The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written ...Prevention of Abuse, Neglect and Exploitation ... Establishing a safe environment. Identifying, correcting, and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified (staff) to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs ..."</p> <p>An immediate jeopardy was identified and the facility Administrator was verbally notified on 9/13/22 at 9:23 a.m. A request for a written plan for immediacy removal was verbally requested at this same time.</p> <p>The immediate jeopardy began on 8/15/22 at 7:41 a.m., when an email authored by facility staff "...begging for help ..." was submitted by Staff "E" to facility Owner "Z", Chief Operating Officer "AA", Nursing Home Administrator (NHA) of Record/Regional Director of Operations, Administrative Staff "Y", and "W". Regional Director of Operations "DD".</p> <p>Facility Removal Plan</p> <p>Include actions that were performed to address the citation for recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the facility's noncompliance and the date the corrective actions were completed. Completion date: 9/14/2022</p>			

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	<p>" Beginning on 9/14/2022- 2 staffing agency contracts signed to procure additional clinical staff.</p> <p>" Beginning on 9/14/2022- Nursing department staffing reviewed and updated to ensure sufficient staffing for resident needs. Additional facility staff/agency staff were scheduled to ensure adequate staffing levels and to provide the necessary resident care. Nursing staffing will be determined by review of daily census, current behaviors, and resident acuity. This will be determined by DON or designee.</p> <p>" Beginning on 9/14/2022- All residents were evaluated for potential neglect. Residents with BIMS scores of 8 and above were interviewed using guardian angel forms. Interview questions include: How are you doing? Are you missing any items? Do you have any concerns? Are you feeling safe here? Are your needs being met? Any identified concerns will be addressed using grievance process. Residents with BIMS scores less than 8 had a physical skin assessment completed as well as observations using guardian angel form. Observations include: resident appearance and room appearance. Any identified concerns will be addressed immediately.</p> <p>" Beginning on 9/14/2022- Resident records reviewed/updated for scheduled showers, turning/repositioning schedules, toileting schedules, and check/change schedules, as applicable. Record review completed by DON or designee and tasks updated to reflect current plan of care.</p> <p>" Beginning on 9/13/2022- Facility Medical Director notified of Immediate Jeopardy at 10:30 a.m. on 9/13/2022</p> <p>" Beginning on 9/13/2022- Facility rounds</p>				

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	<p>completed by the Administrator to identify and correct any immediate environmental concerns in consultation with Regional EVS staff and outside resources.</p> <p>Actions to Prevent Occurrence/Recurrence:</p> <p>Include actions the facility will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, by whom and when those actions were completed. (Completion Date: 9/14/22)</p> <p>" Beginning on 9/14/2022- The Administrator reviewed and revised the Facility Assessment related to staffing patterns.</p> <p>" Beginning on 9/14/2022- 2 staffing agency contracts signed to procure additional clinical staff. The facility has actively been recruiting nurses and nurse aides. Contracts completed with Lake Superior Nursing contracting for one nurse and one CNA. Additionally, a contract completed with One Staff nursing agency and they have posted available openings for CNA's. Contracts in place as of 9/14/22.</p> <p>" Beginning on 9/14/2022- Schedule created with sister-facilities EVS Directors to ensure adequate oversight and assistance twice weekly until a full-time EVS Director is onboarded.</p> <p>" Beginning on 9/14/2022- Staff educated on importance of completing care needs based on resident care plan and chart task complete.</p> <p>" Beginning on 9/14/2022 Completed contracts with outside staffing agencies and with State assistance program for CNAs.</p> <p>" Beginning on 9/14/2022 The DON or designee will audit staffing sheets daily. Audits will</p>			

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	<p>continue daily for a minimum of 3 months. Audit to include review of daily posted staffing assignments in relation to current resident acuity and resident behaviors.</p> <p>" Beginning on 9/14/2022 COO reviewed the vendor A/P report to determine outstanding vendor concern that would affect chain fluidity. Any concerns were corrected.</p> <p>" Beginning on 9/14/2022 Encouraged staff to enroll in direct deposit or pay card option to ensure timely payroll transactions. And that by not doing so, they understand that they may be subject to a delay in mailing paper checks that are outside the control of the payroll process.</p> <p>" Beginning on 9/14/2022 Initiated CNA sponsorship program including paid hourly wage while in program. Those completing the CNA program will be eligible for receiving the sign on bonus, Sign on bonus in place, staff referral bonus in place, Job postings to be reviewed and updated, Local outreach to schools to recruit candidates.</p> <p>During a phone interview on 9/14/22 at 10:35 a.m., Contract Representative (CR) "FFF" confirmed the signature on a contract agreement with the facility for temporary nursing staff, dated 9/13/22, as part of the facility Removal Plan. The addendum to the contract detailed specific payment requirements, to continue services. CR "FFF" confirmed the Addendum payment structure was necessary due to prior non-payment for services in another corporate building. CR "FFF" confirmed continued services with the facility corporation were contingent on prompt payment and confirmed the outstanding balances were finally paid. CR "FFF" also confirmed she had a candidate to start work on 9/26/22, but there was no one in the facility to process the</p>			

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	<p>candidate.</p> <p>At the time of exit from the facility on 9/14/22 at 2:30 p.m., the facility had not removed the immediate jeopardy due to the following ongoing concerns:</p> <ol style="list-style-type: none"> 1. Facility staffing levels were at substandard levels based on the updated Facility Assessment as of 9/15/22. 2. Signed staffing agency contracts were present but required additional corporate considerations due to past outstanding financial affairs between the staffing agency and the facility. No firm date for staff to be available in the building for the performance of resident care needs. 3. Residents continue to report lack of showers, with continued observations of unshaven, unbathed, and unkempt residents. 4. Dependent residents continued in bed in hospital gowns, without getting out of bed during the day. 5. Continued concern with the lack of Maintenance staff in the facility. 6. Environmental issues with building repairs not satisfactorily resolved, including safety concerns related to facility bus transportation. 7. No Social Service Designee or Social Worker. <p>Deficient Practice Statement B:</p> <p>Based on interview and record review, the facility failed to prevent physical and verbal abuse for two Residents (#50 and #53) from 16 reviewed for abuse. This deficient practice resulted in the potential for psychosocial, physical and emotional</p>			

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	<p>harm, distress and withdrawal from daily life. Findings include:</p> <p>Resident #50</p> <p>The facility Investigation Summary, undated, revealed on 7/4/22 at approximately 4:00 p.m., RN "L" witnessed Resident #51 swearing at Resident #50 and trying to physically prevent her from entering the activity room. The Summary indicated Resident #51 was cognitively intact and Resident #50 was severely cognitively impaired. The Summary also indicated Resident #50 was unable to be interviewed, and Resident #51 admitted putting out his hand to stop Resident #50, but denied swearing at her.</p> <p>The Witness Statement, authored by RN "L" and dated 7/5/22, revealed, "...[Resident #51] grabbed at [Resident #50's] wheel chair attempting to block her from entering the activities room, while swearing and calling her a b#tch..."</p> <p>During an interview on 9/6/22 at 2:05 p.m., RN "L" confirmed Resident #51 tried to grab and hit Resident #50 while trying to enter the activity room on 7/4/22. RN "L" said Resident #51 would have hit Resident #50 hard if she did not physically remove her. RN "L" said Resident #51 was swearing and calling Resident #50 a B#TCH. RN "L" said Resident #51 did not belong in the facility because he was dangerous and had other instances of going after female residents. RN "L" said Resident #51 hated women and was territorial about the activity room. RN "L" then re-stated Resident #51 would have hurt Resident #50 had she not intervened.</p> <p>The progress note, dated 7/4/22, revealed, "Resident [#51] has been verbally and physically threatening other female resident [#50] when she attempted to enter the activity room. He tried to</p>			

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	<p>physically block the female resident and then swore at her when writer helped her enter the activity room and writer asked resident to stop..."</p> <p>The facility Investigation Summary, undated, revealed, on 7/1/22 at approximately 2:30 p.m., Staff "DDD" reported Resident #52 hit Resident #50 in the arm with a bottle. The Summary indicated Resident #52 was moderately cognitively impaired while Resident #50 was severely impaired. The Summary indicated Resident #52 admitted to hitting Resident #50.</p> <p>The Witness Statement, dated 7/1/22 and authored by Staff "DDD" revealed, [Resident #52] hit [Resident #50] in the arm...he said she was in his way..."</p> <p>The Witness Statement, dated 7/1/22 and signed by Resident #52, revealed, "I hit her with my hand to keep her away from me. I understand I can't hit people here."</p> <p>During an interview on 9/6/22 at 2:55 p.m., Staff "DDD" confirmed the incident and her Witness Statement. Staff "DDD" stated, "He whacked her in the arm." Staff "DDD" said Resident #52 was yelling at Resident #50, but she was just sitting there and he didn't want her there. When asked if Resident #51 ever yelled and Resident #50, Staff "DDD" said yes, and stated, "Everybody yells at her."</p> <p>During an interview on 9/6/22 at 3:08 p.m., Resident #55 confirmed he spent much of his day in the activity room. The Resident said he witnessed Resident #52 hit and slap Resident #50 more than once and she started crying once when it happened.</p> <p>Resident #53</p>				

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	<p>The facility Investigation Summary, not dated, revealed on 7/1/22, during a resident council meeting, a group of residents reported they witnessed Resident #54 throw a cup of coffee on Resident #53 in the dining room, on 6/29/22 at the evening meal. The Summary indicated Resident #54 was severely cognitively impaired and was independently mobile in a wheel chair. Resident #53 was cognitively intact. The Summary also indicated Resident #53 was in the dining room on 6/29/22 waiting for dinner when Resident #54 came over and threw a cup of coffee on her and said 'Take this'. The Summary indicated no staff were in the vicinity.</p> <p>The Witness Statement, dated 7/1/22, and signed by Resident #53, confirmed the Investigation Summary.</p> <p>The Witness Statement, dated 7/1/22 and signed by Resident "A", revealed, "...[Resident #54] was calling [Resident #53] names: fatso, telling her she stinks then [Resident #54] threw her cup with coffee in it at [Resident #53] and called her a b#tch..."</p> <p>Other Witness Statements, dated 7/1/22, signed by Resident "B" and Resident #55, both confirmed the incident.</p> <p>During an interview on 9/6/22 at 3:37 p.m., Resident #53 confirmed the incident as described in the facility investigation.</p> <p>During an interview on 9/7/22 at 9:00 a.m., Staff "V" confirmed there should always be a staff person in the dining room with meals. Staff "V" could not explain why there were no staff present on 6/29/22 for the evening meal.</p> <p>The Policy, Abuse, Neglect and Exploitation,</p>			

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F0609 SS= D	<p>dated 6/2022, revealed, "...It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse...the facility will...prevent abuse...Establishing a safe environment..."</p> <p>Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c) (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>This citation pertain to intake MI00131019</p>	F0609			

