

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175542	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/16/2022
NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF OVERLAND PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following citations represent the findings of a partial extended survey and complaint investigation #KS00169443. On 02/16/22 at 05:08 PM the facility was provided copies of the "Immediate Jeopardy (IJ) Templates" and Administrative Staff A was notified of the IJs for Resident (R) 1. The facility failed to ensure Resident (R)1 remained free from abuse and neglect when the facility failed to prevent an episode of staff to resident verbal abuse, mistreatment and neglect. The facility further failed to ensure staff identified a situation of verbal abuse, neglect and mistreatment as an alleged violation. The facility failed to ensure staff immediately reported the alleged violation to Administrative Staff A. Administrative Staff A failed to acknowledge the allegation as abuse and failed to alert the appropriate state agencies as required. On 02/06/22 at approximately 0430 AM Certified Nurse Aide (CNA) M entered R1's room while R1 pleaded for help. CNA M called R1 a liar, stated R1 was "talking nasty" and told R1 "you're the devil." CNA M told R1 nobody wanted to hear her. CNA M mocked R1 as R1 cried for assistance, repeatedly stating R1 could not hear. CNA M dressed R1, placed her in the wheelchair but neglected to ensure the call light was within reach for R1 to summon staff assistance. These failures placed R1 in immediate jeopardy. The 2567 was sent electronically to the facility on 02/21/22..	F 000			
F 600	Free from Abuse and Neglect	F 600			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 600 SS=J	Continued From page 1 CFR(s): 483.12(a)(1) §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: The facility identified a census of 36 residents. The sample included three residents reviewed for abuse. Based on record review and interviews, the facility failed to ensure Resident (R)1 remained free from abuse and neglect when the facility failed to prevent an episode of staff to resident verbal abuse, mistreatment and neglect. On 02/06/22 at approximately 04:30 AM, Certified Nurse Aide (CNA) M entered R1's room while R1 pleaded for help. CNA M called R1 a liar, stated R1 was "talking nasty" and told R1 "you're the devil." CNA M told R1 nobody wanted to hear her. CNA M mocked R1 as R1 cried for assistance, when R1 repeatedly stated she could not hear. CNA M dressed R1, placed her in the wheelchair, but neglected to ensure the call light was within reach for R1 to summon staff assistance. This failure placed the resident in immediate jeopardy.	F 600			

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F 600	Continued From page 2 Findings included: - R1 admitted to facility on 01/28/22 and discharged on 02/11/22. The "Electronic Medical Record (EMR)" documented diagnoses of fracture of the sacrum (large triangular bone between the two hip bones), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and fall on same level. The "Admission Minimum Data Set (MDS)" dated 02/03/22, documented R1 had a Brief Interview for Mental Status of 15 which indicated intact cognition. R1 had moderate difficulty with hearing and the speaker had to increase volume and speak distinctly. R1 used hearing aids or other hearing appliances. R1 required extensive physical assistance with two staff members for bed mobility, transfers, and toileting; extensive physical assistance with one staff member for dressing; limited physical assistance with one staff member for walking, locomotion, and personal hygiene; and supervision with setup help only with eating. The "Communication Care Area Assessment (CAA)" dated 02/06/22, documented R1 had minimal difficulty hearing when not in a quiet environment and she had hearing aids. Nursing assisted with hearing aids as needed and staff raised voice volume as needed when addressing resident. R1 generally did not have a problem understanding staff and was able to effectively communicate all wants and needs to staff and family.	F 600			

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F 600	Continued From page 3 The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential CAA" dated 02/06/22, documented R1 required extensive to limited assistance with mobility and ADLs. The "Baseline Person Centered Care Plan" dated 01/28/22, documented R1 needed assistance with ADLs and wore hearing aids. A recorded message revealed the following interaction between R1 and CNA M on 02/06/22: R1- "I'm in trouble, I'm laying here naked and the girl took away my number to call for help and she left me on the bed, naked with no clothes. And I'm in, I can't move, my feet are hanging over the bed, I can't move. Somebody you got to help me; I don't know who to call. Please help me, please. Somebody I'm laying here naked in the bed; all twisted my feet are getting the end of the bed. And she won't do anything, she took my call button away. So, I got to get somebody, I don't know who to call. I can't do it, I can't move. Please somebody, I'm laying here, I can't move. She walked out on me with no, nothing, I can't even push a button for help. She was nobody, she walked out on me like this, I'm screaming, please help me somebody. Please, please. I don't know what to do, I don't know. Oh my god, oh my god. Hello? I can't lay like this. [sobbing in background] getting some help. no, I can't lay like this, no, I can't. I can't, I can't go back, I can't go forward, I can't, I can't, I have nothing, but in here with you." CNA M: "You calling your family lying." R1: "I didn't do anything."	F 600			

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F 600	Continued From page 4 CNA M: "Calling your family lying. Here, give me that." R1 and CNA M: [unable to discern words] CNA M: "You're about to get up, I'm going to put you in your chair." R1: "You let me lay here like this." CNA M: "You're not going to like this." R1: "I can't lay here like this. I can't, I can't lay like this. I didn't do anything." R1 and CMA M-: [unable to discern words] R1: "Help me please, I can't lay like this." CNA M: "See, that's what you do, you talking nasty then you call and tell lies to your family. Quit lying, you're the devil. " R1: "I can't lay like this. [unable to discern words]" CNA M: "You go waking up the whole hall with this foolishness." R1: "Where's my thing at?" CNA M: 'This is Sunday, don't nobody want to hear that." R1: "I can't hear you, I'm sorry." CNA M: I'm sorry, I'm deaf too." R: "I'm deaf."	F 600			

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F 600	Continued From page 5 CNA M: "I'm sure." R1: "I can't hear you." CNA M: "Okay, yeah" R1: "I can't lay like this, I'm uncomfortable." In a "Progress Note" dated 02/06/22 at 07:01 AM, Licensed Nurse (LN) H documented the following: around 04:50 AM, LN H was doing rounds when she heard R1 calling for help. She rushed to R1's room immediately and asked what was wrong. R1 stated that she was in pain and needed a pain pill. LN H took an as needed (PRN) pain pill to R1 and R1 was calm. At around 05:50 AM, R1's representative called and stated she heard R1 being abused and harassed and recorded the whole incident. R1's representative narrated that R1 told her the aide who was helping R1 left her naked and uncovered, yelled at R1, and took her call light away. R1's representative stated she was afraid R1 was being abused and she was making arrangements to move her out of the facility. LN H asked R1 about the accusations and R1 did not report any abuse to LN H. In a "Progress Note" at 04:01 PM LN G documented she, along with two other unidentified nurses, spoke with R1's representative related to the incident with R1 and CMA M overnight. LN G documented Administrative Staff A and Administrative Nurse D were notified of the conversation and advised to contact R1's representative on Monday morning. R1's representative requested R1 move to a room closer to the nurse's station as soon as possible.	F 600			

