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| F 000 | INITIAL COMMENTS<br><br>An onsite revisit was conducted on 1/9/24 through 1/10/24. Tags F578, F582, F641, F644, F658, F677, F727, F730, F756, F758, and F803 were corrected as of 1/10/24. Repeat tags were cited. New tags were also cited as a result of the complaint investigation survey that was conducted at the same time as the revisit. The facility is still out of compliance. | F 000 | | |
| F 550 SS=G | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen | F 550 | | |

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

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| F 550 | Continued From page 1 | F 550 | | |

or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff, and resident interviews, the facility failed to treat a resident with dignity and respect when Nursing Assistant (NA) #3 refused to assist Resident #2 with eating her meal at lunch time and then yelled at Resident #2 when her lunch tray fell on the floor. Nurse #2 observed the resident "shaking" and "crying" after the incident with NA #3. This occurred for 1 of 2 residents reviewed for dignity and respect.

Findings included:

Resident #2 was admitted to the facility on 12-13-23 with multiple diagnoses that included muscle weakness, arthritis in the right shoulder, and post left shoulder surgery.

The 5-day Minimum Data Set (MDS) dated 12-19-23 revealed Resident #2 was moderately cognitively impaired and required substantial to maximal assistance with eating. There were no behaviors documented on the MDS.

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The facility's initial allegation report dated 1-2-24 for an incident occurring on 1-1-24 documented Resident #2 reported NA #3 had refused to feed her after Resident #2 had requested help with eating and that NA #3 spoke in a loud voice to Resident #2. The allegation report also documented Resident #2 had shoulder surgery and that Resident #2 had stated she had difficulty feeding herself.

Resident #2 was interviewed on 1-10-24 at 11:45am. Resident #2 explained on 1-1-24 NA #3 had brought her lunch tray and sat the tray on her table. The resident stated she told NA #3 that she needed to have help eating and she said NA #3 had told her "No you can feed yourself." The resident stated NA #3 left the room and when she tried to feed herself, she accidentally knocked her tray on the floor before she was able to eat any of her lunch. Resident #2 stated when NA #3 answered her call light, NA #3 told her "You did it on purpose" and began "screaming" at her. The resident said she told NA #3 to leave her room because she did not want to be "screamed" at and NA #3 left the room. The resident explained Nurse #2 came in later and cleaned up the spilled lunch tray, brought her a new lunch tray, and assisted her in eating. Resident #2 stated a "couple of days" later NA #3 came to her room to help her eat her soup. She said NA #3 said to her "I don't want a hissy fit anymore." The resident discussed taking a couple of spoonful's of soup and then told NA #3 she was done because she was afraid the NA may do something. Resident #2 stated when the incident on 1-1-24 occurred, she was upset and crying.

Nurse #2 was interviewed on 1-10-24 at 12:05pm. The nurse confirmed she had been

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| F 550 | Continued From page 3 | F 550 | | |

assigned to Resident #2 on 1-1-24. Nurse #2 discussed not being aware of the incident with NA #3 until a short time later when she entered Resident #2's room and found her shaking and crying. She said Resident #2 had told her NA #3 had refused to help her eat and then "yelled" at her when she accidentally knocked her tray on the floor. The nurse stated Resident #2 told her she had not received another lunch tray and was hungry, so the nurse said she had obtained a lunch tray for Resident #2 and assisted her in eating. Nurse #2 stated Resident #3 had never showed any behaviors and had not had any incidences with any other NA. Nurse #2 stated she had reported the incident to the Director of Nursing (DON) as soon as she was finished assisting Resident #2 and was told by the DON to educate NA #3 on customer service. The nurse discussed not providing the education to NA #3 because "she kept walking away from me." She explained when Resident #2 was admitted, she needed assistance in eating due to her shoulder surgery and the NAs were aware through the staff's morning report that Resident #2 needed assistance. Nurse #2 also explained Resident #2 needed assistance with eating up until a week and a half ago when the resident had progressed in her treatment and could now feed herself.