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F0686	<p>Based on interview and record review, the facility failed to report an allegation of physical abuse for one Resident (#57) from 16 reviewed for abuse. This deficient practice resulted in the potential for continued abuse. Findings include:</p> <p>On 9/6/22 at 11:40 a.m., Resident #57 told this Surveyor a Certified Nurse Aide (CNA) hurt her the day prior, by pulling and jerking her arms during care. Resident #57 said the CNA yelled at her to stop yelling. The Resident said she told the other CNA working but couldn't remember who it was.</p> <p>On 9/6/22 at 11:45 a.m., the agency administrator worker, Staff "A" confirmed she was the working administrator in the building. This Surveyor reported the allegation and Staff "A" said it was the first she heard about it.</p> <p>During an interview on 9/6/22 at 12:30 p.m., CNA "F" confirmed Resident #57 told her of the allegation that morning just after 6:00 a.m. when she arrived to work. CNA "F" confirmed she did not tell anyone about the allegation because she thought the Resident was "Just talking".</p> <p>During an interview on 9/6/22 at 12:36 p.m., Interim Director of Nursing (Staff) "V", confirmed CNA "F" was aware of the allegation at 6:00 a.m., but did not report it to anyone. When explained the concern regarding timely reporting, Staff "V" stated, "I know. I know."</p> <p>The policy, Abuse, Neglect and Exploitation, dated 6/2022, revealed, "...The facility will...Report...all alleged violations to the Administrator, state agency...immediately, but not later than 2 hours after the allegation is made..."</p>	F0686			

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SS= G	<p>Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:</p> <p>This deficient practice pertains to Intake #MI00131016 and MI00130451.</p> <p>Based on interview and record review, the facility failed to provide appropriate activities of daily living (ADLs) that included, turning and repositioning, checking and changing of incontinence briefs, hydration, and wound care management to prevent the development and worsening of a facility-acquired Stage 3 pressure injury resulting in harm to one Resident (#59) of two residents reviewed for pressure injuries. This deficient practice resulted in worsening of condition, an increased in size of the Stage 3 pressure injury, and potential coccyx wound infection that required emergent medical care. Findings include:</p> <p>A Facility Reported Incident of potential neglect was identified and reported to the State Agency on 6/7/22. The investigation summary, completed by the Nursing Home Administrator as of that date (6/7/22) revealed Certified Nurse Aide</p>				

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	<p>(CNA) "TTT" was 'neglecting' the residents on 5/14/22 when incontinence checks were not done on the night shift. Five residents including Residents #57, #59, #63, #64, and #65 were incontinent (wet) when staff came on at 2:00 a.m. on 5/14/22. The night nurse informed CNA "TTT" it was an expectation to perform incontinence checks. When CNA "TTT" was interviewed by the NHA, regarding this allegation, the Investigation Summary documented "[CNA "TTT"] stated the staff on duty had told her not to worry about the incontinence checks", and the investigation concluded "[CNA "TTT"] did not perform midnight incontinence checks on Mary 14, 2022 ..."</p> <p>Review of Resident #59's MDS assessment, dated 3/22/22, revealed the Resident required extensive two-person assistance with bed mobility, dressing, toilet use, personal hygiene, and was dependent upon staff for bathing. Resident #59 had functional limitations in range of motion (ROM) of bilateral upper extremities (arms) and used a wheelchair for mobility. Resident #59 did not ambulate and was documented as "Activity occurred only once or twice" for transfers, and (wheelchair) locomotion on or off the unit. Resident #59 was always incontinent of urine and bowel, and had active diagnoses that included: anxiety, depression, heart failure, need for assistance with personal care, and history of urinary (tract) infections (UTIs). Resident #59 was documented as at risk for development of pressure ulcers, with no unhealed pressure injuries as of the 3/22/22 MDS assessment. Resident #59 scored 13 of 15 on the BIMS reflective of intact cognition.</p> <p>Review of Resident #59's Admission Record, printed 6/6/22, found no diagnoses related to pressure ulcers as of that date.</p>			

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	<p>Review of Resident #59's functional bowel and bladder incontinence care plan revealed the following intervention, in part: "INCONTINENT" Check me every 2 hours and as needed for incontinence. Wash, rinse, and dry perineum. Apply barrier cream after each incontinent episode and PRN (as needed) ... Date Initiated: 10/05/2020."</p> <p>Review of the "Positioning and Transfer" policy, revised 12/2018, revealed the following, in part: "...Any resident confined to bed should be repositioned at least every two (2) hours unless contraindicated..."</p> <p>Review of Resident #59's "Turned and Repositioned every 2 hours" POC (point of care) Response History, revealed Certified Nurse Aide (CNA) staff documentation of turning and repositioning of Resident #59 during the past 30 days (from 9/9/2022) included the following, in part:</p> <ol style="list-style-type: none"> 1. Eight days were documented for one shift only. 2. Ten days were documented on two shifts only. 3. No documentation of task completion was noted on 8/24/22 and 8/30/22. <p>During an interview on 9/8/22 at 3:20 p.m., Staff "N" said right before the Emergency CNAs started a night shift was staffed with two nurses. Staff "N" stated, "We also had a weekend and a few other night shifts where it was one nurse and one CNA. The CNA had just graduated high school. [A Resident] said 'Nobody came in and offered to change and turn me.' It happened a second time, and it was each time it was just the one CNA working at night. I don't think we can provide the care that the residents need..."</p>			

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	<p>During an interview on 9/8/22 at 3:20 p.m., Staff "N" stated, "We had a weekend and a few other night shifts where it was one nurse and one CNA (working). The CNA had just graduated high school. [A Resident] said 'Nobody came in and offered to change and turn me.' It happened a second time, and it was each time it was just the one CNA working at night. I don't think we can provide the care that the residents need. [Resident #59] was also a bed bound resident who was not turned and repositioned and her bottom developed a coccyx wound which was previously healed and then she wasn't turned, and she developed a Stage III pressure injury to her coccyx." Staff "N" said Resident #59's urine had a strong odor and was a thick consistency. "I was concerned Resident #59 was not getting the care she needed ... I have lost all hope and heart in this place."</p> <p>During a telephone interview on 9/11/22 at 2:00 p.m., Staff "N" confirmed the following concerns related to Resident #59, who was transferred out to the acute care hospital with emergency care needs:</p> <ol style="list-style-type: none"> 1. Prior to discharge to the hospital Resident #59 was observed to be dehydrated, with extremely dry oral mucosa, and was not observed offered sufficient oral hydration. 2. Resident #59 was not being timely changed and repositioned at nights, which was observed, reported, and education provided to the involved CNAs related to checking and changing briefs and repositioning of the resident. 3. Resident #59 was found wet, when she should have been checked and changed by inexperienced CNA staff. <p>Resident interviews conducted on 9/7/22 at 12:30</p>			

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	<p>p.m. and 3:01 p.m., 9/9/22 at 2:58 p.m., 3:45 p.m. and 3:48 p.m., and 9/14/22 at 9:00 a.m., with Residents #58, #55, #57, #62, #63, and Resident #55 respectively, all said the facility did not have adequate staff to meet their needs, showers were not being performed as scheduled, and call light response times were very slow, especially at night.</p> <p>Staff interviews conducted on 9/7/22 at 12:02 p.m., 1:17 p.m., 2:17 p.m., 3:25 p.m., and 3:35 p.m., 9/8/22 at 9:30 a.m., 10:24 a.m., 10:50 a.m., 12:09 p.m. and 3:20 p.m., 9/9/22 at 10:08 a.m., Staff "L", Staff "E", Staff "T", Staff "H", Staff "I", Staff "J", Administrative Staff "A", Staff "D", Administrative Staff "B", Staff "N", and Medical Provider "NN", acknowledge a serious staffing shortage. Direct care staff, of the above identified "Staff", confirmed showers were not being done as scheduled, call lights were not being timely addressed, and dependent residents were not being repositioned every two hours.</p> <p>Review of Resident #59's Progress Notes revealed the following, in part:</p> <p>5/23/22 12:04 p.m., "Resident obtained stage 3 pressure injury to coccyx ... Educated CNA staff on freq (frequent) repositioning and brief changing ..."</p> <p>5/31/22 11:46 a.m., "Weekly wound assessment to stage 3 coccyx wound show (sic) area larger ..." Reminded staff to do more freq brief checks with peri cares and repositioning at least q (every) 2 hours ..."</p> <p>6/6/22 12:59 p.m., "Weekly wound assessment to stage 3 show little improvement ..."</p> <p>7/1/22 11:58 a.m., "Weekly Wound Note ... unstageable pressure injury to coccyx. Wound</p>			

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	<p>Measurements: Length x Width x Depth: 2.5 x 2 x 0.2 cm (centimeters) ..."</p> <p>7/2/22 10:47 a.m., "...Resident calling for nurse; this nurse found resident to be on a deflated mattress. Upon investigation, the CPR cord had been detached, therefore, not retaining air/allowing air to escape ..."</p> <p>7/12/22 11:05 a.m., "New pressure injury right coccyx unstageable pressure injury r/t slough. Wound Measurements: Length x Width x Depth: 1.5 x 1 cm ... New Wound ..."</p> <p>7/12/22 12:04 p.m., "IDT team wound and weight; Resident continues with pressure injuries to coccyx, right buttock and left buttock areas noted to be open with slough to the wound beds. New open area right of previous coccyx wound measuring 1.5 x 1 cm with slough in the wound bed ...Orders placed for weekly weights r/t pressure injuries ..."</p> <p>7/19/22 2:32 a.m., "Coccyx pressure injury ...Unable to get into treatment cart for supplies ..."</p> <p>7/19/22 11:15 a.m., "Late Entry: Coccyx III (Stage 3 Pressure Injury) ... Wound Measurements: Length x Width x Depth: 4 x 2.5 ..."</p> <p>8/8/22 8:44 a.m., "Weekly weights on Mondays r/t pressure injuries ...We are extremely short staffed and have not gotten a weight yet ..."</p> <p>8/12/22 12:27 p.m., "Note sent to MD regarding deteriorating wound and request foley to aid in wound healing ..."</p> <p>8/15/22 23:20 (11:20 p.m.) and 8/22/22 23:14 (11:14 p.m.) "Weekly weights on Mondays r/t pressure injuries ... Weight not obtained ..."</p>				

