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DULLES HEALTH & REHAB CENTER	2978 CENTREVILLE ROAD HERNDON, VA 20171

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 12/5/22 through 12/7/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey. [VA00057031: unsubstantiated, VA00057025: substantiated with deficiencies cited]. The census in this 166 certified bed facility was 147 at the time of the survey. The survey sample consisted of 25 resident reviews.	F 000		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §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. §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. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a	F 585		

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

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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:
(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;
(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;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

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F 585	Continued From page 2 (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; (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; (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 (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. This REQUIREMENT is not met as evidenced by: Based on Resident interview, facility staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to respond to, and take measures to resolve, concerns affecting residents on 4 of 4 nursing units.	F 585		

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The findings included:

The facility staff failed to respond in an effective manner to ensure resolution of ongoing concerns regarding the lack of call bell responses.

On 12/5/22, in the course of a complaint investigation, a review of grievance forms from multiple residents revealed concerns reported to the facility staff of ongoing issues of facility staff not responding to call lights. The grievance forms documented the following:

i. On 8/5/22, Resident #18 reported that her call light goes unanswered for a long time.

ii. On 8/12/22 Resident #11's family reported that staff do not answer her call light promptly.

iii. On 8/17/22, Resident #11's family reported another concern with regards to the resident call bell.

iv. On 8/22/22, Resident #10's family reported that the Resident's call bell was taken away from her and she was told she uses it too much and not to call them/staff.

v. On 10/4/22, Resident #20 reported that she engaged her call bell at 3:45 AM, and it wasn't until 9:30 AM that staff responded to her request.

vi. On 11/18/22, Resident #22's family reached out to facility staff to notify them that Resident #22 had pressed her call bell and it was over 30 minutes before staff responded to the call bell.

vii. On 11/24/22, Resident #23 reported that the staff do not respond to the call bell.

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viii. On 11/25/22, Resident #14 reported that the facility staff do not respond to her call bell.

On 12/6/22 at 9 AM, the maintenance director confirmed that the facility is unable to provide any kind of report or log to indicate how long call bells are engaged before the staff respond or disengage them.

Resident interviews were conducted and revealed the following:

i. On 12/6/22 at 1:11 PM, an interview was conducted with Resident #20. When asked about the call bells Resident #20 said, "I've used it at 4 AM and not heard from anyone until 9 AM. They see it and say, 'Oh, she just wants something heated up,' so they don't' even come." Resident #20 went on to say, "I've quit using the call bell because they won't answer it."

ii. On 12/6/22 at 4 PM, an interview was conducted with Resident #14. Resident #14 reported that, "I don't like to complain but no one helps me when I use my call bell. I have to call my son on the phone and get him to call to get someone to come help me." The resident went on to say, "The other night I was calling and calling with the call bell, I kept my son on the phone so he could see how long it takes them. I am so thankful I can call my son so he can get them to come help me when I need it."

iii. On 12/7/22 at 8:20 AM, an interview was conducted with Resident #22. Resident #22 said that "several times I've had to call the main number to get someone to come in to help me because they wouldn't answer the call bell."

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iv. On 12/7/22 at approximately 8:30 AM, an interview was conducted with Resident #20 in response to the resident's request. When asked about call bell response, the Resident said, "I've called between 3-4 AM, and they didn't come until 8:30 AM." Resident #20 stated she has reported it to the facility staff.

v. On 12/7/22 at 9:15 AM, an interview was conducted with Resident #6. When asked about the call bell response time, the Resident said, "The night shift forbids me from getting up on my own, they are scared of falls. One night I cut my call bell on and waited 20 minutes. I couldn't wait anymore so I got up and went to the bathroom and came back. It was 2 hours and 18 minutes before anyone came in to see what I needed. This has happened several times."

Staff were interviewed regarding call bells and the following was noted:

i. On 12/6/22 at 9:15 AM, an interview was conducted with CNA (certified nursing assistant) K. CNA K stated that call bells are used for the Residents to get in touch with facility staff for any needs they may have. CNA K added that all staff are to answer call bells and staff are to respond immediately. She stated, "The policy is to answer within 1 minute."

ii. On 12/7/22 at 8:45 AM, an interview was conducted with CNA D. CNA D reported, "They always say they call, and no one came during the night- sometimes it's true because they remember. I tell the supervisor so they can look into it."