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F 600	Continued From page 6 Upon request, the facility provided the following witness statements: In an undated written statement at 02:30 PM, CNA M wrote R1 complained of pain after dinner and took her gown off. [R1] appeared naked and stated something about "sexual misconduct" where R1 worked. CNA M wrote she asked R1 "not to talk that way as it was [there were] visitors outside her door." CNA M further documented she closed R1's door for privacy. CNA M recorded R1 "complained" of "wanting to be pulled up" and the nurse helped CNA M put R1 in her chair. CNA M wrote that she asked R1 why R1 was treating CNA M "this way" and asked R1 to please not yell and calm down because it was Sunday. CNA M wrote she asked R1 several times not to talk that way. CNA M wrote she stated to R1 "please cover up and have some dignity!!" CNA M wrote she asked R1 to "keep her voice down" as R1 kept stating "why?" CNA M documented she responded to R1 by saying "it's Sunday. I have no time for foolishness." CNA M got R1 dressed, put her up in her chair, and R1 calmed down. CNA M documented R1 called R1's representative to complain and CNA M told R1 and/or her representative CNA M was not entertaining R1's "foolish and nonsense conversation," and sexual misconduct. CNA M recorded she let R1 and/or R1's representative know "that was unacceptable conversation and behavior." In a typed statement dated 02/07/22, Administrative Staff A documented he received a text from LN H who spoke to R1 about an incident involving CNA M at approximately 04:45 AM on 02/06/22. The text stated R1 called her representative to tell her the following: "reported	F 600			

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F 600	Continued From page 7 that she was left naked, her call light taken away by the aide and that she was yelling at her, her family member admitted recording the whole incident, asked the aide and she denied the accusations. She also stated that she's making arrangements to come get her mom out of there. Patient did not report any abuse." In a typed statement dated 02/07/22, Administrative Staff A documented he received the following statement from CNA N regarding the incident between CNA M and R1: On 02/06/22 around 03:30 AM to 4:15 AM, CNA N walked down to hall one to grab the ice chest but heard someone yelling for help and moaning like they were in pain. CNA N followed the voice down to R1's room and the nurse for the hall happened to be right behind her. CNA N approached R1 who sat in the wheelchair. R1 told CNA N that R1 was left naked in bed and the call light was "taken away." R1 was dressed when CNA N walked into her room. R1 did not have her call light on her, it was behind her on the recliner, out of her reach. CNA N pinned R1's call light to R1. R1 complained her back was hurting and CNA N placed a pillow behind R1 in the wheelchair to give her some support. LN H gave R1 a pain pill. In a typed statement dated 02/07/22, Administrative Staff A documented he received reports about an incident regarding a "verbal altercation" between CNA M and R1. CNA M gave a statement and was immediately placed on the facility's "do not return list" through the contracting agency. Administrative Staff A received reports from LN H and CNA N then spoke to R1 to make sure she was "ok." Administrative Staff A notified R1 that CNA M would not return to the facility. R1 thanked	F 600			

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F 600	Continued From page 8 Administrative Staff A for the help. Administrative Staff A called R1's representative and notified her that CNA M was placed on "do not return list." In a witness statement obtained on 02/16/22, LN G wrote she came to work for the 06:00 AM shift on 02/06/22 and the night nurse, LN H, was writing an incident report. LN H explained that "something happened" with the agency CNA overnight and R1's representative had something recorded. LN G encouraged LN H to report to Administrative Staff A and Administrative Nurse D immediately and encouraged CNA M to write a statement. LN G checked on R1. Around lunch, R1's representative arrived and requested to speak with nurse. LN G and two other unidentified nurses went to speak with R1's representative. R1's representative played the recorded interaction between R1 and CNA M. LN G referred R1's representative immediately to Administrative Staff A and Administrative Nurse D. R1's representative requested R1 be relocated to a room closer to the nurses' station. In a witness statement obtained on 02/16/22, Administrative Nurse D documented on 02/06/22 (Sunday) at 12:53 PM, she was notified by a day nurse of a "situation" that needed addressed by Administrative Staff D and Administrative Staff A on Monday morning. She was notified on 02/06/22 via text by LN H that R1 called and reported she was left naked; her call light was taken away by an aide and yelled at by a CNA. R1's representative also reported she was removing R1 from the facility. LN H stated R1 was not naked and denied any form of abuse. Administrative Nurse D notified the unidentified staffing coordinator and Administrative Staff A of the text and asked the	F 600			

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F 600	Continued From page 9 staffing coordinator to take CNA M off the schedule and notify her contracting agency. Administrative Nurse D asked all staff working to write a statement and called Administrative Staff A when the statements were completed. In a witness statement obtained on 02/16/22, Administrative Staff A wrote he was notified Sunday morning, 02/06/22, that LN H and CNA N assisted R1. Administrative Staff A documented LN H and CNA N found R1 upright in a wheelchair, clothed, and complaining of back pain. Administrative Staff A recorded LN H reported R1 denied abuse. Administrative Staff A documented he talked to R1 on Monday, 02/07/22, in the morning and R1 requested to be moved closer to the nurses' station. He told R1 that CNA M had been placed on the "do not return" list and confirmed R1 would be moved into another room. Administrative Staff A recorded he called R1's representative and notified her CNA M would not be back to the facility and R1 was moving to another room that afternoon. Administrative Staff A recorded he called the corporate office and was instructed to gather the statements. Administrative Staff A documented R1 mentioned she had a verbal altercation with an agency CNA and he immediately notified her that the CNA would not be returning to the facility. On 02/15/22 at 02:58 PM, Administrative Staff A stated the incident with R1 was not treated as an abuse allegation and R1 did not report abuse when interviewed. On 02/16/22 at 11:16 AM, LN M stated on the morning of the incident, she came in at shift change and LN N was "frazzled" trying to figure out what she should do. LN M stated she knew	F 600			

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F 600	Continued From page 10 something happened with R1 and CNA M around 04:00 AM that morning and R1's representative had "something recorded." LN M stated she instructed LN N to notify Administrative Staff A and Administrative Nurse D, complete an incident report, and document. She stated she checked on R1 first thing and R1 was "pretty shaken." LN M stated R1's representative came into the facility around lunch time and wanted to speak with the nurse. LN M, along with two other nurses as witnesses, spoke to R1's family member. LN M stated R1's family member played the voicemail for LN M. LN M told R1's representative it would be reported immediately to Administrative Staff A. R1's representative wanted to make sure R1 would be safe and was notified CNA M would not be returning to the facility. LN M stated she considered the verbal altercation between CNA M and R1 as abuse. On 02/16/22 at 11:51 AM, Administrative Nurse D stated if abuse was suspected, staff notified administration and if abuse was found after the facility investigation, it was reported appropriately. Administrative Nurse D said if a resident stated they were being verbally abused or staff were being rough, then an investigation was initiated, but if the resident denied abuse, then an investigation was not completed or needed. She stated if the residents' representative alleged abuse, but the resident denied the abuse, then it did not count as an allegation of abuse. Administrative Nurse D stated the incident with R1, and CNA M was reported to her on 02/06/22 at 07:00 AM. She stated the staffing agency was contacted so agency aide CNA M would not return to facility. She stated the nurse that worked during the incident stated she spoke to R1 regarding abuse allegations and R1 denied any	F 600			