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	<p>8/23/22 13:48 (1:48 p.m.), "Coccyx stage III pressure injury ... 3.4 x 2 x 0.2 ..."</p> <p>8/28/22 17:15 (5:15 p.m.), "Resident's catheter was leaking all night and this morning ... not able to be flushed ... catheter removed and replaced ... Urine is amber. Frequent thick white matter noted in the catheter tubing. MD notified via fax."</p> <p>8/29/22 14:40 (2:40 p.m.), "Coccyx pressure injury's (sic): Change 3 times a week and PRN if soiled or lifting every day shift every Mon, Wed, Sat for wound care. Pressure ulcer dressing not changed sleeping x 2 when I went in ..."</p> <p>9/4/22 14:54 (2:54 p.m.), "Approximately at 1330 (1:30 p.m.) sent resident to the ER (Emergency Room) ... for changes in condition ... she had low urine output and it did have blood in it."</p> <p>9/4/22 17:39 (5:39 p.m.), "[ER] called report on Resident (#59), stated she has pneumonia, UTI, Septic ...Nurse stated they cannot keep her blood pressure up despite all their interventions ..."</p> <p>9/6/22 11:23 a.m., "Nurse received phone call from [acute care hospital], Resident (#59) passed away."</p> <p>Review of Resident #59's "Wound Assessment" forms included the following information, in part:</p> <p>5/23/22 New skin condition, acquired in-house, coccyx, pressure, Stage III (3), 1 x .4 x .2 cm.</p> <p>5/31/22, coccyx, Stage III pressure, 2 x 1 x .2 (increased in size).</p> <p>6/6/22, coccyx, Stage III pressure, 2 x 1 x .2 cm.</p> <p>6/14/22, coccyx, Stage III pressure 2 x 1 x .2 cm.</p>				

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	<p>6/21/22, coccyx, Stage III pressure 1.8 x 1.0 x .2 cm.</p> <p>7/8/22, coccyx, Unstageable, pressure 2.5 x 2 x 0.2 cm (increased in size).</p> <p>7/12/22, coccyx, Unstageable, pressure 2.5 x 1.7 x 0.1cm. (This wound assessment signed on 7/12/22 by a sister facility Director of Nursing (DON).)</p> <p>7/31/22, coccyx, Stage II Pressure, 3.5 x 3 x 0.1 cm.</p> <p>8/11/22, coccyx, Unstageable pressure, 4.2 x 8 x 0.2 cm, Additional Information: "Deteriorating: wounds (left and right coccyx pressure injuries combined to 1). Pain was associated with wound. Education provided related to frequent repositioning and the air mattress.</p> <p>8/18/22, Stage III pressure, originally unstageable wound, 4 x 2 x 0.2 cm.</p> <p>Review of the [Physician Group] Wound Care Clinic documentation signed 7/15/22 at 12:34 p.m., The #7 Stage III (3) Coccyx pressure injury was "not healed" and measured 2.2 x 1.3 x 0.2. and the new #8 Stage 2 coccyx pressure injury which was "not healed" and measured 0.7 x 0.5 x 0.1. These wounds were both documented as the "Initial" wound encounter, and the "Initial" exam. The "Multi Wound Chart Details," dated 7/14/22, included additional facility acquired pressure injuries that included: #4, Left, proximal, lateral sacral Stage III pressure injury that measured 0.6 x 1.5 x 0.1, #5, Left, proximal sacral Stage II pressure ulcer that measured 0.5 x 0.5 x 0, and a right, proximal sacral Stage III pressure ulcer that measured 1.5 x 1.7 x 0.2.</p>				

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	<p>Review of the acute care hospital Emergency Department "Physician Documentation: History of Present Illness," dated 9/4/22, revealed the following, in part: "...Patient (Resident #59) has known sacral (coccyx) ulcer. She had an indwelling Foley catheter as she is incontinent of urine, and this was to protect the sacral ulcer ... Foley in place with urine that is thick, purulent, and discolored. Breathing is shallow ... B/P (blood pressure) was 80/44, and pulse oximetry (percentage of oxygen in the blood) was 95% on room air ..." ED Summary: "Initial evaluation patient appears septic ..."</p> <p>Review of the [Acute Care Hospital] "Assessment/Plan, signed 9/4/22, and 9/5/22, revealed the following, in part: "</p> <p>1. Septic Shock: "Patient with chronic indwelling Foley catheter and stage III (Stage 3) sacral ulcer. Both could be related to septic shock. Pressure improved with fluid resuscitation ... patient is not making enough urine. Will wait for urine output with fluid resuscitation ..." (9/5/22) "... Blood culture positive for enterobacteria family and Proteus ..."</p> <p>8. Dehydration: "Continue IV hydration ..."</p> <p>Review of the facility "Skin and Pressure Injury Risk Assessment and Prevention", revised 7/2021, revealed the following, in part: "...Interventions for Prevention and to Promote Healing:</p> <p>a. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions ...</p>			

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F0689 SS= E	<p>b. Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care intervention could include, but are not limited to:</p> <ul style="list-style-type: none"> i. Redistribute pressure (such as repositioning, protecting, and/or offloading heels, etc.); ii. Minimize exposure to moisture and keep skin clean, especially of fecal contamination; iii. Provide appropriate, pressure-redistributing, support surfaces; iv. Maintain or improve nutrition and hydration status ... <p>11. Modifications of Interventions:</p> <ul style="list-style-type: none"> a. Interventions on a resident's plan of care will be modified as needed. Considerations for needed modifications include: <ul style="list-style-type: none"> i. Changes in resident's degree of risk for developing a pressure injury. ii. New onset or recurrent pressure ulcer development. iii. Lack of progression towards healing ..." <p>Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as</p>	F0689			

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	<p>evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to appropriately supervise and monitor residents and the environment, for hazards and prevention of accidents, affecting potentially any facility resident able to mobilize throughout the facility. This deficient practice resulted in the potential for injuries and illness. Findings include:</p> <p>On 9/7/22 at 10:15 a.m., this Surveyor walked down the hallway along the laundry room to find water flooding the carpeted hallway, from under the laundry room doors. It was not known if the water was contaminated, electrified or otherwise unsafe. This Surveyor was aware of a 220 volt electrical cord from the residential dryer in use, lying on the floor inside the laundry room, and was immediately alarmed for the safety of the flooding water. An unidentified resident was wheeling toward the water with only socks on the feet and a urinary drainage bag hanging no more than one half inch above the floor from the underside of the wheel chair. No staff were in the vicinity. This Surveyor loudly called out for help three times before any staff arrived. The unidentified resident wheeled within inches of the rising water before staff arrived without urgency. This Surveyor then had to assume command of the situation and instruct arriving staff to keep residents away from the area, as several more residents arrived from the smoking area. This Surveyor then entered the laundry room to find hot water spraying from a fixture on the opposite wall. There was approximately two inches of hot water covering 90% of the laundry room floor and spilling out into the hall. At that time the water was within three feet of the 220 volt electric line on the floor behind residential dryers. There was an overhead page for a staff person to come to the laundry room. No staff reported the</p>			

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F0725 SS= F	<p>emergency to the Administrator (NHA). This Surveyor, when all residents in the vicinity were safely monitored and with staff, reported the emergency to the NHA. The NHA and several corporate staff from the office proceeded down the hall. As of the survey exit on 9/14/22 at 2:30 p.m., no qualified professional performed a water system analysis to determine safety of the system, or root cause analysis of the ruptured line.</p> <p>During an interview on 9/7/22 at 11:00 a.m., agency administrator as listed "worker" on the staff list, Staff "A" was asked her expectation of staff in response to any perceived emergency. Staff "A" said her expectation was that "#1 residents are kept safe" and secondly that staff would report the emergency to her immediately.</p> <p>The policy Environmental Services Safety Procedures, dated, 1/11/21, revealed, "It is the policy of this facility to ensure general safety procedures are followed in the course of performing housekeeping and/or laundry duties..."</p> <p>The Emergency Operations Program and Plan Manual, not dated, on pages 66-68, revealed, "...It is the policy of this facility to protect our residents, staff and others who may be in our facility from harm during emergency events....Monitor emergency progress, structural integrity of the facility and infrastructure systems...continue care and monitoring of residents..."</p> <p>Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident</p>	F0725			

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	<p>assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:</p> <p>This deficient practice pertains to the following Intakes: #MI00130451, #MI00130427, #MI00130213, #MI00129738, #MI00129110, and #MI00131016.</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate and competent staff to provide for resident care and safety needs, to ensure the highest practicable physical, mental, and psychosocial well-being of all facility residents. This deficient practice resulted in lack of scheduled showers, delayed or unmet incontinence care, slow call light responses, failure to reposition dependent residents, and the potential for resident-to-resident altercations and injuries with insufficient staff available for adequate supervision. Findings include:</p> <p>Due to the critical content of the interviews and evidence provided during this survey with</p>			

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	<p>repeated verbalization of resident and staff concerns related to potential retaliation by the facility, all staff will be identified as "Staff" unless the position title is critical to deficiency understanding.</p> <p>During a telephone interview on 9/6/22 at 5:22 p.m., Complainant "FF", said in June and July of 2022 the facility was noticeably short of nursing staff, especially on the night shift. Complainant "FF" stated, "Once in a while there was only one nurse and one aide (all night)." Complainant "FF" said the concern was voiced to facility administration who said they were doing the best they could, "I often had to wait for a respiratory treatment, and that made me short of breath and more anxious. I am incontinent and with one aide you may get changed once a night, and on afternoons you (I) had to wait over a half hour for a brief change with stool in it ... With the showers, you never got the showers you were scheduled. I probably got a shower a month ..." Complainant "FF" reported wanting showers, but staff said they "did not have time ..."</p> <p>During a telephone interview on 9/7/22 at 8:06 a.m., anonymous Complainant "EE", an advocacy organization employee, reported having been in the building approximately three to four weeks previous. Anonymous Complainant "EE" stated, "The day I was there many of the residents were fearful of the staffing situation (low staffing levels). One of the huge complaints I got was the (lack of) showering."</p> <p>During an interview on 9/7/22 at 12:02 p.m., Staff "L" stated, "Staffing has been absolutely horrible." Staff "L" said they were terribly short on Certified Nurse Aides (CNAs), with three CNAs working day shift that day. Staff "L" said normally there would be five, and stated, "...but we are short today."</p>				