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iii. On 12/7/22 at 9 AM, an interview was conducted with LPN (licensed practical nurse) C. LPN C was asked about call bells and if Residents ever report that they have called for assistance, and it took a long time for staff to respond, or they didn't respond at all. LPN C said, "At times when I come in, they all are asking for water because they didn't get any overnight."

iv. On 12/7/22 at 9:59 AM, an interview was conducted with Employee E, the receptionist. Employee E confirmed that frequently she will receive phone calls from the Residents and families reporting that Residents need assistance and staff are not responding to the call lights. Employee E said the calls are more frequent from some Residents than others, but that it is an ongoing thing, and she will always call the station and try to get someone to respond.

A review of the facility policy, "Call Lights: Accessibility and Timely Response," revealed, in part: "All employees who see or hear an activated call light are responsible for responding. If the employee cannot provide what the patient desires, the appropriate personnel should be notified."

A review of the facility grievance policy revealed, in part: "All information about the grievance and any resulting actions will be recorded on the Grievance/Concern Form. 12. All staff involved in the grievance investigation or resolution should make prompt efforts to resolve the grievance in coordination with the Grievance Official, or designee. 13. the Grievance Official, or designee, will keep the patient appropriately apprised of progress toward resolution of the grievance..."

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F 585	Continued From page 7 In the mid-morning of 12/7/22, a meeting was held with the facility Administrator, Director of Nursing and Corporate Clinical Specialist. When asked if they had identified any concerns or systemic problems with regards to call lights, they said, "No not lately." Surveyor B told them there was a significant number of complaints regarding staff not responding to call bells, and during Resident interviews, many reported this is an ongoing issue. The Administrator stated that the last time call lights were a focus was September 2022, but they have an upcoming Quality Assurance meeting next week and can look into it. The facility staff then provided evidence of multiple in-services being conducted in August with regards to call bells and then once in November and again on 12/6/22. Each in-service contained approximately 5-10 staff signatures. Complaint related deficiency.	F 585		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §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 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,	F 607		

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F 607	Continued From page 8 §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and in the course of a complaint investigation, the facility staff failed to implement their abuse policy for 7 Residents (Resident #15, 12, 2, 11, 16, 13, and 14), in a survey sample of 25 Residents. The findings included: 1. For Residents #15, 11, 16, 13, 14, and 12, the facility staff failed to implement their abuse policy with regards to conducting investigations in response to allegations of abuse. On 12/5/22, during the course of a complaint investigation it was determined that multiple Residents had reported allegations of abuse to the facility staff, and the facility staff failed to conduct an investigation regarding the allegations.	F 607		

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F 607	Continued From page 9 i. Resident #15 had reported on 10/25/22 that an assigned CNA (certified nursing assistant(CNA H) was very argumentative and unprofessional. Review of the grievance form revealed that LPN E had written a statement that read, "In the morning while passing medications standing in front of [room number redacted], I heard staff talking loud. I called him immediately to come outside which he [CNA H] did. I asked him what happened and told him I could hear him from outside and he said, Let me talk this resident is alert and let me tell her the truth...This nurse went into resident's room to give her her scheduled medications and resident told her that a staff was yelling at her for putting on her call light, when all she wanted was a cup of water, crying telling this nurse that staff doesn't know what she has been through. She continues "at 7 years of age I was sexually abuse by my own father and since then if anyone speaks to me in a loud voice I become frighten and my whole day is spoil...[sic]" ii. Resident #11's spouse had reported to a facility staff member on 8/12/22, that he "is not happy with the way staff treat his wife." The complaint read, "Last night a staff told his wife to shut up when she want to ask question [sic]..." A grievance form was completed and contained no supporting evidence of any investigation being conducted. The "grievance official follow up" read, "review plan of care with staff and educated on good customer service and techniques with understanding verbalized. Educated on resident's rights as well. UM [unit manager] spoke with RP [responsible party]/spouse and patient at bedside and concerns addressed to satisfactory with all questions answered."	F 607		

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iii. A grievance was filed by Resident #16 on 9/8/22, who reported to a facility staff member that "[CNA B's name redacted] was not gentle with her while changing her and the CNA had an attitude." The grievance form indicated that the Resident reported the same to the unit manager upon interview. The CNA was educated and provided with a counseling form that indicated "First Incident- In-service."

