Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: H5258050M

Date Concluded: August 18, 2021

Name, Address, and County of Licensee Investigated:
Franciscan Health Center
3910 Minnesota Ave
Duluth, MN 55802
Saint Louis County

Facility Type: Nursing Home

Investigator's Name:
Jana Wegener, RN, Special Investigator

Finding: Inconclusive

Nature of Visit:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Allegation(s):
It is alleged a facility staff, alleged perpetrator (AP), verbally and physically abused the resident when the AP yelled at the resident, held the residents head back and pried her teeth open to force the resident to drink.

Investigative Findings and Conclusion:
It was inconclusive whether abuse occurred due to being unable to identify the date and time the incident occurred, inconsistencies with interviews, and lack of evidence to show the abuse occurred.

The investigation included interviews with facility staff including administrative, licensed, and unlicensed staff. The residents medical record, staff schedules, employee records, dining room seating, and facility policy and procedures were reviewed.

The resident was admitted to the facility with diagnoses including dementia without behavioral disturbances, anxiety disorder, and failure to thrive with life expectancy of less than six months.

The residents medical record indicated the resident was at risk for abuse related to cognitive impairment. The staff were directed to monitor the residents intake and assist the resident with meal and supplement set up, and que the resident with eating and drinking. Staff were directed to notify the nurse manager with any decreased intake noted.

The resident's progress notes indicated she had periods of increased confusion and agitation with poor intake. The AP documented several entries of the resident having poor fluid intake and attempts to encourage and assist the resident to eat and drink. One progress note included documentation by the AP of the resident's refusal of fluids by putting her hands up.

During an interview a facility staff member stated he had observed the AP assisting the resident in the dining room by placing her hand on the back of the resident's head and neck to get the resident to drink. The staff stated the resident attempted to swat at the AP and told her to stop but the AP continued to try and get the resident to drink. The staff member stated he had never seen or heard the AP cause the resident to choke.

Several facility staff were interviewed and stated they had never observed the AP threaten the resident or force the resident to drink fluids.

A facility resident stated she ate in the dining room and had never seen or heard staff tell a resident they had to drink or force them to drink fluids.

The AP's personnel record indicated the AP's tone of voice and abrupt communication often made others feel as though she was yelling at them.

During an interview the AP denied any wrongdoing and stated the resident needed assistance to drink while swallowing a pill because she was coughing. The AP stated she had placed her hand behind the resident's head/neck to assist the resident but never forced the resident to drink.

In conclusion, abuse is inconclusive. It was reported the incident occurred sometime in March or April, and a timeline of the incident could not be established to identify potential witnesses of the incident. The interviews done with facility staff and resident's conflicted with the observations reported in the allegation. As a result, it was inconclusive whether abuse occurred.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.

Vulnerable Adult interviewed: No, unable.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility suspended the AP, investigated the incident, provided training to the AP and facility staff, and completed audits of compliance with assisting a resident with eating and drinking.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long-Term Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING ______ B. WING ______	C 05/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN HEALTH CENTER	**3910 MINNESOTA AVENUE DULUTH, MN 55802**

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F 000	INITIAL COMMENTS On 5/17/21, through 5/19/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5258044C (MN72806), with deficiencies cited at F600, F609. H5258045C (MN72802), with a deficiency cited at F550. H5258046C (MN72797), with deficiencies cited at F550, F576, F690. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. 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.	F 550		6/27/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 06/16/2021

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 §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. §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. §483.10(b) Exercise of Rights. 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. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 4 residents (R2, R8) reviewed for dignity were provided proper clothing to wear. In addition, the facility failed to ensure dignity was provided with toilet use for 1 of 4	F 550	Resident Rights/Exercise of Rights The Administrator and Environmental Services Director will oversee all sections of this plan of correction, including the education, auditing and review of those	

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F 550 Continued From page 2

residents (R3) reviewed for toileting.

Finding include:

R2's Face Sheet printed on 5/19/21, indicated R2's diagnoses included cerebrovascular accident (stroke), aphasia (loss of the ability to understand or express speech), and hemiplegia and hemiparesis (paralysis of one side of the body).

R2's admission Minimum Data Set (MDS) dated 3/17/21, indicated R2 was severely cognitively impaired. R2's MDS indicated he required an assist of one for dressing.

