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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435039 | A. BUILDING _____ B. WING _____ | C 12/14/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVANTARA NORTON | 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105 |

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| F 000 | INITIAL COMMENTS<br><br>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 12/12/23 through 12/14/23. Areas surveyed included resident abuse and quality of care. Avantara Norton was found not in compliance with the following requirements: F550 and F585. | 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 or resident of the United States. | F 550 | 1. Resident 252 discharged from facility on 12/21/2023 and no further corrective action can be completed at this time. Resident 144 has been visited 3 or more times weekly since survey by facility temporary manager and grievances have been filed with any concerns reported to facility temporary manager. Administrator and facility temporary manager conducted interview by January 11, 2024, with resident 144 identifying all issues listed: recent staff treatment, call light wait times, specific staff concerns, mechanical lift sling placement, and toileting. All outstanding issues were placed on grievance form and process followed. Resident 144 care plan was updated with any changes needed. All residents have the potential to be affected by the stated deficiencies.<br>2. The facility temporary manager will meet with resident 144 each business day she is in facility as part of the guardian angel program and report findings to administrator and utilize grievance program as needed to report concerns. | 01/11/2024 |

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

Ashley Nickel | LNHA | 1/4/2024

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 550 | Continued From page 1<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and review of grievances, the provider failed to ensure staff interactions and services were provided in a manner that maintained a sense of dignity and respect for two of two sampled residents (144 and 252).<br>Findings include:<br><br>1. Observation and interview on 12/14/23 at 3:40 p.m. with resident 252 revealed she:<br>*Was in her room on the Warren wing eating a late lunch while seated in a wheelchair.<br>*Had moved in on Thursday, 12/7/23, into a room on the East wing and then was moved to the Warren [Medicare A therapy] wing on 12/11/23.<br>*Had been "left completely on my own" in her room after moving in, and "felt like a non-entity."<br>*Waited for a nurse to go over her medications with her and take her insulin to the refrigerator but she "never saw a nurse until 4 a.m."<br>*Had asked for the nurse to "come in to take my blood sugar. I kept calling for the nurse to do it. The nurse was upset with me. I overheard her tell someone, 'Tell her I'll get there when I get there.'"<br>*Waited "over an hour for someone to come | F 550 | The facility temporary manager is reviewing grievances and the processes each day she is in the facility. The Vice President of Operations for the facility will complete education with the interdisciplinary team on completion of grievance form, following up on each stated issue in grievance, and expected resolution documentation on January 3, 2024, and those staff not present for education sessions will be educated prior to their first shift worked.<br>The Administrator, Director of Nursing, and Interdisciplinary Team in collaboration with the governing board, medical director, and any consulting agencies utilized to review, revise, create as necessary policies and procedures to support review of maintaining residents' dignity and admission process.<br>Education to all staff on maintaining residents' dignity, therapeutic communication, and customer service will occur no later than January 11, 2024, and those staff not present for education sessions will be educated prior to their first shift worked.<br>3. Administrator or designee will complete random interviews with 5 random residents to ensure staff interactions and services are provided in a manner that maintains their sense of dignity and respect weekly for 4 weeks then monthly for 2 months. The Administrator will discuss audits in monthly QAPI for further review of progress and discussion of continuation/discontinuation of audits. | |

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| F 550 | Continued From page 2<br>clean the toilet" after it was soiled by a resident who shared the bathroom. No one returned after a staff person had initially answered her call light, and she "ended up having to use paper towels to clean the toilet."<br>*Heard one staff person say they had "inadequate staff," and the staff appeared to be "were running around."<br>-Being "left completely on my own" after moving in, and she said "I felt like a non-entity."<br>-Could hear a resident repetitively saying, "Please help me" followed eventually by someone saying, "What do you want?"<br>*Talked "a bit" with social services designee (SSD) E on Thursday, and then SSD E "came back on Friday and asked, 'How was your first night?' She made excuses to address what had happened."<br>*Reported to her physician on Friday when he came to check on her that she "wasn't getting my anti-rejection drugs. The nurse gave excuses in front of him."<br>*Believed the nurse did not put her insulin in the refrigerator and it had gotten "ruined" because, when she changed the insulin in the reservoir for her insulin pump on Saturday night, her blood sugar on Sunday was "high at breakfast, and even higher at noon."<br>*Did not get the daily chronicle or snacks for the first two days, not until Sunday.<br>*Felt completely different on 12/11/23 after she moved to a room on the Warren wing.<br>*Had tears in her eyes and struggled to talk several times when describing her experience.<br><br>Administrator/temporary manager (ADM/TM) C was present and observed during the interview with resident 252. | F 550 | | |