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F 600	Continued From page 11 abuse. Administrative Nurse D stated if a resident complained of being abused, the facility would investigate. She stated she spoke with R1's family member throughout the week but had not heard the recording. Administrative Nurse D stated the facility's policy directed abuse complaints were investigated only if the residents said they were abused. Administrative Nurse D stated the facility had 24 hours to report once allegations were found to be actual abuse. On 02/16/22 at 12:24 PM, Administrative Staff A stated he was notified early Sunday morning, 02/06//22, about an incident that occurred around 04:30 AM. R1's representative had a recording from around that time. LN H reported to Administrative Staff A that she entered R1's room with CNA N in response to R1 calls for help. R1 was upright in her wheelchair and clothed. He stated LN H asked R1 follow-up questions and asked R1 if she felt abused or neglected. R1 denied feeling abused or neglected. Administrative Staff A stated R1 told him she did not get along with CNA M and that they had a "verbal altercation." He informed R1 that CNA M would not return to the facility and R1 requested to move closer to the nurse's station. He stated that to his understanding, if a resident or family member alleged abuse then there was a short window of 24 hours to report it. If there was any abuse, he would do an investigation and call the police. Administrative Staff A said R1 had not complained of abuse, and there was no investigation as there was no allegation since R1 denied abuse. He stated R1 said she did not get along with CNA M, CNA M raised her voice at R1, seemed agitated, and not compassionate. Administrative Staff A stated anything had the potential to be verbally abusive. He had not	F 600			

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F 600	Continued From page 12 listened to the recording, but stated the resolution was simple as it was an agency aide, she was not allowed back. He stated he had not read the "Progress Note" by LN H that documented R1's family member alleged abuse and harassment and it was not reported to him as such. On 02/16/22 at 02:00 PM, CNA N stated on 02/06/22 she was working on hall two and heard someone yelling. CNA N and LN H went down to R1's room, R1 sat in her wheelchair, yelling that she was naked in bed. R1 was dressed and did not have call light within reach as it was behind her. CNA N pinned her call light on her CNA N stated if she witnessed abuse, she would report to the nurse, Administrative Nurse D and Administrative Staff A. On 02/16/22 at 02:41 PM, LN H stated she was the nurse on duty on the morning of 02/06/22 and R1's representative called with concerns about R1. R1's representative voiced a concern about R1 being abused. LN H went into R1's room to make sure she had not been abused and had not been naked. LN H stated she reported R1's representative's concerns to Administrative Staff A. The facility's "Abuse Policy and Procedure" last updated 08/06/20, directed any form of resident abuse, mistreatment, neglect, misappropriation, exploitation, or deprivation of goods and/or services was not tolerated and it was the responsibility of all employees to report abuse to the Administrator or Director of Nursing. All residents have the right to be free from any verbal, sexual, physical, and mental abuse, mistreatment, neglect, misappropriation, and deprivation of goods and/or services. Residents	F 600			

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F 600	Continued From page 13 were not subjected to abuse by anyone including staff, other residents, consultants or volunteers, contract employees or staff from other agencies serving the residents. Verbal abuse was defined as any use of oral, written, or gestured language that included disparaging and derogatory terms to residents or families or within hearing distance to describe residents regardless of their age, ability to comprehend, or disability. All alleged or suspected violations involving including abuse, neglect, mistreatment, misappropriation, exploitation or deprivation of goods and/or services were promptly reported to the Administrator and/or Director of Nursing. The person observing an incident of resident abuse or suspected abuse must immediately ensure resident safety then immediately report such incidents to their immediate supervision and/or the charge nurse. The supervisor and/or charge nurse contacted the Administrator or Director of Nursing. The Director of Nursing or Administrator ensured the safety of the resident, began the investigation, and if necessary, report information to the police and any other appropriate agency.	F 600			
F 607 SS=F	The facility failed to ensure R1 remained free from abuse and neglect when the facility failed to prevent an episode of staff to resident verbal abuse, mistreatment and neglect. This failure placed the resident in immediate jeopardy. Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and	F 607			

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F 607	Continued From page 14 misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: The facility identified a census of 36 residents. The sample included three residents. Based on record review and interview the facility failed to develop and implement a policy that included the current required reporting timeframes for any allegation of abuse, neglect and exploitation. This placed all residents in the facility at risk. Findings included: - On 02/16/22 at 11:51 AM Administrative Nurse D stated that if abuse was found, staff would notify Administrative Staff A or herself. Administrative Nurse D further stated that if abuse was found after the investigation then it would be reported. Administrative Nurse D stated that if a family alleged abuse but the resident denied abuse allegation it was not investigated. Administrative Nurse D revealed that if a resident stated she was abused then it would be investigated. She continued to state that the policy stated that abuse is investigated if a resident says he/she was abused. Administrative Nurse D stated that according to the facility abuse policy, she had 24 hours to report to the state agency if the abuse allegations are found to be true. She stated that staff were to report abuse immediately. On 02/16/22 at 12:24 PM Administrative Staff A	F 607			

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F 607	Continued From page 15 stated that if a resident or a family alleges abuse then the facility has a short window to report, 24 hours. Administrative Staff A reported he hadn't had to report yet. He further stated that if it was abuse he would do an investigation and call the police. Administrative Staff A stated that he would also do one on one training with staff if it was required. He stated anything had the potential to be verbally abusive. He stated the facility updated the abuse policy if there is anything said to the facility during an annual survey . The "State Operating Manual: Appendix PP" directed a facility must have and implement written policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves identifying, correction and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur. It further directed that a facility would assure that the staff assigned had the knowledge of the individual residents' care needs and behavioral symptoms. IV. Identification: The facility must have written procedures to assist staff in identifying abuse, neglect, and exploitation of residents, and misappropriation because some cases of abuse are not directly observed, understanding resident outcomes of abuse could assist in identifying whether abuse is occurring or has occurred. V. Investigation: The facility must have written procedures for investigation abuse, neglect, misappropriation and exploitation that include: investigation different types of alleged violations; focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and the cause; and providing complete and thorough	F 607			