R2's care plan initiated on 3/15/21, indicated R2 needed assistance with dressing. R2's goals were to participate in dressing and he would be appropriately dressed daily.

On 5/17/21, at 2:35 p.m. R2's family member (FM)-D was interviewed and stated that R2 was made ready for bed on at least one occasion during his stay, wearing only an incontinence brief because he didn't have any clean clothes. FM-D also stated she was told the facility did not have any gowns available. FM-D stated she found R2 in tears, he was forced to sit in his own bowel movement. FM-D stated she would find R2 in bed wearing only an incontinent brief because he had no clean clothes, and the facility had no clean gowns.

R8's Face Sheet printed on 5/19/21, indicated R8's diagnoses included mild cognitive impairment, and adult failure to thrive.

R8's quarterly MDS dated 3/24/21, indicated R8

F 550

materials.

- R2 is no longer a resident at the care center. The Administrator and Environmental Services Director reviewed the inventory of linens available for R8. Personal laundry inventory reviewed for R8 and was provided more laundry as necessary.
- All residents have potential to be impacted by this deficient practice.
- The care center policy on Dignity was reviewed by the IDT and no updates needed.
- Administrator and Environmental Services Director reviewed inventory of house-wide linens for all residents.
- On 5/7/2021 Administrator placed linen order.
- Facility par level reviewed for all linen and adjustments were made as needed.
- Administrator educated Environmental Services Director on maintaining proper par levels.
- Environmental Services Director will audit linen par levels weekly and Administrator will be auditing linen par levels monthly starting on 6/11/2021.
- Linens will be ordered as needed.
- Audit results will be brought to the QAPI committee quarterly for review and further recommendations.
- Based on surveyor interviews and documentation review facility failed to ensure a bathroom was accessible to resident R3.
- All residents within the facility could potentially be impacted by this practice.
- R3 currently is not a resident within

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F 550	Continued From page 3 was totally dependent on staff for dressing. R8's care plan initiated on 2/19/18, indicated R8 required assitance with dressing. R8's goal was to accept assistance with dressing and would be appropriately dressed daily. On 5/18/21, nursing assistant (NA)-E was interviewed. NA-E stated that R8 was put to bed wearing only an incontinent brief because she had no clean clothes. The facility did not have any gowns for her to wear. -at 12:44 NA-E was interviewed. NA-E stated she had observed residents in bed wearing only an incontinent brief because they didn't have clean clothes or clean gowns to put on them. NA-E stated she put R8 to bed wearing just an incontinent brief the night before because she could not find any clothing or a gown. NA-E stated the facility had been very short on linens, including gowns. -at 1:43 p.m. environmental service (ES)-C was interviewed. ES-C stated laundry was done at an outside facility with deliveries on Monday, Wednesday, and Friday. On 5/19/21, at 10:28 a.m. the director of nursing (DON) was interviewed. The DON stated it was not dignified to leave a resident in only an incontinent brief if the resident's preference was to sleep in pajama's or a gown. R3's Face Sheet printed 5/19/21, indicated R3's diagnoses included spastic hemiplegia (muscles on one side of the body in a constant state of contraction) affecting left non-dominant side, and cerebral infarction (stroke).	F 550	the facility. • Assessments will be completed of all residents that use tub/shower bathrooms to determine if the use of that bathroom is still appropriate by the Nurse Manager. Resident preferences will be reviewed. Adjustments to resident care plans will be completed as needed by the Nurse Manager. • All staff will be educated on Resident Dignity in SNF created by the American Health Care Association (AHCA) • Resident preferences will be discussed at residents quarterly care conference and as requested by the resident by the Social Services Director or designee. • Bathroom use/preference audits will be conducted 3x/week for 2 weeks and weekly thereafter to ensure resident preferences are met. • Results will be brought and reviewed to quarterly QAPI committee for further recommendations if needed.	

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F 550	Continued From page 4	F 550		

R3's admission MDS dated 2/15/21, indicated R3 was cognitively intact, was occasionally incontinent of urine and always continent of bowel. R3's MDS indicated she required extensive assistance with toileting and dressing.

On 4/24/21, at 4:48 a.m. a progress note indicated R3 was upset about the difficulty in using the tub/shower room bathrooms, and not being able to use the bathroom because the rooms were in use by other residents.