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	<p>During an interview on 9/7/22 at 12:30 p.m., when asked about facility staffing, Resident #58 stated, "They do not have enough staff", and noted staffing was less at night, call light response times were slow, with an extended time left wet and in BM (bowel movement), and showers were not received twice as week as scheduled.</p> <p>During an interview on 9/7/22 at 1:17 p.m., when asked about staffing, Staff "E" stated, "They (Corporate Management) say we have adequate staff, but we don't ... We have been begging and pleading with corporate. Out of a five-day week, staff are working four 16 hours shifts (because of mandated overtime) ... They (residents) are not getting the care they need ... We are in a crisis for staffing. I am scared (about) staffing ..."</p> <p>During an interview on 9/7/22 at 2:17 p.m., Staff "T" stated that staffing had been "horrible" before the State Emergency Staff arrived the previous week. Staff "T" stated, "Regional (Corporate) kept saying it was fine and there was not an issue. We see them (CNAs) working 16-hour shifts - you cannot do that (to staff) ... It is day to day right now on staffing ..."</p> <p>During an interview on 9/7/22 at 3:01 p.m., when asked about showers in the facility, Resident #55 stated, "Sometimes I go two weeks without a shower. I (had) a shower day on Monday, and that was the first shower I had in 21 days." Resident #55 said staff would say they did not have time to give him a shower. When asked about call light response times, Resident #55 stated, "It is sometimes horrible at night here. Sometimes it is just the nurse here, and there is no aide." Resident #55 stated, "The good aides quit now. They were getting sick of being mandated. They quit and went somewhere else."</p>			
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	<p>During an interview on 9/7/22 at 3:25 p.m., Staff "H" confirmed the facility was noticeably short of staff, particularly CNAs. Staff "H" stated, "Staffing has been terrible. There are some days I leave here (at approximately 10:00 p.m.) and there is nobody to work for nights ... There are always two nurses (at night) if there are no aides, but there may be no aides. I am sure they (residents) don't get changed as often as they should be on night shift. The nurse can't pass pills and do all the medical things, and make sure everyone is checked and changed. Showers do not get done often, unless we have a shower aide ... The 'with-it' (cognitively intact) residents say, 'I haven't had a shower in weeks', and you feel sorry for them (residents), but you just don't have the time." When asked about residents being left for extended periods of time in wet and/or soiled briefs, Staff "H" said that was a possibility because there wasn't enough staff.</p> <p>During an interview on 9/7/22 at 3:35 p.m., when asked about staffing levels, Staff "I" stated, "It has been terrible. Everyone is getting mandated (required overtime) over and over and over. Everyone is exhausted ... Showers do not get done ... I get mandated into nights, and one night it was one nurse and me ... The residents are complaining about care not being provided ..."</p> <p>Review of the "Facility Assessment," updated July 1, 2022, revealed the following, in part: "Staffing is maintained at a level to meet the needs of the resident population. Mandatory overtime is utilized to maintain levels and increased efforts have been made to recruit and retain staffing ... The facility assesses the resident population through review of documentation from referral source (i.e., hospital, family, physician, homecare agency) prior to admission, assessments conducted upon admission into facility by IDT (Interdisciplinary Team), initial care planning meeting held with resident and/or</p>				

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	<p>their family or responsible party, and ongoing assessments completed per policy. The facility determines the acuity of residents following review of above documentation and assessments. The facility determines staffing levels upon review of acuity and availability and will adjust staff as needed."</p> <p>Activities of Daily Living documentation in the "Facility Assessment" included the following numbers for "Assist of 1 or 2" which included 30-55 residents for transfers, dressing, and toileting, and "Dependent" which included 5-10 for transfers, and 0-10 for Mobility." No data was present showing the level of staffing that would be provided based on the resident acuity level for the facility.</p> <p>Review of the Updated Facility Assessment "Staffing Appendix - 9/13/22" revealed the following additional information: "Staffing is maintained at a level to meet the needs of the resident population. Mandatory overtime is utilized to maintain levels and increased efforts have been made to recruit and retain staffing ... Base on the average acuity of [Facility Name], direct care staffing to meet the needs of the facility has been determined to be 2.9 PPD as of 9/13/22, but this PPD (patient pay day) is subject to change based on acuity and needs of the facility ... [Facility Name] uses 2 licensed nurses per 12 hour shift, however, this may vary based on acuity changes. Based on the average acuity in the facility, the facility has determined an adequate staffing pattern. This pattern is subject to change based on acuity and is to be reviewed by the QA (Quality Assurance) committee during routine meetings. The example staffing pattern (subject to change) is shown below:</p> <p>Census Licensed Nurse Hours per Day [CNA hours per day]</p>			

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30 48 39					
35 48 54					
40 48 68					
45 48 83					
50 48 97					
55 48 112					
	<p>Review of the "Nursing Department Daily Staffing" sheets from 8/22/22 through 9/13/22 revealed the following days with inadequate CNA hours based upon the updated facility assessment, which previous did not identify how staffing was determined: (Note: The "Nursing Department Daily Staffing" sheets do not identify the facility Census, so the actual number of residents is not able to be determined. A Resident Census of 42, as present on 9/6/22 will be presumed).</p> <p>8/22/22, 50 CNA hours on Nursing Department Daily Staffing sheet, 68 required for Census of 40 as noted above.</p> <p>8/23/22, 48 CNA hours, 68 required for Census of 40 as noted above.</p> <p>8/24/22, 40 CNA hours, 68 required...</p> <p>8/25/22, 56 CNA hours, 68 required...</p> <p>8/26/22, 48 CNA hours, 68 required...</p> <p>8/27/22, 32 RN hours, 48 required, 64 CNA hours, 68 required...</p> <p>8/28/22, 60 CNA hours, 68 required ...</p>				

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	<p>8/29/22, 56 CNA hours, 68 required...</p> <p>8/30/22, 40 RN hours, 48 required, 48 CNA hours, 68 required...</p> <p>9/4/22, 36 RN hours, 48 required ...</p> <p>9/6/22, 56 CNA hours, 68 required...</p> <p>9/7/22, 36 RN hours, 48 required, 64 CNA hours, 68 required...</p> <p>9/8/22, 36 RN hours, 48 required...</p> <p>9/9/22, 36 RN hours, 48 required...</p> <p>9/11/22, 36 RN hours, 48 required, 48 CNA hours, 68 required...</p> <p>9/12/22, 56 CNA hours, 68 required...</p> <p>9/13/22, 64 CNA hours 68 required...</p> <p>9/14/22, 32 RN hours, 48 required, 56 CNA hours, 56 required.</p> <p>Review of Payroll documentation for facility staff between 8/17/22 and 9/14/22, revealed Emergency CNA staff provided through the [State Name] began on 8/30/22 with the addition of five additional CNA agency staff members. The staffing shortage continued during this time, as the facility continued to operate with an insufficient amount of nurse and CNA hours to meet resident needs, although notification of an Immediate Jeopardy (IJ) at F600 for Neglect was served on 9/13/22.</p> <p>During an interview on 9/8/22 at 9:30 a.m., when asked about staffing, Staff "J" stated "It is horrible. I think we only have five people that are</p>			

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	<p>full-time. We had two of our best employees quit because they were getting nailed for four 16-hour shifts when mandated. It is insane here - because we don't have enough staff ... Showers are not getting done. There is no staff time to do them. They got used to saying, 'I don't have time to do it'. They got into that rut, and we were really short, and we didn't have time. They are not getting done. I think there are pressure ulcers because people are not getting turned. They (Residents) are not getting out of bed, because there is no time to get them out of bed. [Residents] will be left in their bed because it is easier. They are not getting checked and changed as frequently as they should"</p> <p>During an interview on 9/8/22 at 10:00 a.m., Emergency Staff "F" said she did not believe residents were being repositioned timely, because they (emergency staffing aides, including Staff "F") placed a piece of paper under [Resident #59] and when they would come in next, they would find the paper in the exact same place as they had placed it. Staff "F" said it was incredibly sad.</p> <p>During an interview on 9/8/22 at 10:24 a.m., when asked if the facility had adequate staff to provide for current resident care needs, Staff "A" stated, "Absolutely not, I do not have enough staff to provide care for the residents we have without the emergency staff that we currently have ... It is crazy here ..."</p> <p>Review of emails provided between facility staff and corporate officers revealed the following, in part:</p> <p>8/26/22 10:28 a.m. - FROM: Facility Staff to NHA of Record/Regional Director of Operations: "... Along with our current critical CNA staffing shortage I do not believe it is ethical to begin taking admissions as our current residents are not</p>			

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	<p>receiving the care that they deserve at this time. We do have 5 CNAs coming from emergency staffing on Monday but, this is not a solution to the crisis we are in. Plus, they will only be giving us 250 hours over 2 weeks which is only 25 hours over 2 weeks per CNA ... We currently have 2 CNA's today for day shift and both will be mandated to work 16 hours. This message is not meant to be negative but ... I need to advocate for all the staff and the residents."</p> <p>9/3/22 10:51 a.m. - FROM Facility Administrative Staff to NHA of Record/Regional Director of Operations: "...One of the day shift nurses called in for today due to a family emergency out of state and there is no one who is willing to pick it up at this point ... Also, they should have two licensed nurses on nights, and they are running with one. Unfortunately, I was led to believe by both Administrative Staff "Y" and Staff "E" that "the nurse(s) are pretty well covered." This is absolutely not the case. The RN staff are burnt, and many have left ..."</p> <p>9/5/22 2:53 p.m. - FROM Administrative Staff to NHA of Record/Regional Director of Operations: "...If we cannot secure adequate staffing, in all honesty, the corporation should be considering all options. To ensure the safety of the residents and whether it would not be in their best interest to close this facility...."</p> <p>During an interview on 9/8/22 at 10:50 a.m., when asked about facility functioning, including staffing, Staff "D" stated, "Staffing is terrible, they (facility administration and staff) have been begging for help forever...."</p> <p>Review of an email dated 8/18/22 at 3:55 p.m., from Staff "E" to facility Owner "Z", Chief Operating Officer "AA", Nursing Home Administrator (NHA) of Record/Regional</p>			

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	<p>Director of Operations, NHA of another [Corporate Name] facility "Y", Regional HR (human resources) Director "BB" and VP (Vice President), Clinical Operations "CC", revealed the following:</p> <p>"Emergent need of help.</p> <p>[Corporate Owner],</p> <p>I am still awaiting your assistance requested on Monday in which you replied: 'I'll take care of this today'. We are still waiting on a reply from a travel CNA agency. Our staffing is at a critical level as of Tuesday, August 22, 2022. We have been begging for help for months now. We have been mandating staff for 16 hrs. (hours) a day 4 days a week and have lost many good CNA's due to the excessive workload. They are feeling hopeless because corporate promises of help have not been met. ... PLEASE give us some help or direction as this building is at a critical level right now."</p> <p>During an interview on 9/8/22 at 12:09 p.m., Administrative Staff "B" requested to speak with this Surveyor and stated, " ... I agree that our residents are not being taken care of with the staff that we have, and it is irresponsible for us to take more new admissions. That is not in the best interest of the residents or our staff."</p> <p>Review of Resident Council Meeting Minute concerns, 3/2022 through 7/2022, revealed the following concerns identified, in part: unsupervised residents, CNAs ignoring people (lack of response to care needs), and multiple complaints related to lack of showers.</p> <p>During an observation and interview on 9/8/22 at 2:58 p.m., when asked about care received in the facility, Resident #62 said she was not routinely</p>				

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	<p>receiving showers from the facility and had been left in a cold, wet brief for two and a half hours one night. Resident #62 said she has a problem with recurrent urinary tract infections, so sitting in a wet brief was a concern to her. Resident #62 was observed in bed wearing a hospital gown. Resident #62 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15.</p> <p>Review of 14 Shower POC (point of care) Response Histories for Residents (#51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, and #64), revealed showers were not provided per the shower schedule for any of the 14 Residents reviewed. Sample Resident #50 and #65 were not reviewed for receipt of scheduled showers.</p> <p>Staff documentation on the "Turning and Repositioning" and "Bed Mobility" POC Response Histories were inconsistently completed by staff on various shifts, with not all shifts recording task completion on the above 14 residents.</p> <p>During an interview on 9/8/22 at 3:20 p.m., Staff "N" said right before the Emergency CNAs started a night shift was staffed with two nurses. Staff "N" stated, "We also had a weekend and a few other night shifts where it was one nurse and one CNA. The CNA had just graduated high school. [A Resident] said 'Nobody came in and offered to change and turn me.' It happened a second time, and it was each time it was just the one CNA working at night. I don't think we can provide the care that the residents need..."</p> <p>During an observation/interview on 9/9/22 at 3:45 p.m., Resident #57 was observed sitting in her wheelchair in the hallway with long (approximately 1 inch in length) facial hairs on her chin. Resident #57 stated, "I want them to shave that, but they only do that when I get a</p>				