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F 607	Continued From page 16 documentation of the investigation. VII. Reporting/Response: The facility must have written procedures that must include immediately reporting all alleged violations to the administrator, state agency, adult protective services and to all other required agencies (law enforcement when applicable) with in specified timeframes. The facility's "Abuse Policy and Procedure" updated 08/06/20 documented that an incident would be reported to the administrator and/or director of nursing immediately. The policy further directed the administrator and/or director of nursing will complete an investigation including a written summary of the findings no later than five working days of the reported occurrence. should the investigation reveal "reasonable cause to believe" that abuse, neglect, mistreatment, misappropriation or exploitation has occurred the administrator and/or director of nursing will report such findings immediately to the required state agency and take appropriate corrective action. The facility failed to develop and implement a policy that directed staff to immediately report to the appropriate state agencies any resident allegation of abuse, neglect or exploitation within the required timeframe of immediately but not later than two hours for alleged violations that involve abuse or result in serious bodily injury and immediately but not later than 24 hours if the alleged violation does not involve abuse and does not result in serious bodily injury.	F 607			
F 609 SS=J	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse,	F 609			

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F 609	Continued From page 17 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: The facility identified a census of 36 residents. The sample included three residents reviewed for abuse. Based on record review and interviews, the facility failed to ensure staff identified a situation of verbal abuse, neglect, and mistreatment as an alleged violation. The facility further failed to ensure staff immediately reported the alleged violation to the facility administrator. Once reported, the facility administrator failed to acknowledge the allegation as abuse and failed	F 609			

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F 609	Continued From page 18 to alert the appropriate state agencies as required. On 02/06/22 at approximately 04:30 AM, Certified Nurse Aide (CNA) M entered R1's room while R1 pleaded for help. CNA M called R1 a liar, stated R1 was "talking nasty" and told R1 "you're the devil." CNA M told R1 nobody wanted to hear her. CNA M mocked R1 as R1 cried for assistance, when R1 repeatedly stated she could not hear. CNA M dressed R1, placed her in the wheelchair, but neglected to ensure the call light was within reach for R1 to summon staff assistance. R1's responsible representative alerted the facility to the occurrence on 02/06/22. This failure placed the resident in immediate jeopardy. Findings included: - R1 admitted to facility on 01/28/22 and discharged on 02/11/22. The "Electronic Medical Record (EMR)" documented diagnoses of fracture of the sacrum (large triangular bone between the two hip bones), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and fall on same level. The "Admission Minimum Data Set (MDS)" dated 02/03/22, documented R1 had a Brief Interview for Mental Status of 15 which indicated intact cognition. R1 had moderate difficulty with hearing and the speaker had to increase volume and speak distinctly. R1 used hearing aides or other hearing appliances. R1 required extensive physical assistance with two staff members for bed mobility, transfers, and toileting; extensive physical assistance with one staff member for	F 609			

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F 609	Continued From page 19 dressings; limited physical assistance with one staff member for walking, locomotion, and personal hygiene; and supervision with setup help only with eating. The "Communication Care Area Assessment (CAA)" dated 02/06/22, documented R1 had minimal difficulty hearing when not in a quiet environment and she had hearing aids. Nursing assisted with hearing aids as needed and staff raised voice volume as needed when addressing resident. R1 generally did not have a problem understanding staff and was able to effectively communicate all wants and needs to staff and family. The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential CAA" dated 02/06/22, documented R1 required extensive to limited assistance with mobility and ADLs. The "Baseline Person Centered Care Plan" dated 01/28/22, documented R1 needed assistance with ADLs and wore hearing aids. A recorded message revealed the following interaction between R1 and CNA M on 02/06/22: R1- "I'm in trouble, I'm laying here naked and the girl took away my number to call for help and she left me on the bed, naked with no clothes. And I'm in, I can't move, my feet are hanging over the bed, I can't move. Somebody you got to help me, I don't know who to call. Please help me, please. Somebody I'm laying here naked in the bed, all twisted my feet are getting the end of the bed. And she won't do anything, she took my call button away. So I got to get somebody, I don't know who to call. I can't do it, I can't move.	F 609			

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F 609	Continued From page 20 Please somebody, I'm laying here, I can't move. She walked out on me with no, nothing, I can't even push a button for help. She was nobody, she walked out on me like this, I'm screaming, please help me somebody. Please, please. I don't know what to do, I don't know. Oh my god, oh my god. Hello? I can't lay like this. [sobbing in background] getting some help. no, I can't lay like this, no, I can't. I can't, I can't go back, I can't go forward, I can't, I can't, I have nothing, but in here with you." CNA M: "You calling your family lying." R1: "I didn't do anything." CNA M: "Calling your family lying. Here, give me that." R1 and CNA M: [unable to discern words] CNA M: "You're about to get up, I'm going to put you in your chair." R1: "You let me lay here like this." CNA M: "You're not going to like this." R1: "I can't lay here like this. I can't, I can't lay like this. I didn't do anything." R1 and CMA M-: [unable to discern words] R1: "Help me please, I can't lay like this." CNA M: "See, that's what you do, you talking nasty then you call and tell lies to your family. Quit lying, you're the devil. "	F 609			

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F 609	Continued From page 21 R1: "I can't lay like this. [unable to discern words]" CNA M: "You go waking up the whole hall with this foolishness." R1: "Where's my thing at?" CNA M: "This is Sunday, don't nobody want to hear that." R1: "I can't hear you, I'm sorry." CNA M: "I'm sorry, I'm deaf too." R: "I'm deaf." CNA M: "I'm sure." R1: "I can't hear you." CNA M: "Okay, yeah" R1: "I can't lay like this, I'm uncomfortable." In a "Progress Note" dated 02/06/22 at 07:01 AM, Licensed Nurse (LN) H documented the following: around 04:50 AM, LN H was doing rounds when she heard R1 calling for help. She rushed to R1's room immediately and asked what was wrong. R1 stated that she was in pain and needed a pain pill. LN H took an as needed (PRN) pain pill to R1 and R1 was calm. At around 05:50 AM, R1's representative called and stated she heard R1 being abused and harassed and recorded the whole incident. R1's representative narrated that R1 told her the aide who was helping R1 left her naked and uncovered, yelled at R1, and took her call light away. R1's representative stated she was afraid R1 was being abused and she was	F 609			

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F 609	Continued From page 22 making arrangements to move her out of the facility. LN H asked R1 about the accusations and R1 did not report any abuse to LN H. In a "Progress Note" at 04:01 PM LN G documented she, along with two other unidentified nurses, spoke with R1's representative related to the incident with R1 and CMA M overnight. LN G documented Administrative Staff A and Administrative Nurse D were notified of the conversation and advised to contact R1's representative on Monday morning. R1's representative requested R1 move to a room closer to the nurse's station as soon as possible. Upon request, the facility provided the following witness statements: In an undated written statement at 02:30 PM, CNA M wrote R1 complained of pain after dinner and took her gown off. [R1] appeared naked and stated something about "sexual misconduct" where R1 worked. CNA M wrote she asked R1 "not to talk that way as it was [there were] visitors outside her door." CNA M further documented she closed R1's door for privacy. CNA M recorded R1 "complained" of "wanting to be pulled up" and the nurse helped CNA M put R1 in her chair. CNA M wrote that she asked R1 why R1 was treating CNA M "this way" and asked R1 to please not yell and calm down because it was Sunday. CNA M wrote she asked R1 several times not to talk that way. CNA M wrote she stated to R1 "please cover up and have some dignity!!" CNA M wrote she asked R1 to "keep her voice down" as R1 kept stating "why?" CNA M documented she responded to R1 by saying "it's Sunday. I have no time for foolishness." CNA M	F 609			