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| F 550 | Continued From page 3<br>Review of grievance and satisfaction forms revealed resident 252 had voiced a grievance by email on 12/10/23 at 4:53 p.m. to a healthcare provider, which had then been forwarded to the nursing home on 12/11/23 at 1:20 p.m. (Refer to F 585, finding 1).<br><br>Review of the Staff Huddle Daily Stand-up Meeting notes revealed resident 252's name was listed:<br>*On 12/7/23, under "Pending Admits" with "(Med A) room 326 (2 pm)."<br>*On 12/8/23, under "Admission" with "(Med A) room 326."<br>*On 12/11/23, under "Changes" noting room 111.<br><br>Review of resident 252's electronic medical record (EMR) revealed:<br>*She moved into the nursing home on 12/7/23.<br>*The 12/7/23 nursing admission UDA, which was locked on 12/8/23 at 11:23 a.m., noted:<br>*Her vitals were recorded on 12/7/23 at 2:45 p.m. in the nursing admission UDA, but the remaining sections were not completed at that time. No time was listed for education regarding "orientation to facility, unit & [and] room," "orientation to call light," and "resident's medication review, upon admission." The UDA was locked on 12/8/23 at 11:23 a.m.<br>*A 12/7/23 "admission summary" progress note at 2:45 p.m. stated, "Arrived to the facility via wheelchair with assist of son.....Insulin pump is controlled by resident. Had kidney transplant in 2017. Alert and oriented communicates with clear speech has a left foot heel ulcer and a pea size mark on her left skin."<br>*A 12/7/23 Skin/Wound Note was documented at 10:18 p.m. that included measurements of the left heel ulcer and a discussion with resident 252 | F 550 | | |

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| F 550 | Continued From page 4 | F 550 | | |

about therapy.
*The 12/8/23 social services UDA noted the "Resident's Attitude Toward Placement" included "Resident displays/is unsure/insecure/anxious about placement."

*A 12/10/23 progress note at 4:24 p.m. noted resident 252 voiced grievances about not receiving therapy on that day.
-"Resident visibly upset (crying) stated that she came to the facility for therapy and wanted to be home for christmas [sic], she said she wasn't here because she needed to be taken care [of].
-Resident said she was writing a letter to her pcp [primary care provider] and asked the therapist's name to which writer did not ask.
-Writer notified DON of situation and asked to have him touch basis [sic] with resident on Monday."
*A 12/12/23 progress note at 3:48 p.m. noted resident 252 "was concerned that her medications were not given at the times she normally takes them, printed off the order list and allowed the resident time to edit list and give times of meds [medications], reviewed list with resident and adjusted times on mar [medication administration record] to reflect resident preferences."

*Review of the care plan revealed:
-Initiated on 12/7/23 and revised on 12/12/23, "requires assistance with ADL's," with an intervention initiated on 12/11/23 for "Transfers: pivot assist 1-2 [staff persons].
-Initiated on 12/7/23 and revised on 12/12/23, "at risk for fluctuating blood sugars," with an intervention initiated on 12/12/23, "Resident self-administers blood glucose checks, supplies are kept at bedside table, she has been assessed