iv. Resident #13 reported on 10/27/22 "a male staff member was very rough while providing care. He was angry and very curt with patient." The facility's response was, "Staff was in-service on caring for resident." There was no evidence provided that an investigation was conducted.

v. For Resident #14, their family member reported on 11/25/22, "3-11 shift CNA was pushing on patient's forehead." The facility's response was, "frequent rounding recommended by staff. Adhere and respond to patient and family concerns as soon as possible. Staff should identify themselves with name and how they can be of help. Staff instructed to be gentle with care and explain care proceeding before care."

vi. For Resident #12, whose family reported the Resident felt harassed by nursing staff and treated like an animal, the facility staff failed to conduct an investigation. On 12/5/22, during the course of a complaint investigation, Surveyor B noted in facility documentation that Resident #12's family reported to facility staff on 8/18/22 that the Resident "felt harassed by nursing staff and treated like an animal." The grievance form was written by Employee H, the social services director. However, there was no grievance

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follow-up noted on the form. Attached was a second grievance form dated the same day, completed by another staff member. The allegations of the Resident feeling that she was harassed by nursing staff and treated like an animal were not noted on the second form. Therefore, this allegation had no follow-up/investigation, etc.

On 12/5/22 and 12/6/22, review of the facility reported incidents, facility provided investigation files, and grievances for the above Residents were reviewed. There was no supporting evidence that the above allegations of abuse were investigated.

On 12/5/22 and 12/6/22, clinical record reviews were conducted for each of the above Residents. There was no documentation within any of the Resident's records to indicate an investigation had been conducted.

On 12/6/22 at 10:49 AM, an interview was conducted with Employee G, a social worker. When asked to explain what abuse is, Employee G said, "It can be mental, physical, psychosocial, it comes in many forms." When asked what she does if someone reports abuse, Employee G said, "I contact my immediate supervisor, then I go into the room and follow-up on what they said." When asked if this conversation gets documented, Employee G said, "yes," and further explained it would be in the Resident's progress notes. When asked if a Resident or family must specifically use the word abuse for it to be considered abuse, Employee G said "no."

On 12/6/22 at 4:12 PM, an interview was conducted with the Social Services

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Director/Employee H. Employee H defined abuse and neglect and explained that anyone can report abuse, including the Resident, a family member, a staff member, or a visitor. Employee H stated that the facility Administrator investigates and will at times ask the Social Services Department to assist. Employee H said she maintains a folder with interview information and other investigation documents in her office. Employee H was asked to provide any such files she may have that took place from August 2022 to the present. On 12/6/22 at 4:24 PM, Employee H returned to Surveyor B and said she had not conducted any investigations and had no such documents for the requested time frame.

A review of the facility policy, "Abuse Prevention," revealed, in part: "V. Investigation: A. Designated staff will immediately review and investigate all reported incidents or allegations. B. Investigations will include collecting physical and documentary evidence which may include taking photographs, as necessary, interviewing residents and staff with personal knowledge of the incident or alleged incident, requesting witness statements, collecting relevant evidence, and documenting each step taken during the investigation. C. The Quality Assurance Committee will conduct analysis for trends. D. Outside investigative bodies, such as the local police will be contacted as directed by the Administrator in accordance with state and local law and Center policy. E. Investigations will be conducted and completed within 5 working days, if possible, of the incident or allegation. In the event the investigation has not been completed a report will be submitted to the state licensing and certification containing as much information as is possible. The Center shall continue

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F 607	Continued From page 13 investigations until complete...." On 12/7/22 at 10:20 AM, a meeting with the facility Administrator, Director of Nursing and Corporate Clinical Specialist was held. These concerns were shared with the facility staff, and the Administrator stated that the above complaints should have prompted an investigation. They were asked to provide any additional documents or evidence they may have to indicate that investigations were conducted. No further information was received, and the facility notified the survey team they had submitted all documentation they had to provide. Complaint related deficiency. 2. For Residents #15, 12, 2, 11, 16, 13, and 14, the facility staff failed to implement their abuse policy with regards to reporting allegations of abuse to the state survey agency and adult protective services. i. Resident #15 had reported on 10/25/22, that an assigned CNA (CNA H) was very argumentative and unprofessional. ii. Resident #12's family reported an allegation of abuse on 8/18/22, that the Resident "felt harassed by nursing staff and treated like an animal." iii. Resident #2's family reported to facility staff an allegation of abuse that the "patient reported they were hurting her during care, when they turned her side to side."	F 607		