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	<p>shower, and I am not getting showers like I am supposed to." Resident #57 said the nurse aides were not nice and said the nurse aides did not have time to give her a shower. When asked about bed repositioning, Resident #57 said she could do that independently, but stated, "There are not enough staff, and you have to wait a long time for them to respond if you need them ... " Resident #57's hair was long and unkempt.</p> <p>During an observation and interview on 9/9/22 at 5:00 p.m., Resident #63 was observed crying out for "help" while lying in her bed, flat on her back. Resident #63 was dressed only in a hospital gown and incontinence brief. Resident #63 had tears in her eyes as she cried, "I hardly have any help anymore. I am not able to get the help I need. I don't want to be here anymore..."</p> <p>During an observation/interview on 9/9/22 at 3:48 p.m., Resident #52 self-propelled up to this Surveyor in his wheelchair and stated, loudly, "I really, really need a shower. I have been sick and had diarrhea, and I need to get cleaned up, but even the new aides say they don't have time to give me a shower. I get really mad when I have to ask and ask, and I need a shower and I don't get one." Resident #52 said several aides who had recently quit would get his showers done. Resident #52 stated, "Now they don't get done."</p> <p>Review of Resident #52's Progress Notes revealed the following, in part: "9/8/22 01:37 (1:37 a.m.), Note Text: The resident was found to have dried BM in his groin creases during cares this night..."</p> <p>Review of facility policies, including: "Routine Resident Checks", dated July 2013, "Incontinence", revised 12/20, "Bathing", Revised 4/22, and "Positioning and Transfer", dated 12/2018, revealed the following, in part:</p>				

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F0726 SS= F	<p>1. "Incontinence" policy: "...Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services ..." No reference to standard of practice time requirements for checking and changing of incontinent residents was identified in this policy.</p> <p>2. "Routine Resident Checks" policy: "To ensure the safety and well-being of our residents, nursing staff shall make a routine resident check on each unit at least once per each 8-hour shift." During interview with Staff "P" and the new NHA, on 9/14/22 at 10:35 a.m., regarding this policy, Staff "P" stated, "Standard of Practice would be checking and changing as necessary every 2 hours." The new NHA stated, "That is not a good policy."</p> <p>3. "Bathing" policy: "...4. A complete tub or shower bath shall be taken, under staff supervision, by (or administered to) an ambulatory resident at least once a week ...5. A bedfast resident shall be assisted with bathing or bathed completely at least twice a week and shall be partially bathed daily and as required due to secretions, excretions, or odors.</p> <p>4. "Positioning and Transfer" policy: "Policy: The patient with limited mobility will be positioned and transferred in a safe manner ... 1. Any resident confined to bed should be repositioned at least every two (2) hours unless contraindicated ..."</p> <p>Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and</p>	F0726		

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	<p>psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>This citation pertains to intake MI00129110 and MI00130451.</p> <p>Based on interview and record review, the facility failed to ensure that licensed nurses had the specific competencies and skill set, and nurse aides demonstrated competency in skills and techniques necessary to care for residents needs in accordance with the facility assessment for three licensed nurses and five certified nurse aides (CNAs) out of eight staff reviewed for completion of annual competency checklists. This deficient practice resulted in the potential for lack of knowledge, competency, and skill in the provision of resident care needs, unmet care</p>			

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	<p>needs, and resident anxiety, depression, and feelings of hopelessness and helplessness when their needs were not addressed. Findings include:</p> <p>Due to the critical content of the interviews and evidence provided during this survey with repeated verbalization of Resident and Staff concerns related to potential retaliation by the facility, all staff will be identified as "Staff" unless the position identification of the position title is necessary.</p> <p>During an interview on 9/13/22 at 10:39 a.m., Staff "T" was asked for licensed nurse and CNA competency checklists for five CNAs and three licensed nurses. Staff "T" stated, "I don't have any competencies for any of the CNAs or the nurses. I presented the list of all the nurses and the CNAs that need(ed) to be done (completed). They could be in the Director of Nurses (DONs) office, but I know ... she would have given them to me (if she had them) ..."</p> <p>During an interview on 9/14/22 at 8:30 a.m., CNA and Nursing Competency Evaluations were requested from the new NHA for five CNAs and three facility nurses. The new NHA said that Staff "T" would have copies of those competencies, which Staff "T" had previously said the competencies were not found.</p> <p>During an interview on 9/14/22 at 8:30 a.m., nursing competency evaluations were requested for the following staff members from the new NHA and Staff "V":</p> <ol style="list-style-type: none"> 1. Staff "H" 2. Staff "I" 3. Staff "VVV" 			

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F0742 SS= F	<p>4. Staff "HH"</p> <p>5. Staff "CCC"</p> <p>6. Staff "O"</p> <p>7. Staff "N" and</p> <p>8. Staff "UUU"</p> <p>During an interview on 9/14/22 at 1:00 p.m., the new Nursing Home Administrator (NHA) confirmed the only documentation to show what information would have been reviewed on licensed nurse and Certified Nurse Aide (CNA) annual competencies, were not job descriptions or a policy (as there was none found), but the blank "Certified Nurse Aide Annual Competency Checklists". The new NHA said no completed Registered Nurse (RN)/Licensed Practical Nurse (LPN), /or CNA competencies were found/available for any of the eight staff requested.</p> <p>Review of the facility provided blank "Certified Nurse Aide Annual Competency Checklist", and the "Licensed Nurse Annual Competency Checklist", contained no documentation, but provided space for the CNA checklist for: "Date Passed Verbally", "Dated Passed by Demonstration", and "Observer Signature", and for the Licensed Nurses: "Instructor's Initials", "Employee's Initials", "Date", and "Return Demonstration Date". No policy was ever provided by the facility before the end of the survey.</p> <p>Treatment/Srvcs Mental/Psychosocial Concerns §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A</p>	F0742			

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	<p>resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to monitor resident behaviors to ensure safety and minimize adverse outcomes, for all residents in the facility. This deficient practice resulted in continued resident to resident altercations, wandering and the potential for injuries and disease transmission. Findings include:</p> <p>Throughout the following time frames several residents were observed to be congregated at the nursing station in chairs and wheel chairs, while staff were at times present and at times not present. Residents had no busying activities and several times were observed with near miss falls from chairs, unkind remarks to each other and others, yelling out, wandering and sleeping:</p> <p>On 9/6/22 from 11:15 a.m. till 12:45 p.m. and 1:30 p.m. till 4:30 p.m.</p> <p>On 9/7/22 from 9:30 a.m. till 10:00 a.m. and 11:00 a.m. till 2:00 p.m.</p> <p>On 9/13/22 from 10:00 a.m. till 11:00 a.m. and 1:00 p.m. till 3:00 p.m.</p> <p>Resident Council Minutes from 4/13/22, revealed the following concerns: "Someone to keep an eye on people by the nurses' station (staff</p>			

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	<p>education/behavior intervention)"</p> <p>On 9/13/22 at 11:06 a.m., Resident #50 was observed wandering into the room just off the nursing station with contact precautions in place. Registered Nurse, (RN) "M" was directly in view, standing at the medication cart, but did not pay attention. A few moments later, RN "M" called to the Resident, who was severely cognitively impaired, and said repeatedly, "Come out of there, come on come on, come on, come out of there." RN "M" noticed this Surveyor observing and walked over to the room, donned a gown and gloves and entered the room to retrieve the Resident, pulling her backwards in the wheel chair from the bathroom, repeating 'no, no, no'. Resident #50 wore no mask, gown or gloves. RN "M" confirmed the resident living in the room was in precautions for C-difficile.</p> <p>During an interview on 9/7/22 at 8:40 a.m., the social service designee (Staff "C" confirmed she was the facility behavior monitor, and a member of the interdisciplinary team (IDT). When asked how she monitored behaviors, Staff "C" said she did not regularly monitor behaviors and the only way she knew of any resident behaviors was if the nurse told her of them or if she heard someone yelling in the hall. When asked how Certified Nurse Aides (CNAs) documented behaviors, Staff "C" stated, "I do not know." Staff "C" confirmed the facility had many residents with psychological diagnoses including psychoses, PTSD (Post Traumatic Stress Disorder) and other mental illnesses. Staff "C" said she knew how to interact with these kinds of residents but most staff did not. When asked if she provided education to staff about residents with behaviors, Staff "C" said did not because she didn't have a college degree and did not know the resources to tap. Staff "C" said the squeaky wheel gets greased and she was made aware of a behavior if she heard yelling episodes; otherwise she was unaware of</p>			
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	<p>any behaviors. Staff "C" confirmed she did not go to the floor to monitor behaviors during cares, meals, activities or resident to resident interactions. Staff "C" said she never received any trauma informed training and was unaware of three of the four resident to resident altercations being investigated.</p> <p>The survey included four reported incidents of resident to resident altercations, including Resident #51 hitting and swearing at Resident #50, Resident #52 hitting Resident #50, Resident #54 throwing coffee on Resident #53, and Resident #55 swearing at Resident #56.</p> <p>According to the electronic medical records (EMRs), Resident #50 was severely cognitively impaired and wandered aimlessly, Resident #51 was cognitively intact with diagnoses including schizophrenia and anxiety, Resident #52 suffered from a traumatic brain injury, Resident #53 had PTSD.</p> <p>The policy Behavior Management Program, dated 12/2020, revealed, "...Residents who display mental disorder, substance abuse, psychosocial adjustment difficulty, trauma, post-traumatic stress disorders, and dementia should receive appropriate services as indicated to optimize the resident's overall wellbeing...Residents will receive culturally competent, trauma informed care in accordance with professional standards of practice accounting for residents' experiences and preferences to eliminate or mitigate triggers that may cause retraumatization...Behaviors shall be identified through...staff interaction...further assessments to identify and manage behaviors may be conducted...Identified behaviors should be evaluated for frequency, duration, intensity and pattern...decide which residents need a behavior management program by evaluating the documented behaviors...Assess the behavior to</p>				

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F0812 SS= F	<p>discern why the resident is engaging in the behavior...Describe in detail the behavior...Examine the extent to which the behavior is a problem...:</p> <p>Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i) (1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i) (2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:</p> <p>This deficient pertains to Intake #MI00129738 & #MI00130451.</p> <p>Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards for food service safety, by failure to dispose of outdated, visibly deteriorated salad and prepared cottage cheese, and prevent contamination of food when two boxes of tater tots (one open box, and one unopened) were stored on the floor in the walk-in cooler. This deficient practice resulted in the potential for foodborne illness with the use of expired and degraded food, and the risk of food contamination when being stored on the walk-in</p>	F0812			