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F 609	Continued From page 23 got R1 dressed, put her up in her chair, and R1 calmed down. CNA M documented R1 called R1's representative to complain and CNA M told R1 and/or her representative CNA M was not entertaining R1's "foolish and nonsense conversation," and sexual misconduct. CNA M recorded she let R1 and/or R1's representative know "that was unacceptable conversation and behavior." In a typed statement dated 02/07/22, Administrative Staff A documented he received a text from LN H who spoke to R1 about an incident involving CNA M at approximately 04:45 AM on 02/06/22. The text stated R1 called her representative to tell her the following: "reported that she was left naked, her call light taken away by the aide and that she was yelling at her, her family member admitted recording the whole incident, asked the aide and she denied the accusations. She also stated that she's making arrangements to come get her mom out of there. Patient did not report any abuse." In a typed statement dated 02/07/22, Administrative Staff A documented he received the following statement from CNA N regarding the incident between CNA M and R1: On 02/06/22 around 03:30 AM to 4:15 AM, CNA N walked down to hall one to grab the ice chest but heard someone yelling for help and moaning like they were in pain. CNA N followed the voice down to R1's room and the nurse for the hall happened to be right behind her. CNA N approached R1 who sat in the wheelchair. R1 told CNA N that R1 was left naked in bed and the call light was "taken away." R1 was dressed when CNA N walked into her room. R1 did not have her call light on her, it was behind her on the recliner, out of her reach.	F 609			

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F 609	Continued From page 24 CNA N pinned R1's call light to R1. R1 complained her back was hurting and CNA N placed a pillow behind R1 in the wheelchair to give her some support. LN H gave R1 a pain pill. In a typed statement dated 02/07/22, Administrative Staff A documented he received reports about an incident regarding a "verbal altercation" between CNA M and R1. CNA M gave a statement and was immediately placed on the facility's "do not return list" through the contracting agency. Administrative Staff A received reports from LN H and CNA N then spoke to R1 to make sure she was "ok." Administrative Staff A notified R1 that CNA M would not return to the facility. R1 thanked Administrative Staff A for the help. Administrative Staff A called R1's representative and notified her that CNA M was placed on "do not return list." In a witness statement obtained on 02/16/22, LN G wrote she came to work for the 06:00 AM shift on 02/06/22 and the night nurse, LN H, was writing an incident report. LN H explained that "something happened" with the agency CNA overnight and R1's representative had something recorded. LN G encouraged LN H to report to Administrative Staff A and Administrative Nurse D immediately and encouraged CNA M to write a statement. LN G checked on R1. Around lunch, R1's representative arrived and requested to speak with nurse. LN G and two other unidentified nurses went to speak with R1's representative. R1's representative played the recorded interaction between R1 and CNA M. LN G referred R1's representative immediately to Administrative Staff A and Administrative Nurse D. R1's representative requested R1 be relocated to a room closer to the nurses' station.	F 609			

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F 609	Continued From page 25 In a witness statement obtained on 02/16/22, Administrative Nurse D documented on 02/06/22 (Sunday) at 12:53 PM, she was notified by a day nurse of a "situation" that needed addressed by Administrative Staff D and Administrative Staff A on Monday morning. She was notified on 02/06/22 via text by LN H that R1 called and reported she was left naked; her call light was taken away by an aide and yelled at by a CNA. R1's representative also reported she was removing R1 from the facility. LN H stated R1 was not naked and denied any form of abuse. Administrative Nurse D notified the unidentified staffing coordinator and Administrative Staff A of the text and asked the staffing coordinator to take CNA M off the schedule and notify her contracting agency. Administrative Nurse D asked all staff working to write a statement and called Administrative Staff A when the statements were completed. In a witness statement obtained on 02/16/22, Administrative Staff A wrote he was notified Sunday morning, 02/06/22, that LN H and CNA N assisted R1. Administrative Staff A documented LN H and CNA N found R1 upright in a wheelchair, clothed, and complaining of back pain. Administrative Staff A recorded LN H reported R1 denied abuse. Administrative Staff A documented he talked to R1 on Monday, 02/07/22, in the morning and R1 requested to be moved closer to the nurses' station. He told R1 that CNA M had been placed on the "do not return" list and confirmed R1 would be moved into another room. Administrative Staff A recorded he called R1's representative and notified her CNA M would not be back to the facility and R1 was moving to another room that afternoon.	F 609			

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F 609	Continued From page 26 Administrative Staff A recorded he called the corporate office and was instructed to gather the statements. Administrative Staff A documented R1 mentioned she had a verbal altercation with an agency CNA and he immediately notified her that the CNA would not be returning to the facility. On 02/15/22 at 02:58 PM, Administrative Staff A stated the incident with R1 was not treated as an abuse allegation and R1 did not report abuse when interviewed. On 02/16/22 at 11:16 AM, LN M stated on the morning of the incident, she came in at shift change and LN N was "frazzled" trying to figure out what she should do. LN M stated she knew something happened with R1 and CNA M around 04:00 AM that morning and R1's representative had "something recorded." LN M stated she instructed LN N to notify Administrative Staff A and Administrative Nurse D, complete an incident report, and document. She stated she checked on R1 first thing and R1 was "pretty shaken." LN M stated R1's representative came into the facility around lunch time and wanted to speak with the nurse. LN M, along with two other nurses as witnesses, spoke to R1's family member. LN M stated R1's family member played the voicemail for LN M. LN M told R1's representative it would be reported immediately to Administrative Staff A. R1's representative wanted to make sure R1 would be safe and was notified CNA M would not be returning to the facility. LN M stated she considered the verbal altercation between CNA M and R1 as abuse. On 02/16/22 at 11:51 AM, Administrative Nurse D stated if abuse was suspected, staff notified administration and if abuse was found after the	F 609			