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iv. Resident #11's spouse reported to facility staff an allegation of abuse on 8/12/22, that he "is not happy with the way staff treat his wife." The complaint read, "Last night a staff told his wife to shut up when she want to ask question [sic]..."

v. Resident #16 filed a grievance on 9/8/22, telling a facility staff member, that "[CNA B's name redacted] was not gentle with her while changing her and the CNA had an attitude."

vi. Resident #13 reported on 10/27/22, "a male staff member was very rough while providing care. He was angry and very curt with patient."

vii. Resident #14's family member reported on 11/25/22, "3-11 shift CNA was pushing on patient's forehead."

For each of the above allegations of abuse, the facility staff failed to provide any evidence that the allegations were reported to the state survey agency and adult protective services.

On 12/6/22 at 4:12 PM, an interview was conducted with the Social Services Director/Employee H. Employee H defined abuse and neglect and explained that anyone can report abuse, including the Resident, a family member, a staff member, or a visitor. Employee H stated that the facility Administrator investigates and will at times ask the Social Services Department to assist. Employee H was able to verbalize the reporting of allegations to the required entities and indicated that the facility Administrator handled that .

A review of the facility policy "Abuse Prevention" revealed, in part: "...VII. Reporting/Response. A.

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F 607	Continued From page 15 Allegations of abuse, neglect, misappropriation of property, exploitation: The center Administrator, DON (director of nursing), or designee must timely report all alleged incidents of abuse, neglect, exploitation, or mistreatment... using the Virginia Office of Licensure & Certification "Facility Reported Incident" form to the (OLC) and to all other required agencies including Adult Protective Services (APS) and local law enforcement. A final report with results of the investigation is filed with the OLC within 5 working days of the alleged incident..." On 12/7/22 at 10:20 AM, a meeting was held with the facility Administrator, Director of Nursing and Corporate Clinical Specialist, and they were made aware of these findings. They were asked to provide any additional documents or evidence they may have to indicate that the allegations were reported to the state survey agency and adult protective services. No further information was received, and the facility notified the survey team they had submitted all documentation they had to provide. Complaint related deficiency.	F 607		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(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,	F 609		

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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:
Based on Resident interview, staff interview, clinical record review, facility documentation review and during the course of a complaint investigation, the facility staff failed to report to the State Survey Agency/Office of Licensure and Certification and Adult protective services allegations of abuse and neglect for 7 Residents (Resident #15, 12, 2, 11, 16, 13 and 14) in a survey sample of 25 Residents.

The findings included:

1. For Resident #15, who had an allegation of abuse, the facility staff failed to report the incident to the state survey agency and adult protective services.

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On 12/5/22, during the course of a complaint investigation it was determined that Resident #15 had reported on 10/25/22 that an assigned CNA (certified nursing assistant), CNA H, was very argumentative and unprofessional. Review of the grievance form revealed that LPN (licensed practical nurse) E had written a statement that read, "In the morning while passing medications standing in front of [room number redacted], I heard staff talking loud. I called him immediately to come outside which he [CNA H] did. I asked him what happened and told him I could hear him from outside and he said, 'Let me talk. This resident is alert, and let me tell her the truth.' This nurse went into resident's room to give her ...scheduled medications and resident told her that a staff was yelling at her for putting on her call light, when all she wanted was a cup of water, crying telling this nurse that staff doesn't know what she has been through. She continues, 'At 7 years of age I was sexually abuse by my own father and since then if anyone speaks to me in a loud voice I become frighten and my whole day is spoil...[sic].'"

Review of the grievance indicated, "associate is counselled and educated to be professional with our resident and treat them with respect and good customer service." There was no evidence that this allegation had been reported to the state survey agency or adult protective services.

On 12/5/22, in the afternoon, Surveyor B met with Resident #15. Resident #15 verbalized that she was verbally, mentally, and sexually abused as a child and has PTSD (post-traumatic stress disorder) and bipolar. When asked if she has had any problems with staff mistreating her she said, "There was one but we have worked it out

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and he apologized."