On 5/17/21, at 2:35 p.m. R3 was interviewed. R3 stated she was not able to use the bathroom in her shared room, her wheelchair was too wide to fit through the door. R3 stated she did not want to use a commode because they move during transfer and do not allow for privacy. R3 stated she was supposed to use the bathrooms in the tub/shower rooms, but the rooms were kept locked, the floors were frequently wet, and they were not available if another resident was using the room for bathing/showering. R3 stated this caused her to have accidents, and this would make her feel bad and she would sometimes cry.

-at 12:26 p.m. NA-B was interviewed. NA-B stated R3's wheelchair would not fit through the bathroom door. NA-B stated it would take R3 about 10 minutes to wheel herself to the shower or tub room. NA-B stated the door was locked, it would alarmed if she tried to open it, and if she had an accident she would need to bring an incontinent brief with her as there were no supplies in the shower and tub rooms.

-at 12:44 NA-E was interviewed. NA-E stated she witnessed R3 have bladder incontinence

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F 550	Continued From page 5 episodes on "multiple" occasions because she couldn't get into the shower/tub bathrooms because the door was locked. On 5/19/21, at 10:28 a.m. the DON was interviewed and stated he was aware R3 could not always get to the shower/tub room bathroom in time to prevent being incontinent of urine. The DON stated this was a dignity issue for R3. -at 11:52 a.m. the administrator was interviewed. The administrator stated it was a dignity issue when someone who was continent of bladder was incontinent because they could not get to a bathroom in time. The facility document Best Practices For Compliance Related to Resident Dignity In Skilled Nursing Facilities created by The American Health Care Association undated, directed staff to maintain or improve his or her abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication system.	F 550		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the	F 576		6/27/21

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F 576	Continued From page 6 facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure mail was delivered to residents on Saturdays. This had the potential to affect all residents in the facility. Findings include: On 5/18/21, at 12:54 p.m. activities aide (AA)-A was interviewed. AA-A stated on the weekend, mail would be placed in the conference room, and	F 576	Right to forms of communication with privacy The Administrator and Activities Director will oversee all sections of this plan of correction, including the education, auditing and review of those materials. • SW-A and AA-A were educated on delivering resident mail on Saturdays. • All residents within the facility could potentially be impacted by this practice.	

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F 576	Continued From page 7 would remain there until Monday. AA-A stated the activities director or the social worker would then go through the mail, and determine what mail should be delivered to residents. AA-A stated this was done to ensure residents didn't throw out any important mail. On 5/19/21, at 9:56 a.m. the social worker (SW)-A was interviewed. SW-A verified mail was not delivered to residents on Saturdays. SW-A stated this was to ensure mail that was supposed to be be forwarded to families was not delivered to residents and accidentally thrown away. SW-A stated this was a violation of rights. -at 10:20 a.m. the director of nursing (DON) was interviewed. The DON was not aware residents were not receiving mail on Saturday. The DON stated this was a violation of resident rights. -at 11:52 a.m. the administrator was interviewed. The administrator was not aware mail was not being delivered on Saturdays. The administrator stated this was a violation of resident rights. A policy on receiving mail was requested, but not provided.	F 576	• Upon admission resident is asked how they would like their mail to be handled. Choices are: 1. Receive all mail. 2. Receive personal mail only; business mail to responsible party. 3. Activities to read personal mail; business mail to be read by responsible party. 4. All mail goes to responsible party. • On 5/19/2021 Administrator educated Activities Director regarding mail procedure. • All Activities staff educated as to preference for mail delivery and procedure, including mail delivery on Saturdays. • Activity Director will conduct random audits on Monday's to ensure mail was passed out per procedure and preferences starting on 5/24/2021. • All audit results will be brought and reviewed with quarterly QAPI committee for further recommendations.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and	F 584		6/27/21

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F 584	Continued From page 8 homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident clothing was laundered and available for 2 of 4 residents (R2, R8) reviewed for linen use. In addition, the facility failed to ensure facility gowns were available.	F 584	Safe/Clean/Comfortable/Homelike Environment The Administrator and Environmental Services Director will oversee all sections of this plan of correction, including the education, auditing and review of those	

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F 584

Continued From page 9

Findings include:

R2's Face Sheet printed on 5/19/21, indicated R2's diagnoses included cerebrovascular accident (stroke), aphasia (loss of the ability to understand or express speech), and hemiplegia and hemiparesis (paralysis of one side of the body).