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	<p>freezer floor. Findings include:</p> <p>During kitchen observation and interview on 9/7/22 at 1:10 p.m., in the presence of Staff "R", the following items were found:</p> <ol style="list-style-type: none"> 1. Two, 5 pound bags of shredded lettuce with a manufacturer's "use by date" of 8/29/22 were found in the walk-in refrigerator. The lettuce was browning and liquid was forming in the packages: one bag was opened and appeared to have been used, the other bag was unopened. 2. Two 1/2 cup servings of cottage cheese were found uncovered, on a tray with a "use by date" written on the tray of 9/6/22. 3. Two boxes of tater tots: one open box, one sealed were placed directly on the walk-in freezer floor. <p>Staff "R" observed the food items identified above and stated, "Oh yeah, they (expired food items) are not to be used." When shown the boxes of tater tots on the walk-in freezer floor, Staff "R" said they were not to be stored on the freezer room floor, but should be stored on the shelves in the walk-in freezer. No cottage cheese was found in the cooler, and the amount of eggs was not sufficient for a facility meal (breakfast) per Staff "R".</p> <p>2013 FDA Food Code reference:</p> <p>3-307.11 Miscellaneous Sources of Contamination.</p> <p>FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306</p> <p>Review of the facility "Food Storage" policy,</p>			

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	<p>revised 1/2021, revealed the following, in part: "...2. Food stored in walk-in refrigerators and freezers will be sorted on shelves, racks or other surfaces that facilitate thorough cleaning and air flow ... 3.a. Fresh produce will have a receive date and be monitored for quality, discarding bruised or spoiled product ... 5. Ready to eat food can be stored by expiration date, until opened, then labeled with open and use-by date if not discarded. 6. Use-by-dates are different for different food products, but do not exceed the product expiration date. 7. Food items that are opened shall be put into sealable container of bag, labeled and dated with open and use-by-date..."</p> <p>During an interview on 9/7/22 at 3:01 p.m., Resident #55 said the facility had run out of eggs, both fresh and hard-boiled, brown sugar, and they hardly ever had cottage cheese (which Resident #55 enjoyed eating).</p> <p>During an interview on 9/7/22 at 3:41 p.m., Staff "Q" confirmed they had received the wrong eggs; regular instead of pasteurized, cottage cheese had run out occasionally, on 9/1/22 the facility ran out of oatmeal, and on Saturday (9/3/22) [Dietitian "S"] had to go and buy five or six gallons of milk with her (personal) funds. When asked how the facility had run out of milk, Staff "Q" was unsure, and said the facility did not have petty cash, the corporation didn't pay for anything, and if Staff "Q" needed to buy something at the store it was with personal funds. Staff "Q" stated, "I try my best to not run out of things. I am working so much in the kitchen (as a cook or dietary aide) I am not spending as much time doing my own job as I should."</p> <p>During an interview on 9/7/22 at 4:14 p.m., Consultant Dietitian "S" confirmed she purchased milk for the facility with personal funds. Dietitian "S" stated, "I was here Saturday and I had to buy</p>			

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F0835 SS= F	<p>milk out of my own pocket. I know we have had some supply chain issues." Dietitian "S" confirmed they had run out of eggs, cottage cheese, and oatmeal.</p> <p>Administration §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:</p> <p>This deficient practice pertains to Intake #MI00130451</p> <p>Based on observation, interview and record review, the facility administration failed to effectively and efficiently maintain sufficient resident care services and facility environment resources and supply chains to ensure:</p> <ol style="list-style-type: none"> 1. Resident care needs were met. 2. Adequate staffing was available to provide resident care. 3. Timely payment of outstanding balances for: pharmaceutical supplies, transportation, facility repairs, lawn maintenance, mechanical vendors, flooring vendors, and medical supply vendors. 4. Facility management was in place to assess and manage critical facility concerns identified and expressed to corporate management. <p>This deficient practice resulted in the potential for compromised resident physical, mental, and psychosocial well-being and had the potential to</p>	F0835		

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	<p>affect all 42 facility residents. Findings include:</p> <p>Due to the critical content of the interviews and evidence provided during this survey with repeated verbalization of resident and staff concerns related to potential retaliation by the facility, all staff will be identified as "Staff" unless the position title is critical to deficiency understanding.</p> <p>An abbreviated survey was completed on 9/14/22 that investigated multiple confidential and anonymous complaints with multiple allegations related to environmental and physical care of facility residents, and insufficient staffing levels.</p> <p>Residents interviews conducted on 9/7/22 at 12:30 p.m. and 3:01 p.m., 9/9/22 at 2:58 p.m., 3:45 p.m. and 3:48 p.m., and 9/14/22 at 9:00 a.m., with Residents #58, #55, #57, #62, #63, and Resident #55 respectively, all said the facility did not have adequate staff to meet their needs, showers were not being performed as scheduled, and call light response times were very slow, especially at night.</p> <p>Staff interviews conducted on 9/7/22 at 12:02 p.m., 1:17 p.m., 2:17 p.m., 3:25 p.m., and 3:35 p.m., 9/8/22 at 9:30 a.m., 10:24 a.m., 10:50 a.m., 12:09 p.m. and 3:20 p.m., 9/9/22 at 10:08 a.m., Staff "L", Staff "E", Staff "T", Staff "H", Staff "I", Staff "J", Administrative Staff "A", Staff "D", Administrative Staff "B", Staff "N", and Medical Provider "NN", acknowledge a serious staffing shortage. Director care staff, of the above identified "Staff" confirmed showers were not being done as scheduled, call lights were not being timely addressed, dependent residents were not being repositioned every two hours, and all said that the Corporate Officers had been informed of the critical concerns for the facility.</p>				

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	<p>During an interview on 9/7/22 at 3:41 p.m., Staff "Q" confirmed she had worked at the facility from March 2021 and had not started her training for becoming a Certified Dietary Manager (CDM) until June of 2022. When asked why there was such a long delay in beginning the CDM training, Staff "Q" said the Facility Corporation had agreed to pay for the CDM training when she was hired in March of 2021. Staff "Q" stated, "I had been submitting the expense reports for it to be paid for months and months ... Eventually we tried to charge the credit card (for the training) and that (was) declined for several months ..."</p> <p>During an interview on 9/8/22 at 9:30 a.m., Staff "J" confirmed the facility bus had been repaired at a local facility, and the bill was paid with the personal credit card of Administrative Staff "Y", who also used the personal credit card to pay for gasoline for the facility bus. Staff "J" identified multiple safety concerns with the facility bus that had gone unrepaired although the repairs had been reported to facility administration.</p> <p>Review of voluntarily provided emails from facility "Staff", revealed the following, in part:</p> <p>Review of an email dated 8/15/22 at 7:41 a.m., sent by Staff "E" to facility Owner "Z", Chief Operating Officer "AA", Nursing Home Administrator (NHA) of Record/Regional Director of Operations, NHA of another [Corporate Name] facility "Y", and "W". Regional Director of Operations "DD" revealed the following:</p> <p>"Non-payment: I am not sure whom to go to anymore, our facility is failing. We had calls over the weekend from [Internet Provider], our computer/internet, non-payment, they are going to turn us off. The hospital did not want to transport a resident back as we owe them money.</p>			

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	<p>We cannot rent from [Medical Supply Vendor] anymore, Non-payment. We cannot rent from [Medical Supply Vendor], wander guard monitors, non-payment. After August 24th we have 4 full-time CNA's (sic) left in this facility. Our lawn looks like a jungle. We have a handful of loyal employees sticking it out, what is happening with [Corporation Name]. We have been begging for help."</p> <p>Review of an email dated 8/18/22 at 3:55 p.m., from Staff "E" to facility Owner "Z", Chief Operating Officer "AA", Nursing Home Administrator (NHA) of Record/Regional Director of Operations, NHA of another [Corporate Name] facility "Y", Regional HR (human resources) Director "BB" and VP (Vice President), Clinical Operations "CC", revealed the following:</p> <p>"Emergent need of help.</p> <p>[Corporate Owner],</p> <p>I am still awaiting your assistance requested on Monday in which you replied: 'I'll take care of this today'. We are still waiting on a reply from a travel CNA agency. Our staffing is at a critical level as of Tuesday, August 22, 2022. We have been begging for help for months now. We have been mandating staff for 16 hrs. (hours) a day 4 days a week and have lost many good CNA's due to the excessive workload. They are feeling hopeless because corporate promises of help have not been met. We have numerous vendors complaining of non-payment. Most supply companies are on a "credit hold". Transportation is an issue because of non-payment. We are unable to transport residents to their specialized MD (doctor) appts. (appointments) and procedures that are scheduled. This is putting them at risk. We never had petty cash available</p>			

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	<p>for emergency use. Our fax machine is not faxing out making outside communication difficult. All our management staff are working in all departments. The first appearance of our building is appalling. Our lawn hasn't been mowed. Weeds are overgrown. Dead trees are still standing. We are unable to get lawn service due to non-payment. Shut off notices are coming in the mail. The staff are concerned that we are going to have to close. This is a small community, and everyone talks. We have little to no suppliers that will deal with us due to our reputation. Our medical director was not paid since February (2022). Our kitchen, housekeeping, and several manger positions are open. We are at our wits end up here. PLEASE give us some help or direction as this building is at a critical level right now."</p> <p>8/26/22 10:28 a.m. - FROM: Facility Staff to NHA of Record/Regional Director of Operations: "... Along with our current critical CNA staffing shortage I do not believe it is ethical to begin taking admissions as our current residents are not receiving the care that they deserve at this time ..."</p> <p>8/31/22 9:07 a.m., - FROM Facility Staff: "We have 3 rooms closed due to leaking windows and have 2 rooms closed for carpeting issues. A total of 8 beds down."</p> <p>During a telephone interview on 9/13/22 at 3:10 p.m., when asked if an email had been received in August regarding the staff's request for help from the corporate office, Corporate Owner "Z" stated, "I have not." Chief Operating Officer "AA" confirmed he had received an email from facility staff, but could not recall what assistance the facility requested.</p> <p>During telephone interviews on the following dates, revealed the following service and supply</p>				

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	<p>chain concerns:</p> <p>9/8/22 12:48: [Pharmacy Vendor] reported charge account frozen. \$611.61 owed and sent to collection. "They do have a corporate account with us, and they are delinquent."</p> <p>9/8/22 12:58 p.m.: [Medical Supply Vendor], "Invoices that were paid in August (2022), included invoices from 3/24/22 and 3/25/22, being paid greater than four months past due."</p> <p>9/8/22 1:05 p.m.: [Grocery Vendor] "...Ownership changed for the facility and (we) were left with a \$2,000 balance that never got paid ... They (facility) reopened the account in February 2022. The last time they charged was in April (2022) ... They (facility) still haven't paid anything and there is a \$400 dollar balance that was owed..."</p> <p>9/8/22 1:16 p.m., [Transportation Vendor] "The wheelchair van is not available from [Ambulance Service] ... Because they have not paid any of the invoices since we started providing services (in) May of 2021. It is right around \$1400.00 (we are owed) ... We were not paid for a year and a half."</p> <p>9/8/22 7:48 p.m., [Lawn Care Vendor] "It was about \$2300 that they owed us this time, and we told them we needed the balance paid, and payment for the (lawn) cut ... It is coming to that we have them pay in advance..."</p> <p>9/9/22 10:08 a.m., [Medical Director], "I remind them every month that I haven't been paid" and said \$8000 was currently owed for previous services provided.</p> <p>9/12/22 9:30 a.m., [Flooring Vendor] "We are supposed to repair the carpet and put vinyl flooring in with four-inch base ... The material is</p>				