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| F 550 | Continued From page 5<br>and is safe to self-admin [administer], ok per MD order."<br><br>*The 12/12/23 Medication Self-Administration Evaluation noted resident 252's cognition was "alert and oriented x [times] 3, Able to recall instructions of how to administer medication. Able to recall what time medication should be taken."<br><br>On 12/13/23 at 3:15 p.m., ADM A was requested to provide a copy of the provider's admission policy. She replied they had no policy related to the admission process.<br><br>On 12/14/23, ADM A provided a typed document titled "Admission Process" that listed eight bullets that stated what each department would do for admission documentation when someone moved into the nursing home.<br><br>Interview on 12/14/23 at 5:39 p.m. with DON B regarding resident 252's experiences after moving in, he<br>*Agreed the approach "should have been better."<br>*Confirmed there was no process that described how a resident would have been welcomed and oriented to the nursing home.<br>*Said those staff actions should happen from "common courtesy."<br>*Wished someone would have reported her concerns to him.<br>*Had been in the nursing home on Saturday and Sunday but had not checked in with her.<br><br>2. Observation and interview on 12/14/23 at 4:04 p.m. with resident 144 revealed she:<br>*Was in her room and seated in a wheelchair with a portable table in front of her while she worked on a beading craft. | F 550 | | |

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| F 550 | Continued From page 6<br>*Voiced concerns about the way staff had treated her recently when she called for help to the bathroom.<br>*Turned on call light, waited "30 minutes before" CNA F came and told her, "You'll have to wait because we are serving meals."<br>*Said that was "about 4:30 [p.m.] It was about 7-7:30 [p.m.] before someone came."<br>*Also voiced concerns about how CNA G "was very belligerent" with how "the sling straps were positioned."<br>*Described the interaction with CNA G as follows:<br>-"That presses the straps into my skin."<br>-CNA G, "We know how to put it on."<br>-"I'm telling you what is comfortable with me."<br>-CNA G, "We know what we are doing." She kept pulling the sling.<br>-"It's not going to work. Put me back on the bed and start over."<br>-CNA G, "You realize you are a lot bigger than we are."<br>-"Honey, I realize that."<br>-CNA G pulled the sling out and threw it on the chair and walked out.<br>*"It really, really upset me.<br>*Had "only been in this condition since April. I've been here since October."<br>*"Never had experience with being in a nursing home" until then.<br>*Had tears in her eyes and struggled to talk twice when describing her concern.<br><br>Administrator/temporary manager (ADM/TM) C was present and observed the interview with resident 144.<br><br>Review of grievance and satisfaction forms revealed resident 144 had voiced two grievances related to the concerns reported above. | F 550 | | |

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| F 550 | Continued From page 7<br>(Refer to F 585, finding 2)<br><br>Review of resident 144's EMR revealed:<br>*She moved into the nursing home on 10/5/23.<br>*The 10/6/23 social services UDA noted the "Resident's Attitude Toward Placement" included:<br>-"Resident views admission as necessary."<br>-"Resident appears to accept."<br>-"Resident appears positive."<br>-"Resident's coping skills" were checked as: "can verbalize feelings," "strong supportive relationships," and "planning/logical thinking."<br>*On the 10/12/23 admission Minimum Data Set (MDS) assessment, the Brief Interview for Mental Status (BIMS) score of 15 noted she had intact cognitive function.<br>*Care plan focuses on 10/5/23 related to:<br>-Activities of daily living (ADLs) with assistance of 2 persons to transfer her using a full-body mechanical lift with a divided leg sling.<br>-At risk for bowel and bladder functioning related to incontinence and high risk for skin breakdown.<br>-At risk for chronic pain related to fibromyalgia and low back pain.<br>*Care plan focuses were added on 10/7/23 for "potential psychosocial well-being problem related to: recent admission" and on 11/17/23 for "manipulative behavior (alleged mistreatment)."<br><br>Review of progress notes for resident 144 revealed:<br>*A behavior note on 11/26/23 at 11:30 a.m. noted similar information as the grievance on 11/27/23 noted above:<br>-Resident 144 "told cnas [sic] to straighten out her hoyer sling because it wasn't [was not] on right...her diaper is in the vagina and its [sic] hurting...the cna told her that it was because she was a much larger person than they were and | F 550 | | |