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F 609	Continued From page 27 facility investigation, it was reported appropriately. Administrative Nurse D said if a resident stated they were being verbally abused or staff were being rough, then an investigation was initiated, but if the resident denied abuse, then an investigation was not completed or needed. She stated if the residents' representative alleged abuse, but the resident denied the abuse, then it did not count as an allegation of abuse. Administrative Nurse D stated the incident with R1, and CNA M was reported to her on 02/06/22 at 07:00 AM. She stated the staffing agency was contacted so agency aide CNA M would not return to facility. She stated the nurse that worked during the incident stated she spoke to R1 regarding abuse allegations and R1 denied any abuse. Administrative Nurse D stated if a resident complained of being abused, the facility would investigate. She stated she spoke with R1's family member throughout the week but had not heard the recording. Administrative Nurse D stated the facility's policy directed abuse complaints were investigated only if the residents said they were abused. Administrative Nurse D stated the facility had 24 hours to report once allegations were found to be actual abuse. On 02/16/22 at 12:24 PM, Administrative Staff A stated he was notified early Sunday morning, 02/06//22, about an incident that occurred around 04:30 AM. R1's representative had a recording from around that time. LN H reported to Administrative Staff A that she entered R1's room with CNA N in response to R1 calls for help. R1 was upright in her wheelchair and clothed. He stated LN H asked R1 follow-up questions and asked R1 if she felt abused or neglected. R1 denied feeling abused or neglected. Administrative Staff A stated R1 told him she did	F 609			

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F 609	Continued From page 28 not get along with CNA M and that they had a "verbal altercation." He informed R1 that CNA M would not return to the facility and R1 requested to move closer to the nurses station. He stated that to his understanding, if a resident or family member alleged abuse then there was a fairly short window of 24 hours to report it. If there was any abuse, he would do an investigation and call the police. Administrative Staff A said R1 had not complained of abuse, and there was no investigation as there was no allegation since R1 denied abuse. He stated R1 said she did not get along with CNA M, CNA M raised her voice at R1, seemed agitated, and not compassionate. Administrative Staff A stated anything had the potential to be verbally abusive. He had not listened to the recording, but stated the resolution was simple as it was an agency aide, she was not allowed back. He stated he had not read the "Progress Note" by LN H that documented R1's family member alleged abuse and harassment and it was not reported to him as such. On 02/16/22 at 02:00 PM, CNA N stated on 02/06/22 she was working on hall two and heard someone yelling. CNA N and LN H went down to R1's room, R1 sat in her wheelchair, yelling that she was naked in bed. R1 was dressed and did not have call light within reach as it was behind her. CNA N pinned her call light on her CNA N stated if she witnessed abuse, she would report to the nurse, Administrative Nurse D and Administrative Staff A. On 02/16/22 at 02:41 PM, LN H stated she was the nurse on duty on the morning of 02/06/22 and R1's representative called with concerns about R1. R1's representative voiced a concern about R1 being abused. LN H went into R1's room to	F 609			

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F 609	Continued From page 29 make sure she had not been abused and had not been naked. LN H stated she reported R1's representative's concerns to Administrative Staff A. The facility's "Abuse Policy and Procedure" last updated 08/06/20, directed any form of resident abuse, mistreatment, neglect, misappropriation, exploitation, or deprivation of goods and/or services was not tolerated and it was the responsibility of all employees to report abuse to the Administrator or Director of Nursing. All residents have the right to be free from any verbal, sexual, physical, and mental abuse, mistreatment, neglect, misappropriation, and deprivation of goods and/or services. Residents were not subjected to abuse by anyone including staff, other residents, consultants or volunteers, contract employees or staff from other agencies serving the residents. Verbal abuse was defined as any use of oral, written, or gestured language that included disparaging and derogatory terms to residents or families or within hearing distance to describe residents regardless of their age, ability to comprehend, or disability. All alleged or suspected violations involving including abuse, neglect, mistreatment, misappropriation, exploitation or deprivation of goods and/or services were promptly reported to the Administrator and/or Director of Nursing. The person observing an incident of resident abuse or suspected abuse must immediately ensure resident safety then immediately report such incidents to their immediate supervision and/or the charge nurse. The supervisor and/or charge nurse contacted the Administrator or Director of Nursing. The Director of Nursing or Administrator ensured the safety of the resident, began the investigation, and if necessary, report information	F 609			

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F 609	Continued From page 30 to the police and any other appropriate agency. The facility failed to ensure staff identified a situation of verbal abuse, neglect and mistreatment as alleged abuse. The facility further failed to ensure staff immediately reported the alleged violation of abuse to the facility administrator. Once reported, the facility administrator failed to acknowledge the allegation as abuse and failed to alert the appropriate state agencies as required . This failure placed the resident in immediate jeopardy.	F 609			
F 610 SS=F	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility identified a census of 36 residents. The sample included three residents reviewed for abuse. Based on record review and interviews,	F 610			

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F 610	Continued From page 31 the facility failed to conduct and document a thorough investigation in response to an allegation of abuse for Resident (R) 1. This placed R1 and all residents in the facility at risk for ongoing abuse and unidentified psychosocial impact as a result of the alleged abuse. Findings included: - R1 admitted to facility on 01/28/22 and discharged on 02/11/22. The "Electronic Medical Record (EMR)" documented diagnoses of fracture of the sacrum (large triangular bone between the two hip bones), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and fall on same level. The "Admission Minimum Data Set (MDS)" dated 02/03/22, documented R1 had a Brief Interview for Mental Status of 15 which indicated intact cognition. R1 had moderate difficulty with hearing and the speaker had to increase volume and speak distinctly. R1 used hearing aides or other hearing appliances. R1 required extensive physical assistance with two staff members for bed mobility, transfers, and toileting; extensive physical assistance with one staff member for dressing; limited physical assistance with one staff member for walking, locomotion, and personal hygiene; and supervision with setup help only with eating. The "Communication Care Area Assessment (CAA)" dated 02/06/22, documented R1 had minimal difficulty hearing when not in a quiet environment and she had hearing aids. Nursing	F 610			

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F 610	Continued From page 32 assisted with hearing aids as needed and staff raised voice volume as needed when addressing resident. R1 generally did not have a problem understanding staff and was able to effectively communicate all wants and needs to staff and family. The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential CAA" dated 02/06/22, documented R1 required extensive to limited assistance with mobility and ADLs. The "Baseline Person Centered Care Plan" dated 01/28/22, documented R1 needed assistance with ADLs and wore hearing aids. A recorded message revealed the following interaction between R1 and CNA M on 02/06/22: R1- "I'm in trouble, I'm laying here naked and the girl took away my number to call for help and she left me on the bed, naked with no clothes. And I'm in, I can't move, my feet are hanging over the bed, I can't move. Somebody you got to help me, I don't know who to call. Please help me, please. Somebody I'm laying here naked in the bed, all twisted my feet are getting the end of the bed. And she won't do anything, she took my call button away. So I got to get somebody, I don't know who to call. I can't do it, I can't move. Please somebody, I'm laying here, I can't move. She walked out on me with no, nothing, I can't even push a button for help. She was nobody, she walked out on me like this, I'm screaming, please help me somebody. Please, please. I don't know what to do, I don't know. Oh my god, oh my god. Hello? I can't lay like this. [sobbing in background] getting some help. no, I can't lay like this, no, I can't. I can't, I can't go back, I can't go	F 610			