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	<p>in my warehouse. As soon as I get my down payment, I will start working on it. I have had trouble with reimbursement from them in the past ... It has always been a pain in the ... to get paid from them."</p> <p>9/12/22 10:40 a.m., [Mechanical Vendor] "All of the payments are months out and they will not pay interest, so we are giving them loans basically ... Some of the checks were made out but sat on for a while. The last time I sent an email back, I have acknowledged that we are willing to go 45 days out (on outstanding balanced), (and) we haven't heard from them since. They made it sound like they can't pay ... They don't get their funding for 90 days or something like that."</p> <p>During interview on 9/11/22 at 1:48 p.m. and 2:00 p.m., Staff "CCC" and Staff "N", respectively confirmed paychecks had been received on 9/8/22 and 9/9/22, when other staff had received direct deposit of their paycheck on 9/2/22. Staff "N" said Staff "KK" had also received her paycheck late in September. Both staff said they had received their paychecks late previously, but the delay was much shorter with only a one-to-two-day delay in receipt of their paychecks.</p> <p>During an interview on 9/12/22 at 10:59 a.m., Staff "T" confirmed paper paychecks were last following the holiday in the beginning of September. Staff "T" stated, "From what I was told, these checks were sent out fed ex on the first and were expected to arrive on the second, but didn't come here until the 7th ...It has happened when they were a day late ... This is the longest it ever came out ... I expected the checks no later than the third..."</p> <p>During an interview on 9/14/22 at 8:30 a.m.,</p>			

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	<p>CNA and Nursing Competency Evaluations were requested from the new NHA for five CNAs and three facility nurses. The new NHA said that Staff "T" would have copies of those competencies, which Staff "T" had previously said the competencies were not found.</p> <p>During an interview on 9/14/22 at 9:00 p.m., Resident #55 stated, "Now they don't even have a Social Worker ... Social Workers keep coming and going ...The Social Workers start planning a discharge, working on how I can go home, and then everyone quits. At this rate, I am never going to get home." Resident #55 said it was extremely discouraging, because all he wanted to do was go home.</p> <p>During an interview on 9/14/22 at 9:55 a.m., the new NHA confirmed Social Service Designee "C" resigned on Monday (9/12/22) morning via email, with no notice provided.</p> <p>During an interview on 9/14/22 at 11:52 a.m., the new NHA, regarding nurse competency evaluations, stated, "I do not have any nurse aide, or nursing competencies to provide to you." No policy, or job descriptions detailed the requirement for annual competencies, but blank competency checklist forms were provided by the facility to show what information should have been completed.</p> <p>During an interview on 9/6/22 at 11:45 a.m., the agency administrator, listed as "worker" on the facility staff list (Staff "A" confirmed she was a traveling Nursing Home Administrator and was working temporarily as the administrator in the building. Staff "A" confirmed her first day of employment was Friday, 9/2/22. Staff "A" was not the Administrator of record with the State Agency (SA).</p>				

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	<p>During an interview on 9/6/22 at 12:36 p.m., Interim Director of Nursing (IDON) Minimum Data Set (MDS) coordinator and Infection Preventionist (IP), (Staff) "V" confirmed she was the IDON. Staff "V" said there was a new DON starting the next day (9/7/22). Staff "V" confirmed she was also the IP and MDS coordinator in the building and was working some floor shifts.</p> <p>During an interview on 9/7/22 at 11:05 a.m., Staff "GG" confirmed the Maintenance Director was usually the supervisor for laundry and housekeeping as well as maintenance, but there was no Maintenance Director employed at that time. Staff "GG" said the staff just work there normal shifts and "figure it out."</p> <p>During an interview on 9/7/22 at 1:45 p.m., the Administrator (NHA) said he was in the building since about 9:00 a.m. that day. The NHA said he was employed with the corporation since 6/20/22 and the NHA of record for the building since 6/21/22. The NHA said his title was Director of Operations for the corporation. When asked how often he was in the building, the NHA said most Mondays since 6/21/22. When asked to provide the exact dates of his presence in the building, the NHA said he would have to get that information.</p> <p>During an interview on 9/13/22 at 10:00 a.m., Staff "V" confirmed she was the interim DON until the previous week on 9/7/22, when a new permanent DON started. Staff "V" said her responsibilities as the interim DON included clinical monitoring, oncall 24/7, staffing audits, risk management, 24-hour reports from staff, and meetings. Staff "V" confirmed these were in addition to her IP and MDS coordinator responsibilities. Staff "V" also confirmed she worked the floor for several shifts during August 2022. Staff "V" said her phone number was in the</p>				

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F0837 SS= F	<p>staffing book and all staff had access to her twenty four hours per day. Staff "V" said she did not think the general staff were informed of her interim DON status and some staff may not have known who to call for various issues or concerns. Staff "V" confirmed she never signed anything formally recognizing her or accepting an interim DON position and never received a position description for the DON position. When asked if she was able to fulfill all of the responsibilities of the DON, IP, MDS coordinator, especially while simultaneously working the floor, Staff "V" said she was not able to fulfill her duties.</p> <p>During an interview on 9/13/22 at 4:02 p.m., Staff "V" reviewed the staffing book at the nursing station with this Surveyor and confirmed her phone number was not in the book nor posted anywhere for staff to contact her in the event of a need.</p> <p>Governing Body §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to engage an active governing body that appropriately developed and implemented policies to manage the operation of the facility,</p>	F0837		

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	<p>for all 42 vulnerable residents. This deficient practice resulted in the mis-management of the facility, lacking consistent leadership and adequate staffing to meet resident needs. Findings include:</p> <p>During an interview on 9/13/22 at 11:26 a.m., the incoming Administrator (Staff) "PP" confirmed the previous day (9/12) was his first day of employment at the facility as Administrator. Staff "PP" said the governing body was the corporation, and the president was the outgoing Administrator of record and Director of Operations for the corporation (NHA). Staff "PP" said he was not yet informed of any regular accountabilities or communications or meetings with the governing body.</p> <p>During a phone interview on 9/13/22 at 11:41 a.m., the NHA (Regional Director of Operations) patched in the Regional Clinical Director (Staff) "X". The NHA was asked who the governing body was for the facility and responded with the corporation's name. When asked who the members specifically were, the NHA said the owner and (Chief Executive Officer) CEO "Z" and the (Chief Operating Officer) COO "AA". When asked if there were any other members, the NHA asked for the definition of "governing body." When asked who the members of the governing body as described/defined in CMS (Center for Medicare and Medicaid Services) regulations, were, the NHA stated, "We can get you that information." When asked if he or Staff "X" were members of the governing body, the NHA said he would have to see who was on the governing body.</p> <p>During a phone interview on 9/13/22 at 3:10 p.m., the CEO "Z" and COO "AA" were conferenced in. CEO "Z" was asked who the governing body for the facility was and</p>			

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	<p>responded, the corporation name. CEO "Z" went on to say the NHA was legally responsible for the facility operations. CEO "Z" then said he, COO "AA", the NHA, Staff "GGG" and Staff "CC", two other corporate individuals, were the governing body. When asked if he could recall what QAPI (Quality Assurance and Performance Improvement) projects were going on in the facility, CEO "Z" stated, "No, I couldn't."</p> <p>During an interview on 9/14/22 at 11:53 a.m., incoming Administrator (Staff) "PP" reviewed QAPI meeting agendas and sign in sheets for August 2022. Staff "PP" stated, "This doesn't look like very good QAPI notes." When asked if one could decipher what performance improvement projects (PIP) were in place and how the projects progressed, based on data, Staff "PP" confirmed one could not tell what was happening in QAPI. Staff "PP" said no direct care staff were involved with QAPI, but should be. Staff "PP" said generally standard QAPI agenda items and PIPs should include the last standard survey deficiencies, with updates regarding the progress of the PIPs and the data associated with them. When asked if the agenda and notes demonstrated a good faith attempt at correcting identified deficiencies, Staff "PP" stated, "I would have to agree." When asked for clarification, Staff "PP" confirmed there was no evidence in the agenda or notes that good faith attempts were made to improve systems or processes. Staff "PP" also confirmed there was no evidence the Governing Body was involved with the QAPI program or its projects.</p> <p>The policy Quality Assurance and Performance Improvement, dated 4/2019, revealed, "...The governing body...is responsible and accountable for the QAPI program...oversight responsibilities include...Ensuring the program is ongoing, defined, implemented, maintained, and addresses identified priorities...Ensuring the program is</p>				

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F0838 SS= F	<p>sustained during transitions in leadership and staffing...Ensuring the program is adequately resourced...Ensuring the program identifies and prioritizes problems...with a formal meeting no less than annually..."</p> <p>The policy Governing Body, dated 1/2021, revealed, "...[Corporation name] governing body is legally responsible for management and operations...Establishes a designated body responsible for implementing and managing the operations of facilities according to federal, state and local laws...Ensure expectations of the organization are set around safety, quality, rights, choice and respect...Administrator...Reports to and is accountable to the governing body...Responsible for the facility practice of hiring...nurse aides...Responsible and accountable for QAPI program in accordance with RoP (requirements of participation)...Sustained during transition of leadership and staffing..Adequately resourced...Corrective actions address gaps in systems..."</p> <p>Facility Assessment §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care</p>	F0838		
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	<p>required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by:</p> <p>This deficient practice pertains to the following</p>			

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	<p>Intakes: #MI00130451, #MI00130427, #MI00129738, and #MI00131016.</p> <p>Based on interview and record review, the facility failed to fully complete a facility-wide assessment that documented how facility staffing levels were determined and utilized based on the facility census and acuity of the resident population to ensure necessary staffing and resources to meet the care needs for facility residents. This deficient practice resulted in insufficient staffing and resources to provide for resident care needs and had the potential to affect all 42 vulnerable residents.</p> <p>Findings include:</p> <p>Due to the critical content of the interviews and evidence provided during this survey with repeated verbalization of resident and staff concerns related to potential retaliation by the facility, all staff will be identified as "Staff" unless the position title is critical to deficiency understanding.</p> <p>During a telephone interview on 9/6/22 at 5:22 p.m., Complainant "FF", said in June and July of 2022 the facility was noticeably short of nursing staff, especially on the night shift. Complainant "FF" stated, "Once in a while there was only one nurse and one aide (all night)." Complainant "FF" said the concern was voiced to facility administration who said they were doing the best they could. Complainant "FF" reported, "I often had to wait for a respiratory treatment, and that made me short of breath and more anxious. I am incontinent and with one aide you may get changed once a night, and on afternoons you (I) had to wait over a half hour for a brief change with stool in it ... With the showers, you never got the showers you were scheduled. I probably got a shower a month ..." Complainant "FF" reported</p>				