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| F 550 | Continued From page 8<br>that's [that is] why...she told them that her depend was on incorrectly and that all the cna did was take out the hoyer sling and left."<br>-The Summary/Outcome noted:<br>--"Two cnas went in to assist resident...was asked about the sling never mentioned about the diaper until cnas were walking out. CNA stated that 'Went adjusted as best as we could' Resident said she was sitting on a knot and cnad [sic] took out the sling from underneath her."<br>--"Resident then changed demeanor with staff and to staff said 'If you would've [would have] done it right like I told you too [sic], it would've been on right!'"<br>--"Cna said to resident 'you're not going to be respectful, we did the best we could.'"<br>--"Resident then said 'I'll [I will] see about that!'"<br>--"Cna states that she never once brought up the resident's size or anything they just told her they couldn't move hoyer sling."<br>--"Resident then called center nurses station asking to speak to DON."<br>*A general progress note on 11/26/23 at 4:07 p.m. noted resident 144 reported concerns regarding staffing:<br>-She "told center med aid [medication aide] that her call light had been on for two hours and no one had answered call light."<br>-"Writer...let resident know that her call light had not been on for two hours since writer had been at nurses station for the last two hours and her call light had not been on until after [sic] and it was on for maybe 5-10 mins [minutes] max [maximum] when another nurse and CNA went in to assist resident."<br>-"Resident stated that she never said that her call light had been on for two hours but that she had put her call light on two different times around noon." | F 550 | | |

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| F 550 | Continued From page 9<br>*A behavior note on 12/2/23 that described the same situation as on the handwritten note by CNAs I and J, noted above.<br>*A social service note on 12/5/23 noted resident 144's family member called and stated, "Under no conditions do I want [CNA F] to be in [resident 144's] room again."<br><br>Interview on 12/13/23 at 4:00 p.m. with licensed practical nurse/unit manager L about CNA F, she replied she was a "good CNA." The interview was interrupted at that time and never resumed..<br><br>During the exit conference on 12/14/23 at 7:15 p.m., administrator A commented that resident 144 "tears up" very easily. | F 550 | | |
| F 585 SS=D | Grievances<br>CFR(s): 483.10(j)(1)-(4)<br><br>§483.10(j) Grievances.<br>§483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.<br><br>§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.<br><br>§483.10(j)(3) The facility must make information on how to file a grievance or complaint available | F 585 | 1. Resident 252 discharged from facility on 12/21/2023 and no further corrective action can be completed at this time. Resident 144 has been visited 3 or more times weekly since survey by facility temporary manager and grievances have been filed with any concerns reported to facility temporary manager. Administrator and facility temporary manager conducted interview by January 11, 2024, with resident 144 identifying all issues listed: recent staff treatment, call light wait times, specific staff concerns, mechanical lift sling placement, and toileting. All outstanding issues were placed on grievance form and process followed. Resident 144 care plan was updated with any changes needed. All residents have the potential to be affected by the stated deficiencies. | 01/11/2024 |

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| F 585 | Continued From page 10<br>to the resident.<br><br>§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:<br>(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;<br>(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;<br>(iii) As necessary, taking immediate action to | F 585 | 2. The facility temporary manager is reviewing grievances and the processes each day she is in the facility. The facility temporary manager is reviewing grievances and the processes each day they are in the facility. The Vice President of Operations for the facility will complete education with the interdisciplinary team on completion of grievance form, following up on each stated issue in grievance, and expected resolution documentation on January 3, 2024, and those staff not present for education sessions will be educated prior to their first shift worked.<br>3. The Administrator or designee will review all grievances weekly to ensure each area identified is investigated and the grievance policy is followed. The Administrator will discuss audits in monthly QAPI for further review of progress and discussion of continuation/ discontinuation of audits. | |

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| F 585 | Continued From page 11<br>prevent further potential violations of any resident right while the alleged violation is being investigated;<br>(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;<br>(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;<br>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and<br>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and grievance policy review, the provider failed to take steps to investigate all allegations reported by two of three sampled residents (144 and 252). Findings include: | F 585 | | |