On 12/6/22, Surveyor B asked to review the employee file for CNA H. Upon review it was noted that CNA H had an "Associate Counseling Form" dated 10/26/22, that read, "First Incident-Verbal.". Detailed description of Incident: "Pt [patient] reported assigned CNA [CNA H name redacted] was very argumentative and unprofessional. Action Taken: Associate was counselled and education to be professional with our resident and treat them with good customer service..."

On 12/7/22, Surveyor B met with the facility Administrator, Director of Nursing and Corporate Clinical Director and discussed this incident. The facility staff was asked to provide any additional evidence with regards to this incident/allegation of abuse being reported to the state survey agency or adult protective services.

A review of the facility policy titled; "Abuse Prevention," revealed, in part: "...VII. Reporting/Response. A. Allegations of abuse, neglect, misappropriation of property, exploitation: The center Administrator, DON (director of nursing), or designee must timely report all alleged incidents of abuse, neglect, exploitation, or mistreatment... using the Virginia Office of Licensure & Certification "Facility Reported Incident" form to the (OLC) and to all other required agencies including Adult Protective Services (APS) and local law enforcement. A final report with results of the investigation is filed with the OLC within 5 working days of the alleged incident..."

The facility provided no additional information.

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2. For Resident #12, whose family reported an allegation of abuse, the facility staff failed to report the allegation and any investigation results to the Office of Licensure and Certification and adult protective services.

On 12/5/22, during the course of a complaint investigation, Surveyor B noted in facility documentation that Resident #12's family reported to facility staff on 8/18/22 that the Resident "felt harassed by nursing staff and treated like an animal." The grievance form was written by Employee H, the social services director. However, there was no grievance follow-up noted on the form. Attached was a second grievance form dated the same day, completed by another staff member. The allegations of the Resident feeling that she was harassed by nursing staff and treated like an animal were not noted on the second form. There was no indication that this allegation was reported to the state survey agency or adult protective services.

Review of the clinical record for Resident #12 revealed that she had been discharged from the facility and, therefore, was not able to be interviewed. Review of the progress notes revealed an entry on 8/18/22 at 15:19 (3:19 p.m.) that read, "UM [unit manager] along with care team met with resident and family to discuss concerns along with plan of care as ordered. patient concerns were acknowledged and addressed, pain management and bowel regimen was reviewed and order changes initiated per md order and consultation. plan of care reviewed with staff nurses and aides. all parties involved

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verbalized understanding of plan of care and care concerns as well. resident remains stable." The note made no mention of the report of "feeling harassed and treated like an animal."

Resident #12's clinical chart revealed that a Medicare/5 day assessment/MDS (minimum data set) was conducted 8/12/22. During this assessment, Resident #12 scored a 12 out of 15 on the brief interview for mental status, which indicated moderately impaired cognition.

On 12/7/22 at 10:20 AM, during an interview with the facility Administrator, Director of Nursing and Corporate Clinical Specialist, several Resident reports were reviewed, to include Resident #12's allegation of feeling harassed and treated like an animal. The Administrator said, "There is definitely an emotional component. It would prompt an investigation and based on the findings we would send a FRI [facility reported incident]." The facility staff were asked to provide any additional information they may have to indicate that this allegation was reported to the state survey agency or adult protective services. The facility had nothing to provide.

No additional information was provided.

3. For Resident #2, who reported staff hurting her during care, the facility staff failed to report the allegation of abuse to the state survey agency and adult protective services.

On 12/5/22, during an entrance conference held with the facility Administrator, the facility staff were asked to provide all facility reported incidents (FRI's) from August 2022 through

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December 2022. The facility staff provided 2 FRI's, which were not regarding Resident #2.

On 12/5/22, during the course of a complaint allegation, Surveyor B noted that Resident #2's family reported to facility staff that the "patient reported they were hurting her during care, when they turned her side to side." The complaint was noted on a grievance form and in the section for "Grievance Official Follow-up" it read, "Please see attached'. There was attached a typed statement that read, "SW (social worker met with patient to discuss her concerns. Patient stated that staff was hurting her on her neck and shoulders when providing care/turning her from side to side. Patient stayed that she asked the staff to stop hurting her [sic]. Patient did state that she did not think the staff was intentionally hurting her. SW asked patient, if they staff had explained what they were going to do and how she could assist if that would have helped prevent the staff from hurting her. Patient said yes that would have helped a lot..."