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F 610	Continued From page 33 forward, I can't, I can't, I have nothing, but in here with you." CNA M: "You calling your family lying." R1: "I didn't do anything." CNA M: "Calling your family lying. Here, give me that." R1 and CNA M: [unable to discern words] CNA M: "You're about to get up, I'm going to put you in your chair." R1: "You let me lay here like this." CNA M: "You're not going to like this." R1: "I can't lay here like this. I can't, I can't lay like this. I didn't do anything." R1 and CMA M-: [unable to discern words] R1: "Help me please, I can't lay like this." CNA M: "See, that's what you do, you talking nasty then you call and tell lies to your family. Quit lying, you're the devil. " R1: "I can't lay like this. [unable to discern words]" CNA M: "You go waking up the whole hall with this foolishness." R1: "Where's my thing at?" CNA M: "This is Sunday, don't nobody want to hear that."	F 610			

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F 610	Continued From page 34 R1: "I can't hear you, I'm sorry." CNA M: I'm sorry, I'm deaf too." R: "I'm deaf." CNA M: "I'm sure." R1: "I can't hear you." CNA M: "Okay, yeah" R1: "I can't lay like this, I'm uncomfortable." In a "Progress Note" dated 02/06/22 at 07:01 AM, Licensed Nurse (LN) H documented the following: around 04:50 AM, LN H was doing rounds when she heard R1 calling for help. She rushed to R1's room immediately and asked what was wrong. R1 stated that she was in pain and needed a pain pill. LN H took an as needed (PRN) pain pill to R1 and R1 was calm. At around 05:50 AM, R1's representative called and stated she heard R1 being abused and harassed and recorded the whole incident. R1's representative narrated that R1 told her the aide who was helping R1 left her naked and uncovered, yelled at R1, and took her call light away. R1's representative stated she was afraid R1 was being abused and she was making arrangements to move her out of the facility. LN H asked R1 about the accusations and R1 did not report any abuse to LN H. In a "Progress Note" at 04:01 PM LN G documented she, along with two other unidentified nurses, spoke with R1's representative related to the incident with R1 and CMA M overnight. LN G documented	F 610			

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F 610	Continued From page 35 Administrative Staff A and Administrative Nurse D were notified of the conversation and advised to contact R1's representative on Monday morning. R1's representative requested R1 move to a room closer to the nurse's station as soon as possible. The facility provided the following witness statements: In an undated written statement at 02:30 PM, CNA M wrote R1 complained of pain after dinner and took her gown off. [R1] appeared naked and stated something about "sexual misconduct" where R1 worked. CNA M wrote she asked R1 "not to talk that way as it was [there were] visitors outside her door." CNA M further documented she closed R1's door for privacy. CNA M recorded R1 "complained" of "wanting to be pulled up" and the nurse helped CNA M put R1 in her chair. CNA M wrote that she asked R1 why R1 was treating CNA M "this way" and asked R1 to please not yell and calm down because it was Sunday. CNA M wrote she asked R1 several times not to talk that way. CNA M wrote she stated to R1 "please cover up and have some dignity!!" CNA M wrote she asked R1 to "keep her voice down" as R1 kept stating "why?" CNA M documented she responded to R1 by saying "it's Sunday. I have no time for foolishness." CNA M got R1 dressed, put her up in her chair, and R1 calmed down. CNA M documented R1 called R1's representative to complain and CNA M told R1 and/or her representative CNA M was not entertaining R1's "foolish and nonsense conversation," and sexual misconduct. CNA M recorded she let R1 and/or R1's representative know "that was unacceptable conversation and behavior."	F 610			

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F 610	Continued From page 36 In a typed statement dated 02/07/22, Administrative Staff A documented he received a text from LN H who spoke to R1 about an incident involving CNA M at approximately 04:45 AM on 02/06/22. The text stated R1 called her representative to tell her the following: "reported that she was left naked, her call light taken away by the aide and that she was yelling at her, her family member admitted recording the whole incident, asked the aide and she denied the accusations. She also stated that she's making arrangements to come get her mom out of there. Patient did not report any abuse." In a typed statement dated 02/07/22, Administrative Staff A documented he received the following statement from CNA N regarding the incident between CNA M and R1: On 02/06/22 around 03:30 AM to 4:15 AM, CNA N walked down to hall one to grab the ice chest but heard someone yelling for help and moaning like they were in pain. CNA N followed the voice down to R1's room and the nurse for the hall happened to be right behind her. CNA N approached R1 who sat in the wheelchair. R1 told CNA N that R1 was left naked in bed and the call light was "taken away." R1 was dressed when CNA N walked into her room. R1 did not have her call light on her, it was behind her on the recliner, out of her reach. CNA N pinned R1's call light to R1. R1 complained her back was hurting and CNA N placed a pillow behind R1 in the wheelchair to give her some support. LN H gave R1 a pain pill. In a typed statement dated 02/07/22, Administrative Staff A documented he received reports about an incident regarding a "verbal altercation" between CNA M and R1. CNA M gave	F 610			

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F 610	Continued From page 37 a statement and was immediately placed on the facility's "do not return list" through the contracting agency. Administrative Staff A received reports from LN H and CNA N then spoke to R1 to make sure she was "ok." Administrative Staff A notified R1 that CNA M would not return to the facility. R1 thanked Administrative Staff A for the help. Administrative Staff A called R1's representative and notified her that CNA M was placed on "do not return list." The facility was lacked a completed investigation which documented the facility interview with R1, R1's representative and all staff involved or with knowledge of the occurrence as well as the facility's efforts to identify if other residents were affected. In a witness statement obtained on 02/16/22, LN G wrote she came to work for the 06:00 AM shift on 02/06/22 and the night nurse, LN H, was writing an incident report. LN H explained that "something happened" with the agency CNA overnight and R1's representative had something recorded. LN G encouraged LN H to report to Administrative Staff A and Administrative Nurse D immediately and encouraged CNA M to write a statement. LN G checked on R1. Around lunch, R1's representative arrived and requested to speak with nurse. LN G and two other unidentified nurses went to speak with R1's representative. R1's representative played the recorded interaction between R1 and CNA M. LN G referred R1's representative immediately to Administrative Staff A and Administrative Nurse D. R1's representative requested R1 be relocated to a room closer to the nurses' station. In a witness statement obtained on 02/16/22,	F 610			