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| F 585 | Continued From page 12<br><br>1. Observation and interview on 12/14/23 at 3:40 p.m. with resident 252 revealed she:<br>*Was in her room on the Warren wing eating a late lunch while seated in a wheelchair.<br>*Had moved in on Thursday, 12/7/23, into a room on the East wing and then was moved to the Warren [Medicare A therapy] wing on 12/11/23.<br>*Described multiple concerns she had experienced the first three days after moving in.<br>*Had tears in her eyes and struggled to talk several times when describing her experience.<br>(Refer to F 550, finding 1.)<br><br>Review of the provider's grievance and satisfaction form dated 12/11/23 at 1:20 p.m. revealed:<br>*Resident 252 had voiced a grievance by email on 12/10/23 at 4:53 p.m. to a healthcare provider, which had then been forwarded to the nursing home.<br>*In addition to the concerns she described during the interview on 12/14/23 at 3:40 p.m., other concerns included:<br>-"Nobody on this side - not even the social worker or the nursing staff, knew that I was here for rehab."<br>-Physical therapy evaluated her on Friday, 12/8/23, and told her she would received therapy 6 days a week, Sundays thru Fridays. "I have not seen a rehab person since...I have now sat here doing nothing for 3 days."<br>-She had not been able to sleep at all while waiting for the nurse to go over her medications.<br>-After her evening meal was delivered, she discovered "no silverware. I pushed my button. Waited 20 minutes to ask for silverware. Aide said she'd be right back. Never came back so after an hour I pushed my button again." | F 585 | | |

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| F 585 | Continued From page 13<br>-"I understand they are over-worked and under-staffed on this side, but I deserve help also but NOT HERE."<br><br>Further review of the grievance and satisfaction form on 12/11/23 revealed:<br>*The investigation notes listed:<br>-Items 1 through 7 that addressed the therapy concern.<br>-Item 8, "Educate staff on not all residents on LTC [long-term care] units are LTC [,] some are rehab to home."<br>-Item 9, "Dietitian, DSM [dietary services manager] meeting with resident regarding diet and preferences."<br>-Item 10, "Moved to room when available on Rehab. 12/11/23."<br>-Item 11, "Nurse management to review medications."<br>-Item 12, "Reviewed concerns w/ [with] Transplant team 12/12/23"<br>*The investigation notes did not address resident 252's concerns regarding being left alone, delayed timing of the nurse on the first day, or delayed response for staff to assist with cleaning the toilet and providing silverware for her meal.<br>*The resolution was, "Moved to rehab unit 12/11/23. Reviewed therapy schedule with resident (frequency). Wound nurse assessed edema followed up on Lasix."<br>*Resident 252 was notified of the resolution on 12/11/23.<br><br>2. Observation and interview on 12/14/23 at 4:04 p.m. with resident 144 revealed she:<br>*Was in her room and seated in a wheelchair with a portable table in front of her while she worked on a beading craft.<br>*Reported two incidents of staff interactions that | F 585 | | |

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| F 585 | Continued From page 14<br>concerned her.<br>*Had tears in her eyes and struggled to talk twice when describing her concern.<br>(Refer to F 550, finding 2)<br><br>Review of grievance and satisfaction forms revealed resident 144 had voiced two grievances as follows:<br>*A grievance was on 11/27/23 regarding CNA G noted:<br>-CNA G, on day shift yesterday [11/26/23, Sunday], "she didn't [did not] put the sling (hoyer sling) under her correctly."<br>-Resident 144 "tried to alert her that she wasn't [was not] going to be able to sit up very long."<br>-CNA G "proceeded to get her up and place her in her w/ch [wheelchair]."<br>-Resident 144 "stated the sling was cutting into her peri-area."<br>-CNA G "told resident that she knows that she is heavy woman."<br>-Resident 144 "felt disrespected that she was called fat."<br>*The investigation by director of nursing (DON) B on 11/29/23 noted the following interview notes with resident 144:<br>-"On Sunday, after lunch."<br>-"Hoyer from bed to chair, very tight and asked to be put back down."<br>-CNA G "continued to put her in chair."<br>-Resident 144 "states 'this is not how it's supposed to be.'"<br>-CNA G "grabs sling and takes it out from under her and throws it on the chair next to her."<br>-Resident 144 said the "helper was 'light skinned,' maybe from Jamaica, Tried to state they need to be further down."<br>*The resolution written by DON B and shared with resident 144 on 11/29/23 revealed: | F 585 | | |