Resident #2 had been discharged from the facility and was not available for interview. A clinical record review was conducted. This review revealed that Resident #2 had a Medicare 5 day assessment/MDS (minimum data set) conducted on 11/30/22. This assessment coded Resident #2 as having had a brief interview for mental status score of 12 out of 15. This indicated Resident #2 had moderately impaired cognition. The entire clinical record for Resident #2 was reviewed with no significant finding and no details regarding the allegation of abuse reported on 11/25/22.

On 12/6/22 at 4:30 PM, Surveyor B met with the

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facility Administrator and Director of Nursing. When asked about the allegation regarding Resident #2, the Administrator said, "The daughter called while we were in morning meeting, and we went to talk with the patient. When the CNA was turning her, she was leaning on her stroke affected side and it hurt her. The mother called the daughter. When we went in, she was in her chair eating, she said she was telling the CNA (CNA J) she was hurting her, and she wasn't paying attention and feels like she was rushing through."

During the above interview with the Administrator, she was asked if a Resident says staff are rough, if that would be an allegation of abuse. The Administrator said, "Yes, usually social worker gets that kind of concern and will interview the resident and get details, ask if they feel safe, if they feel like it was intentional. It's still an allegation."

On 12/7/22 at 10:20 AM, a meeting was held with the facility Administrator, Director of Nursing and Corporate Clinical Specialist. During this interview, the Administrator acknowledged that when Residents report staff are rough, it is an allegation of abuse, and an investigation and reporting is required. The facility was advised that all documentation provided thus far doesn't reveal this was done. The facility was instructed to provide any additional information.

No further information was provided with regards to Resident #2's allegation of abuse to indicate that the allegation of abuse was reported to the state survey agency or adult protective services.

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4. For Resident #11, whose spouse reported to facility staff an allegation of abuse, the facility staff failed to report the allegation and failed to report the results of an investigation.

On 12/5/22, during the entrance conference held with the facility Administrator and Director of Nursing, the facility staff were asked to provide any Facility Reported Incidents (FRI's) and investigations conducted from August through the present. The facility provided 2 FRI's, neither of which involved Resident #11.

On 12/5/22, during the course of a complaint investigation, Surveyor B determined that Resident #11's spouse had reported to a facility staff member on 8/12/22, that he "is not happy with the way staff treat his wife." The complaint read, "Last night a staff told his wife to shut up when she want to ask question [sic]..." A grievance form was completed and contained no supporting evidence of any investigation being conducted. The "grievance official follow up" read, "review plan of care with staff and educated on good customer service and techniques with understanding verbalized. Educated on resident's rights as well. UM [unit manager] spoke with RP [responsible party]/spouse and patient at bedside and concerns addressed to satisfactory with all questions answered."

Resident #11 was discharged from the facility and was not able to be interviewed. Review of the clinical record revealed that on 8/17/22 and on 10/11/22, a MDS (minimum data set) (an assessment tool) was conducted, and Resident #11 had a BIMS (brief interview for mental status) score of 15 on both assessments. This score

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indicated that Resident #11 had answered all questions correctly and was cognitively intact. Both assessments were also coded as Resident #11 not having any symptoms of delirium. There was no documentation within the progress notes with regards to the above allegation. Resident #11 had a care plan initiated on 8/11/22, that read, "[Resident #11's name redacted] is adjusting to a new environment r/t [related to] new admission." The interventions associated with this care plan read, " Allow patient/resident to express/discuss feelings and provide reassurance and support, encourage family, friends and other support persons to visit., Introduce to staff and other patients/residents on the unit."

On 8/17/22, Resident #11's spouse reported another complaint, and it was recorded on a facility grievance form. The details of the complaint read, "On Monday 8/15/22 at 7 PM; CNA came into the room and changed my spouse's brief at 7PM & stated, "This is the last change for the night" CNA closed the door and didn't leave the call bell within reach. She was frightened. She did not get brief changed until the next day." The facility staff wrote on the grievance form that this grievance was resolved on 8/17/22 and the follow-up read, "CNA and staff on shift educated with good customer services and techniques, Patient's rights and communication skills with understanding verbalized. Resident has right to call for incontinence checks and assistance at all times." There was no evidence of the education provided to staff, any investigation into who the CNA was that told the Resident this and then neglected to provide any further care that night.