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	<p>wanting showers, but staff told him they did not have time .</p> <p>During a telephone interview on 9/7/22 at 8:06 a.m., anonymous Complainant "EE", an advocacy organization employee, reported having been in the building approximately three to four weeks previous. Anonymous Complainant "EE" stated, "The day I was there many of the residents were fearful of the staffing situation (low staffing levels). One of the huge complaints I got was the (lack of) showering."</p> <p>Review of the "Facility Assessment," updated July 1, 2022, revealed the following, in part: "Staffing is maintained at a level to meet the needs of the resident population. Mandatory overtime is utilized to maintain levels and increased efforts have been made to recruit and retain staffing ... The facility assesses the resident population through review of documentation from referral source (i.e., hospital, family, physician, homecare agency) prior to admission, assessments conducted upon admission into facility by IDT, initial care planning meeting held with resident and/or their family or responsible party, and ongoing assessments completed per policy. The facility determines the acuity of residents following review of above documentation and assessments. The facility determines staffing levels upon review of acuity and availability and will adjust staff as needed."</p> <p>Review of the "Activities of Daily Living" documentation in the "Facility Assessment" included the following numbers for "Assist of 1 or 2" which included 30-55 residents for transfers, dressing, and toileting, and "Dependent" which included 5-10 for transfers, and 0-10 for Mobility." No data was present showing the level of staffing that would be provided based on the resident acuity level, which</p>			

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	<p>was not documented in the "Facility Assessment" for the facility.</p> <p>Review of the Updated Facility Assessment "Staffing Appendix - 9/13/22" (updated seven days following start of the abbreviated survey) revealed the following additional information: "Staffing is maintained at a level to meet the needs of the resident population. Mandatory overtime is utilized to maintain levels and increased efforts have been made to recruit and retain staffing ... Base on the average acuity of [Facility Name], direct care staffing to meet the needs of the facility has been determined to be 2.9 PPD as of 9/13/22, but this PPD is subject to change based on acuity and needs of the facility ... [Facility Name] uses 2 licensed nurses per 12 hour shift, however, this may vary based on acuity changes. Based on the average acuity in the facility, the facility has determined an adequate staffing pattern. This pattern is subject to change based on acuity and is to be reviewed by the QA committee during routine meetings. The example staffing pattern (subject to change) is shown below:</p> <p>Census Licensed Nurse Hours per Day [CNA hours per day]</p> <p>30 48 39</p> <p>35 48 54</p> <p>40 48 68</p> <p>45 48 83</p> <p>50 48 97</p> <p>55 48 112</p> <p>This "Appendix" was not included on the</p>			

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F0840 SS= F	<p>"Facility Assessment" received 9/7/22, when originally requested from the facility</p> <p>Review of the "Nursing Department Daily Staffing" sheets from 8/22/22 through 9/13/22 revealed multiple days with inadequate staffing hours based upon the updated facility assessment "Staffing Appendix" for both nurses and CNAs. The "Facility Assessment" did not previously identify how staffing was determined.</p> <p>Review of the "Facility Assessment" policy, dated 12/20, revealed the following, in part: "Policy: The facility will conduct and document a facility-wide assessment to determine what resources are necessary to care for its resident competently during both day-to-day operation and emergencies ... The facility assessment will include but not limited to (sic) the following ... 1. ... The care required by the resident population considering the types of diseases, condition, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population ... The staff competencies that are necessary to provide the level and types of care needed for the resident population ... 2. The facilities resources, including but not limited to; ... All personnel, including manager, staff (both employees and those who provide services under contract, and volunteers, as well as their education and/or training and any competencies related to resident care ...3. A facility-based and community-based risk assessment, utilizing an all-hazards approach. 4. The facility assessment will be reviewed and updated whenever there is, or the facility plans for, any change that would require a substantial modification to any part of the assessment ..."</p> <p>Use of Outside Resources §483.70(g) Use of outside resources. §483.70(g)(1) If the facility does not employ a qualified professional</p>	F0840			

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	<p>person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section. §483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for-</p> <p>(i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to utilize outside resources to maintain the physical building when identified concerns could not be met with existing staff affecting all 42 vulnerable residents. This deficient practice resulted in the potential for worsening dilapidation, unsafe living conditions, and embarrassment for residents. Findings include:</p> <p>During an entrance conference on 9/6/22 at 11:45 a.m. the agency administrator (Staff "A" confirmed the facility had no maintenance personnel employed including no maintenance director.</p> <p>During an interview on 9/6/22 at 1:35 p.m., Staff "II" confirmed there was no supervisor overseeing facility maintenance, housekeeping or laundry.</p> <p>During an interview on 9/13/22 at 2:37 p.m., the incoming Administrator, Staff "PP" and Staff</p>			

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F0850 SS= F	<p>"III" both confirmed no outside vendors/companies were contacted to fill the building maintainance needs. Two sister facilities in the area had maintenance staff but were not contributing to the facility. Both Staff "PP" and Staff "III" confirmed knowledge of a laundry flood with no follow up, a leaking roof and windows, out of order commercial dryers, an out of order shower room, wall damage, and other maintenance issues. Both confirmed at that time repairs were on hold awaiting hire of a new maintenance person. At time of survey there were no likely candidates for this position.</p> <p>Qualifications of Social Worker >120 Beds §483.70(p) Social worker. Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is: §483.70(p)(1) An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and §483.70(p)(2) One year of supervised social work experience in a health care setting working directly with individuals. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to employee a social service worker to provide medical social services to all 42 vulnerable Residents. This deficient practice resulted in the potential for injury and depression. Findings include:</p> <p>During an interview on 9/14/22 at 9:00 a.m., Resident #55 stated, "Now they don't even have a Social Worker ... Social Workers keep coming</p>	F0850		

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	<p>and going ...The Social Workers start planning a discharge, working on how I can go home, and then everyone quits. At this rate, I am never going to get home." Resident #55 said it was extremely discouraging, because all he wanted to do was go home.</p> <p>Resident Council Minutes from 4/13/22, revealed the following concerns: "Someone to keep an eye on people by the nurses' station (staff education/behavior intervention)"</p> <p>On 9/13/22 at 11:06 a.m., Resident #50 was observed wandering into the room just off the nursing station with contact precautions in place. Registered Nurse, (RN) "M" was directly in view, standing at the medication cart, but did not pay attention. A few moments later, RN "M" called to the Resident, who was severely cognitively impaired, and said repeatedly, "Come out of there, come on come on, come on, come out of there." RN "M" noticed this Surveyor observing and walked over to the room, donned a gown and gloves and entered the room to retrieve the Resident, pulling her backwards in the wheel chair from the bathroom, repeating 'no, no, no'. RN "M" confirmed the resident living in the room was in precautions for C-difficile.</p> <p>During an interview on 9/7/22 at 8:40 a.m., the social service designee (Staff "C" confirmed she was the facility behavior monitor, and a member of the interdisciplinary team (IDT). When asked how she monitored behaviors, Staff "C" said she did not regularly monitor behaviors and the only way she knew of any resident behaviors was if the nurse told her of them or if she heard someone yelling in the hall. When asked how Certified Nurse Aides (CNAs) documented behaviors, Staff "C" stated, "I do not know." Staff "C" confirmed the facility had many residents with psychological diagnoses including psychoses, PTSD (Post</p>			

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F0865 SS= F	<p>Traumatic Stress Disorder) and other mental illnesses. Staff "C" said she knew how to interact with these kinds of residents but most staff did not. When asked if she provided education to staff about residents with behaviors, Staff "C" said did not because she didn't have a college degree and did not know the resources to tap. Staff "C" said the squeaky wheel gets greased and she is made aware of a behavior if she hears yelling episodes; otherwise she was unaware of any behaviors. Staff "C" confirmed she did not go to the floor to monitor behaviors during cares, meals, activities or resident to resident interactions. Staff "C" said she never received any trauma informed training and was unaware of three of the four resident to resident altercations being investigated.</p> <p>The survey included four reported incidents of resident to resident altercations, including Resident #51 hitting and swearing at Resident #50, Resident #52 hitting Resident #50, Resident #54 throwing coffee on Resident #53, and Resident #55 swearing at Resident #56.</p> <p>According to the electronic medical records (EMRs), Resident #50 was severely cognitively impaired and wandered aimlessly, Resident #51 was cognitively intact with diagnoses including schizophrenia and anxiety, Resident #52 suffered from a traumatic brain injury, Resident #53 had PTSD.</p> <p>During an interview on 9/14/22 at 9:55 a.m., the new NHA confirmed Social Service Designee "C" resigned on Monday (9/12/22) morning via email, with no notice provided.</p> <p>QAPI Prgm/Plan, Disclosure/Good Faith Attmpt §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the</p>	F0865			

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	<p>State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to implement and maintain an effective Quality Assurance Performance Improvement (QAPI) program to ensure continuously improved quality of care and quality of life for all 42 vulnerable Residents. This deficient practice resulted in the potential for Resident functional debility, depression and withdrawal. Findings include:</p> <p>During an interview on 9/14/22 at 11:53 a.m., Incoming Administrator (Staff) "PP" reviewed QAPI meeting agendas and sign in sheets for August 2022. Staff "PP" stated, "This doesn't look like very good QAPI notes." When asked if one could decipher what performance improvement projects (PIP) were in place and how the projects progressed, based on data, Staff "PP" confirmed one could not tell what was happening in QAPI. Staff "PP" said it looked like there was supposed to be a PIP for pressure wounds, but couldn't tell what was happening with it. Staff "PP" said no direct care staff were involved with QAPI, but should be. Staff "PP" said generally standard QAPI agenda items and PIPs should include the last standard survey deficiencies, with updates</p>				

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	<p>regarding the progress of the PIPs and the data associated with them. When asked if the agenda and notes demonstrated a good faith attempt at correcting identified deficiencies, Staff "PP" stated, "I would have to agree." When asked for clarification, Staff "PP" confirmed there was no evidence in the agenda or notes that good faith attempts were made to improve systems or processes. Staff "PP" also confirmed there was no evidence the Governing Body was involved with the QAPI program or its projects.</p> <p>The policy Quality Assurance and Performance Improvement, dated 4/2019, revealed, "...It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life...Develop and implement appropriate plans of action to correct identified quality deficiencies...Regularly review and analyze data...and act on available data to make improvements...The QAPI program will address...activities necessary to identify and correct quality deficiencies...Tracking and measuring performance...Establishing goals and thresholds...identifying and prioritizing quality deficiencies...Systematically analyzing underlying causes of systemic quality deficiencies...Monitoring and evaluating the effectiveness of corrective action...draw data from multiple sources...The facility assessment...Clinical logs such as for...pressure injuries...Staffing trends...Survey outcomes..."</p>				