R2's admission Minimum Data Set (MDS) dated 3/17/21, indicated R2 was severely cognitively impaired, and required assistance with dressing.

R2's care plan dated 3/15/21, indicated R2 needed assistance with dressing. R2's goals were to participate in dressing and he would be appropriately dressed daily.

R8's Face Sheet printed on 5/19/21, indicated R8's diagnoses included mild cognitive impairment, and adult failure to thrive.

R8's quarterly MDS dated 3/24/21, indicated R8 was totally dependent on staff for dressing.

R8's care plan dated 2/19/18, indicated R8 required assistance with dressing. The goal on 2/14/20, was R8 would be appropriately dressed daily.

On 5/17/21, at 2:35 p.m. family member (FM)-D was interviewed. FM-D stated the facility staff would leave R2 lying in bed with only his incontinence brief on because he had no clean clothes.

-at 12:44 nursing assistant (NA)-E was interviewed. NA-E stated she had observed residents in bed wearing just an incontinent brief

F 584

materials.

- R2 is no longer a resident at the care center. The Administrator and Environmental Services Director reviewed the inventory of linens available for R8. Personal laundry inventory reviewed for R8 and was provided more laundry as necessary.
- All residents have potential to be impacted by this deficient practice.
- The care center policy on Dignity was reviewed by the IDT and no updates needed.
- Administrator and Environmental Services Director reviewed inventory of house-wide linens for all residents.
- On 5/7/2021 Administrator placed linen order.
- Facility par level reviewed for all linen and adjustments were made as needed.
- Administrator educated Environmental Services Director on maintaining proper par levels.
- Environmental Services Director will audit linen par levels weekly and Administrator will be auditing linen par levels monthly starting on 6/11/2021.
- Linens will be ordered as needed.
- Audit results will be brought to the QAPI committee quarterly for review and further recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING ______ B. WING ______	C 05/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN HEALTH CENTER	3910 MINNESOTA AVENUE DULUTH, MN 55802

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F 584	Continued From page 10 because they didn't have clothes or gowns to put on them. NA-E stated she had put R8 to bed wearing just a brief the night before because she could not find any of their clothing or a facility gown. NA-E stated the facility had been very short on linens, including facility gowns. -at 1:43 p.m. environmental service (ES)-C was interviewed. ES-C stated laundry was done at an outside facility with deliveries on Monday, Wednesday, and Friday. On 5/19/21, at 10:28 a.m. the director of nursing (DON) was interviewed. The DON stated he had been aware for two to three weeks that staff were saying there was not enough linen. -at 11:52 a.m. the administrator was interviewed. The administrator stated she had been aware for the past two weeks that staff were saying there was not enough linen.	F 584		
F 600 SS=D	Free from Abuse and Neglect 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	F 600		6/27/21

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F 600	Continued From page 11 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were free from abuse related to an allegation of staff to resident abuse for 1 of 4 reviewed for abuse. Findings include: R1's Disease Diagnosis & Allergies list printed on 5/19/21, indicated R1 had diagnoses which included unspecified dementia without behavioral disturbance. R1's quarterly Minimum Data Set (MDS) dated 3/31/21, indicated R1 was severely cognitively impaired, and was able to eat independently. R1's care plan dated 3/31/21, indicated staff was to provide set up assist and cues with meals as needed. A report submitted to the State Agency (SA) on 5/12/21, indicated registered nurse (RN)-B was observed sometime in March or April of 2021, forcing R1 to drink juice. The report indicated they heard RN-B say R1 needed to drink, and if she couldn't drink, RN-A would make sure she drank. RN-B was observed holding R1's mouth forcing it open, and forcing the juice down R1's throat. It was reported R1 screamed, choked, and lashed out with her arms. The reporter stated she told staff present about the incident. On 5/18/21, at 2:14 p.m. RN-B was interviewed. RN-B stated she has had to push fluids with R1, and stated she had put her hand on the back of R1's head and forced her to drink.	F 600	Free from Abuse and Neglect The Administrator and Director of Nursing will oversee all sections of this plan of correction, including the education, auditing and review of those materials. • Based on interviews, documentation reviewed by surveyor and report submitted to state agency RN-B was observed sometime in March or April of 2021 forcing resident R-1 to drink juice. • All residents within the facility could potentially be impacted by this practice. • Resident interviews were completed by social services director asking if they had ever been forced "to take medications, food or liquids against their will". All residents expressed that this had never happened to them and expressed no further concerns. • IDT reviewed Maltreatment Prohibition Policy with no changes noted. • On 5/20/2021 1:1 Education provide to staff member RN-B on the maltreatment prohibitions policy and assisting resident with taking oral medications, food and liquids and honoring resident wishes when refusing those services by Director of Nursing. • On 5/19/2021 House wide Licensed Nursing education provided on the proper assistance when offering residents medications, food and liquids. • Audits will be performed on the proper administration of medications, food and liquids and process to be used by nurses then the resident refuses those items	