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F 610	Continued From page 38 Administrative Nurse D documented on 02/06/22 (Sunday) at 12:53 PM, she was notified by a day nurse of a "situation" that needed addressed by Administrative Staff D and Administrative Staff A on Monday morning. She was notified on 02/06/22 via text by LN H that R1 called and reported she was left naked; her call light was taken away by an aide and yelled at by a CNA. R1's representative also reported she was removing R1 from the facility. LN H stated R1 was not naked and denied any form of abuse. Administrative Nurse D notified the unidentified staffing coordinator and Administrative Staff A of the text and asked the staffing coordinator to take CNA M off the schedule and notify her contracting agency. Administrative Nurse D asked all staff working to write a statement and called Administrative Staff A when the statements were completed. In a witness statement obtained on 02/16/22, Administrative Staff A wrote he was notified Sunday morning, 02/06/22, that LN H and CNA N assisted R1. Administrative Staff A documented LN H and CNA N found R1 upright in a wheelchair, clothed, and complaining of back pain. Administrative Staff A recorded LN H reported R1 denied abuse. Administrative Staff A documented he talked to R1 on Monday, 02/07/22, in the morning and R1 requested to be moved closer to the nurses' station. He told R1 that CNA M had been placed on the "do not return" list and confirmed R1 would be moved into another room. Administrative Staff A recorded he called R1's representative and notified her CNA M would not be back to the facility and R1 was moving to another room that afternoon. Administrative Staff A recorded he called the corporate office and was instructed to gather the	F 610			

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F 610	Continued From page 39 statements. Administrative Staff A documented R1 mentioned she had a verbal altercation with an agency CNA and he immediately notified her that the CNA would not be returning to the facility. On 02/15/22 at 02:58 PM, Administrative Staff A stated the incident with R1 was not treated as an abuse allegation and R1 did not report abuse when interviewed. On 02/16/22 at 11:16 AM, LN M stated on the morning of the incident, she came in at shift change and LN N was "frazzled" trying to figure out what she should do. LN M stated she knew something happened with R1 and CNA M around 04:00 AM that morning and R1's representative had "something recorded." LN M stated she instructed LN N to notify Administrative Staff A and Administrative Nurse D, complete an incident report, and document. She stated she checked on R1 first thing and R1 was "pretty shaken." LN M stated R1's representative came into the facility around lunch time and wanted to speak with the nurse. LN M, along with two other nurses as witnesses, spoke to R1's family member. LN M stated R1's family member played the voicemail for LN M. LN M told R1's representative it would be reported immediately to Administrative Staff A. R1's representative wanted to make sure R1 would be safe and was notified CNA M would not be returning to the facility. LN M stated she considered the verbal altercation between CNA M and R1 as abuse. On 02/16/22 at 11:51 AM, Administrative Nurse D stated if abuse was suspected, staff notified administration and if abuse was found after the facility investigation, it was reported appropriately. Administrative Nurse D said if a resident stated	F 610			

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F 610	Continued From page 40 they were being verbally abused or staff were being rough, then an investigation was initiated, but if the resident denied abuse, then an investigation was not completed or needed. She stated if the residents' representative alleged abuse, but the resident denied the abuse, then it did not count as an allegation of abuse. Administrative Nurse D stated the incident with R1, and CNA M was reported to her on 02/06/22 at 07:00 AM. She stated the staffing agency was contacted so agency aide CNA M would not return to facility. She stated the nurse that worked during the incident stated she spoke to R1 regarding abuse allegations and R1 denied any abuse. Administrative Nurse D stated if a resident complained of being abused, the facility would investigate. She stated she spoke with R1's family member throughout the week but had not heard the recording. Administrative Nurse D stated the facility's policy directed abuse complaints were investigated only if the residents said they were abused. Administrative Nurse D stated the facility had 24 hours to report once allegations were found to be actual abuse. On 02/16/22 at 12:24 PM, Administrative Staff A stated he was notified early Sunday morning, 02/06//22, about an incident that occurred around 04:30 AM. R1's representative had a recording from around that time. LN H reported to Administrative Staff A that she entered R1's room with CNA N in response to R1 calls for help. R1 was upright in her wheelchair and clothed. He stated LN H asked R1 follow-up questions and asked R1 if she felt abused or neglected. R1 denied feeling abused or neglected. Administrative Staff A stated R1 told him she did not get along with CNA M and that they had a "verbal altercation." He informed R1 that CNA M	F 610			

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F 610	Continued From page 41 would not return to the facility and R1 requested to move closer to the nurses station. He stated that to his understanding, if a resident or family member alleged abuse then there was a fairly short window of 24 hours to report it. If there was any abuse, he would do an investigation and call the police. Administrative Staff A said R1 had not complained of abuse, and there was no investigation as there was no allegation since R1 denied abuse. He stated R1 said she did not get along with CNA M, CNA M raised her voice at R1, seemed agitated, and not compassionate. Administrative Staff A stated anything had the potential to be verbally abusive. He had not listened to the recording, but stated the resolution was simple as it was an agency aide, she was not allowed back. He stated he had not read the "Progress Note" by LN H that documented R1's family member alleged abuse and harassment and it was not reported to him as such. On 02/16/22 at 02:00 PM, CNA N stated on 02/06/22 she was working on hall two and heard someone yelling. CNA N and LN H went down to R1's room, R1 sat in her wheelchair, yelling that she was naked in bed. R1 was dressed and did not have call light within reach as it was behind her. CNA N pinned her call light on her CNA N stated if she witnessed abuse, she would report to the nurse, Administrative Nurse D and Administrative Staff A. On 02/16/22 at 02:41 PM, LN H stated she was the nurse on duty on the morning of 02/06/22 and R1's representative called with concerns about R1. R1's representative voiced a concern about R1 being abused. LN H went into R1's room to make sure she had not been abused and had not been naked. LN H stated she reported R1's	F 610			

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F 610	Continued From page 42 representative's concerns to Administrative Staff A. The facility's "Abuse Policy and Procedure" last updated 08/06/20, directed any form of resident abuse, mistreatment, neglect, misappropriation, exploitation, or deprivation of goods and/or services was not tolerated and it was the responsibility of all employees to report abuse to the Administrator or Director of Nursing. All residents have the right to be free from any verbal, sexual, physical, and mental abuse, mistreatment, neglect, misappropriation, and deprivation of goods and/or services. Residents were not subjected to abuse by anyone including staff, other residents, consultants or volunteers, contract employees or staff from other agencies serving the residents. Verbal abuse was defined as any use of oral, written, or gestured language that included disparaging and derogatory terms to residents or families or within hearing distance to describe residents regardless of their age, ability to comprehend, or disability. All alleged or suspected violations involving including abuse, neglect, mistreatment, misappropriation, exploitation or deprivation of goods and/or services were promptly reported to the Administrator and/or Director of Nursing. The person observing an incident of resident abuse or suspected abuse must immediately ensure resident safety then immediately report such incidents to their immediate supervision and/or the charge nurse. The supervisor and/or charge nurse contacted the Administrator or Director of Nursing. The Director of Nursing or Administrator ensured the safety of the resident, began the investigation, and if necessary, report information to the police and any other appropriate agency.	F 610			

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F 610	Continued From page 43 The facility failed to conduct and document a thorough investigation in response to an allegation of abuse for R1. This placed R1 and all residents in the facility at risk for ongoing abuse and unidentified psychosocial impact as a result of the alleged abuse.	F 610			