A telephone interview occurred with NA #3 on 1-10-24 at 1:40pm. NA #3 confirmed she had been assigned to Resident #2 on 1-1-24. The NA explained she had brought Resident #2 her lunch tray and the resident had asked her to help feed her. NA #3 said she told the resident "No" because Resident #2 could feed herself. The NA stated right after she walked out of Resident #2's room she heard a noise, so she went back into the room and saw Resident #2's lunch tray on the

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| F 550 | Continued From page 4<br>floor. NA #3 stated Resident #2 told her "See I told you I can not feed myself." The NA explained she started cleaning up the lunch tray from the floor and Resident #2 began "yelling and cussing at me and then asked me to leave." NA #3 said she had reported the incident to Nuse #2. The NA stated she had been assigned to Resident #2 prior to the incident on 1-1-24 and did not have any issues.<br><br>NA #2 was interviewed on 1-10-24 at 12:28pm. NA #2 stated she was familiar with Resident #2 and aware the resident required assistance in eating until 1.5 weeks ago when Resident #2 had progressed well enough to feed herself. She stated she was made aware of the requirement to assist Resident #2 in eating during the staff's morning report. The NA discussed not working on 1-1-24 but stated she had never heard of Resident #2 throwing her meal tray on the floor or yelling at any staff member.<br><br>During an interview with the Administrator and DON on 1-10-24 at 1:29pm, the DON discussed speaking with NA #3 on 1-2-24 and the NA had told her Resident #2 had refused to allow NA #3 to assist her with her meal and then the resident threw her lunch tray on the floor. The DON also stated NA #3 told her she had not raised her voice at Resident #2. The Administrator discussed training being provided to all staff on dignity/respect and customer service prior to the incident and did not know why the incident occurred as NA #3 had not had any issues with customer service prior to the incident on 1-1-24. | F 550 | | |
| F 867 SS=E | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) | F 867 | | |

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| F 867 | Continued From page 5<br>§483.75(c) Program feedback, data systems and monitoring.<br>A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:<br><br>§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.<br><br>§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.<br><br>§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.<br><br>§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. | F 867 | | |

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| F 867 | Continued From page 6<br>§483.75(d) Program systematic analysis and systemic action.<br><br>§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.<br><br>§483.75(d)(2) The facility will develop and implement policies addressing:<br>(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;<br>(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and<br>(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.<br><br>§483.75(e) Program activities.<br><br>§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.<br><br>§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. | F 867 | | |

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| F 867 | Continued From page 7<br><br>§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).<br>Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.<br><br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, resident, and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put in place following the recertification and | F 867 | | |

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| F 867 | Continued From page 8 | F 867 | | |

complaint surveys of 4/1/21, 8/11/22 and 11/30/23 and the complaint survey of 1/18/23. This was for a deficiency in the area of Residents Rights/Exercise of Rights (F550). The continued failure during five federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program.

Findings:

This tag is cross-referenced to:

F550: Based on record review, staff, and resident interviews, the facility failed to treat a resident with dignity and respect when Nursing Assistant (NA) #3 refused to assist Resident #2 with eating her meal at lunch time and then yelled at Resident #2 when her lunch tray fell on the floor. Nurse #2 observed the resident "shaking" and "crying" after the incident with NA #3. This occurred for 1 of 2 residents reviewed for dignity and respect.

During recertification and complaint survey of 4/1/21 the facility was cited for failing to provide a resident with pants resulting in the resident being embarrassed and feeling bad.

During the recertification and complaint survey of 8/11/22 the facility was cited for failing to treat residents in a dignified manner when staff entered a resident's room without knocking or asking permission to enter.

During the complaint survey of 1/18/23 the facility was cited for failing to treat a resident with dignity by not providing incontinence care when needed.

During the recertification and complaint survey of

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| F 867 | Continued From page 9<br>11/30/23 the facility was cited for staff using racial slurs and vulgar hand gestures when interacting with a resident.<br><br>During an interview with the Administrator on 1/10/24 at 10:54 am, the Administrator discussed continued monitoring of residents for dignity and respect from their previous survey. She also discussed the facility conducting education with all staff on dignity/respect and using their Quality Assurance Committee to ensure compliance with the issue of dignity and respect. | F 867 | | |