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F 600	Continued From page 12 On 5/19/21, at 10:28 a.m. the director of nursing (DON) was interviewed. The DON stated it would be physical abuse if a staff member prevented a resident from moving their head and forced them to drink fluids. -at 11:52 a.m. the administrator was interviewed. The administrator stated it would be abuse if a staff member prevented a resident from moving their head and forced them to drink fluids. The facility policy Maltreatment Prohibition reviewed/amended 2/19/18, defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.	F 600	2x/week X4 weeks and then 2X/month X 2 months starting on 5/20/2021. • All audit results will be brought and reviewed with quarterly QAPI committee for further recommendations.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in	F 609		6/27/21

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F 609	Continued From page 13	F 609		

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:
Based on interview and document review the facility failed to report an allegation of abuse for 1 of 4 residents (R1) reviewed for abuse.

Findings include:

R1's Disease Diagnosis & Allergies list printed 5/19/21, indicated R1 had diagnoses which included unspecified dementia without behavioral disturbance.

R1's quarterly Minimum Data Set (MDS) dated 3/31/21, indicated R1 was severely cognitively impaired, and was able to eat independently.

R1's care plan dated 3/31/21, indicated staff was to provide set up assist and cues with meals as needed.

A report submitted to the State Agency (SA) on 5/12/21, indicated registered nurse (RN)-B was observed sometime in March or April of 2021, forcing R1 to drink juice. The report indicated they heard RN-B say R1 needed to drink, and if she couldn't drink, RN-A would make sure she drank. RN-B was observed holding R1's mouth forcing it open, and forcing the juice down R1's throat. It

Reporting of Alleged Violations
The Administrator and Director of Nursing will oversee all sections of this plan of correction, including the education, auditing and review of those materials.

- R1 abuse allegation was reported on 5/19/2021 to the State Agency (SA). Tracking ID #342025
- All residents within the facility could potentially be impacted by this practice.
- All allegations of abuse will be reported timely to the Administrator. Facility will report timely and report according to facility policy and state and federal guidelines.
- Maltreatment Reporting Guidelines policy was reviewed by the Social Services Director, Director of Nursing and Administrator regarding reporting of allegations of abuse.
- All staff have been educated on the Maltreatment Reporting Guidelines policy by the Administrator or designee, regarding reporting immediately to the Administrator any alleged abuse.
- Audits will be completed on a continuous bases. Social Services

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F 609	Continued From page 14 was reported R1 screamed, choked, and lashed out with her arms. The reporter stated she told staff present about the incident. On 5/18/21, at 2:14 p.m. registered nurse (RN)-B was interviewed. RN-B stated she has had to push fluids with R1, she puts her hand on the back of her head and forced her to drink. On 5/18/21, at 2:14 p.m. RN-B was interviewed. RN-B stated she has had to push fluids with R1, and stated she had put her hand on the back of R1's head and forced her to drink. The facility policy Maltreatment Prohibition reviewed/amended 2/19/18, defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. The policy directed staff to report immediately as soon as possible, but not later than two hours after the allegation is made.	F 609	Director will review copies of concern forms and reporting checklist with Administrator. Administrator will review all documentation for potential abuse and neglect and timely reporting to SA. • Administrator will audit all alleged abuse complaints to ensure that they have been reported timely to the SA on an on-going basis starting on 5/19/2021. • All audit results will be brought and reviewed with quarterly QAPI committee for further recommendations.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an	F 690		6/27/21

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F 690	Continued From page 15	F 690		

Summary statement of deficiencies (F 690):

indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure a bathroom was accessible to prevent incontinence for 1 of 4 residents (R3) reviewed for bladder incontinence.