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

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| F 585 | Continued From page 15<br>-"Competencies continued w/ [with] staff."<br>-"Don't [do not] have [CNA G] help [resident 144] again unless CNA can act right and listen."<br><br>*A second grievance on 12/5/23 regarding CNA F noted, "resident crying, saying CNA hates her & [and] never takes her to the bathroom."<br>*The investigation notes documented by director of nursing (DON) B on 12/7/23 noted the following interview notes with resident 144:<br>-"Put on call light, CNA F came in, said 'Someone was using hoyer so it would be a minute.'"<br>-"Called main number, [activity director K] answered."<br>-"Two CNAs came in...took 25 minutes in total - she looked @ (at) clock."<br>-"Going to the bathroom is more important than other people's lunches."<br>-"When it's [it is] [CNA F] coming in it's 'you always have to wait.'"<br>*Three handwritten notes revealed the following:<br>-By CNA F, not dated: "Answered call light...told her CNA H would be right back in with her [,] I went to break and when I returned...she yelled at me to get out of her room and not talk to her."<br>-A note that was not signed or dated, "[CNA F] left to pick up daughter, CNA H "said he was going to take her to the bathroom, never did." When CNA F checked on resident 144, she was "already on bed pan" and "was crying saying [CNA F] always does 'this' to her & that [CNA F] hates her."<br>-By CNAs I and J, on 12/2/23: "[Resident 144] asked...where's all the girls, I need to go the bathroom."<br>--CNA I said, "I think they are getting people up or they might even still be doing breakfast."<br>--Resident 144 said, "That's not my problem! Me going to the bathroom is more important than that." | F 585 | | |

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| F 585 | Continued From page 16<br>--While CNA I and J proceeded to transfer resident 144 onto her bed, CNA I explained the other CNAs were busy with other residents and "can't [cannot] do two things at once."<br>--Resident 144 said, "I don't care they can stay in bed so I can get layed [sic] down."<br>--CNA J offered the bed pan twice and resident 144 replied twice, "I'm not using that I'm going to pee in my brief."<br>--CNA I offered the call light after getting resident 144 situated in bed and resident 144 said, "don't bother I'm not going to turn it on anyway."<br>--Resident 144 did turn on the light and she "was crying" when CNA I and J returned to change her and transfer her back into her chair.<br>*The resolution documented by DON B and shared with resident 144 on 12/6/23 included:<br>-"Follow-up w/ [with] social services on referrals to [another location]."<br>-"Discussing/educating at all staff [meeting] on toileting policy."<br><br>Review of the working nursing staff schedules from 11//22/23 through 12/11/23 to correlate resident 144's concerns to the staff involved revealed:<br>*For the grievance on 11/27/23:<br>-CNA G, a contracted agency CNA, worked on 11/26/23, which was consistent with the date reported by resident 144. However, Resident 144 resided on East and CNA G's assignment was "Center bath aide."<br>-CNA G also worked on 11/25/23 as "T-wing CNA," 11/24/23 at "East/T-wing Bath-Aide," and 11/23/23 as "T-wing CNA."<br>*For the grievance on 12/5/23:<br>-CNA F worked on 12/5/23 as "East/T-wing Bath-Aide," 12/4/23 as "T-wing CNA," and 12/1/23 as "East CNA." | F 585 | | |

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| F 585 | Continued From page 17<br>-CNA H worked on 12/5/23 as "East CNA," and on 12/4/23 as "East CNA."<br>-CNAs I and J worked on 12/2/23 as "East/T-wing meds" and "East CNA," respectively.<br><br>Interview on 12/14/23 at 5:39 p.m., DON B provided no further information about resident 144's grievances.<br><br>3. Review of the provider's policy for "Grievances" revealed the provider did not follow the procedures to:<br>*"Confer with persons involved in the incident and other relevant persons."<br>*"Include ...<br>-"The steps taken to investigate the grievance.<br>-A summary of the pertinent findings or conclusions regarding the resident concerns.<br>-A statement as to whether the grievance was confirmed or not confirmed.<br>-Any corrective action taken to be taken by the facility as a result of the grievance.<br>-The date the written decision was issued."<br>"Determine who was involved, what happened and the circumstances surrounding the issues...determine the root cause of the issue based upon the information you have received.<br>"Based upon the facts determine if your investigation needs to be expanded to identify any other potential 'like' residents." | F 585 | | |