Finding include:

R3's Face Sheet printed 5/19/21, indicated R3's diagnoses included spastic hemiplegia (muscles on one side of the body in a constant state of contraction) affecting left non-dominant side, and cerebral infarction (stroke) of left mid cerebral artery.

R3's admission MDS dated 2/15/21, indicated R3 was cognitively intact, and required extensive

Provider's plan of correction (F 690):

Bowel/Bladder Incontinence, Catheter, UTI
The Administrator and Director of Nursing will oversee all sections of this plan of correction, including the education, auditing and review of those materials.

- Based on surveyor interviews and documentation review facility failed to ensure a bathroom was accessible to resident R3.
- All residents within the facility could potentially be impacted by this practice.
- R3 currently is not a resident within the facility.
- Assessments will be completed of all

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F 690	Continued From page 16 assistance with transfers and toilet use. R3's MDS further indicated she was occasionally incontinent of bladder. R3's care plan dated 2/8/21, indicated R3's goal was to not decline in bladder continence. The care plan directed staff to encourage fluid intake, and offer assistance to toilet every two to three hours and as needed. On 4/24/21, at 4:48 a.m. a progress note indicated R3 was upset about the difficulty in using the tub/shower bathrooms. R3 was sometimes not able to use the bathroom because other residents were bathing or showering. On 5/17/21, at 2:35 p.m. R3 was interviewed. R3 stated she was not able to use the bathroom in her room, her wheelchair was too wide. The facility's solution was for her to use a commode in her room. R3 did not find this a satisfactory solution, not enough privacy and the commodes have potential to slide during transfers. The facility said she could use the bathrooms in the shower room or the bathroom in the tub room. R3 stated the rooms were frequently in use for showers or baths, and the floors were often wet. R3 stated the rooms were kept locked when not in use, the key not accessible for a person in a wheelchair, and the doors were alarmed if someone tried to open the door without a key. R3 stated if she could not get there in time she would have an accident. On 5/18/21, at 7:17 a.m. registered nurse (RN)-A was interviewed. RN-A stated it R3's wheelchair did not fit into the bathroom, she stated it was part of R3's therapy to be able to get herself to and from the bathroom to discharge to her home	F 690	residents that use tub/shower bathrooms to determine if the use of that bathroom is still appropriate by the Nurse Manager. Resident preferences will be reviewed. Adjustments to resident care plans will be completed as needed by the Nurse Manager. • All staff will be educated on Resident Dignity in SNF created by the American Health Care Association (AHCA) • Resident preferences will be discussed at residents quarterly care conference and as requested by the resident by the Social Services Director or designee. • Bathroom use/preference audits will be conducted 3x/week for 2 weeks and weekly thereafter to ensure resident preferences are met. • Results will be brought and reviewed to quarterly QAPI committee for further recommendations if needed.	

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F 690	Continued From page 17	F 690		

safely.

-at 12:26 p.m. NA-B was interviewed. NA-B stated R3's wheelchair would not fit through the bathroom door. NA-B stated it would take R3 about 10 minutes to wheel herself to the shower or tub room. NA-B stated the door was locked, it would alarmed if she tried to open it, and if she had an accident she would need to bring a brief with her as there were no supplies in the shower and tub rooms.

-at 12:44 NA-E was interviewed. NA-E stated she witnessed R3 have bladder incontinence episodes on "multiple" occasions because she couldn't get into the shower/tub bathrooms because the door was locked.

On 5/19/21, -at 10:28 a.m. the director of nursing (DON) was interviewed. The DON was aware that R3 could not always get to the shower/tub room bathroom in time to prevent being incontinent of urine.

-at 2:14 p.m. RN-B was interviewed. RN-B stated she was aware that R3 was incontinent of urine because she couldn't get into the bathroom on time.

The facility document Best Practices For Compliance Related to Resident Dignity In Skilled Nursing Facilities created by The American Health Care Association undated, directed staff to maintain or improve his or her abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication system.