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On the morning of 12/7/22, the facility Administrator was asked to provide any and all evidence of any investigation and reports made regarding the above allegations. The Administrator stated she had called the former Administrator, who is out on leave, and they had no further documents to provide.

No evidence of the allegation of abuse being reported to the status survey agency or adult protective services was provided prior to the conclusion of the survey.

On 12/7/22 at 10:20 AM, during an interview with the facility Administrator, Director of Nursing and Corporate Clinical Specialist, several Resident reports, to include Resident #11's allegation of being told "to shut up" were discussed. The facility Administrator acknowledged that this could be "emotional abuse" and an investigation should have been conducted. When asked, "What if a Resident's call bell is taken away or they are told that is the last change for the night?" The Administrator immediately said, "Oh that's abuse."

The facility staff provided no further evidence with regards to Resident #11's allegations prior to the survey exit and stated they had submitted all evidence they had.

5. For Resident #16 who reported a staff member was not gentle during care, the facility staff failed to report the allegation of abuse to the state survey agency and adult protective services.

On 12/5/22, during a complaint investigation, Surveyor B noted a grievance filed by Resident

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#16 on 9/8/22, who reported to a facility staff member, that "[CNA B's name redacted] was not gentle with her while changing her and the CNA had an attitude." The grievance form indicated that the Resident reported the same to the unit manager upon interview. The CNA was educated and provided with a counseling form that indicated "First Incident- In-service."

There was no evidence that the facility staff reported the allegation nor filed a report within 5 days of the results of an investigation to the state survey agency or adult protective services.

On 12/5/22, in the afternoon, Surveyor B met with Resident #16 in their room. Resident #16 was asked about the above noted allegation. Resident #16 only responded to questions by nodding her head and indicated that no one had come to talk with her about her complaint. Review of Resident #16's clinical record revealed an MDS that was a quarterly assessment completed 11/29/22. Resident #16 had a BIMs score of 14, which indicated the Resident was cognitively intact. There were no progress notes with regards to the allegation.

On 12/7/22 at 10:20 AM, during an interview with the facility Administrator, Director of Nursing and Corporate Clinical Specialist, several Resident reports were reviewed, to include Resident #16's allegation of a staff not being gentle and having an attitude. The Administrator stated, "We would have to look into it and investigate."

The facility staff provided no further evidence with regards to Resident #16's allegations prior to the survey exit and stated they had submitted all evidence they had.

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6. For Resident #13 who reported an allegation of abuse, the facility staff failed to report the allegation and results of an investigation to the state survey agency and adult protective services.

On 12/5/22, during the course of a complaint investigation, Surveyor B determined through facility records that Resident #13 reported on 10/27/22, "a male staff member was very rough while providing care. He was angry and very curt with patient." The facility's response was, "Staff was in-service on caring for resident." There was no evidence provided that the allegation was reported to the state survey agency and adult protective services. There was also no evidence that the results of an investigation were reported.

Resident #13 had been discharged from the facility and was not able to be interviewed. Review of the clinical record revealed no documentation with regards to this reported incident. Resident #13 had an admission MDS/assessment completed 10/24/22. During this assessment Resident #13 had a BIMS score of 14, which indicated she was cognitively intact and a reliable historian.

On 12/7/22 at 10:20 AM, during an interview with the facility Administrator, Director of Nursing and Corporate Clinical Specialist several Resident reports were reviewed, to include Resident #13's allegation of a staff being "rough." The Administrator said, "we would have to interview and look at willfulness." When asked if this would mean an investigation would have to be conducted, the Administrator said, "Yes." The

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Administrator further stated that reports of or allegations of abuse have to be reported to the "OLC (Office of Licensure and Certification) (state survey agency), Adult Protective services and the Ombudsman.

The facility staff provided no further evidence with regards to Resident #13's allegations prior to the survey exit and stated they had submitted all evidence they had.

7. For Resident #14, who had an allegation of possible abuse reported by a family member, the facility staff failed to report the allegation to the state survey agency and adult protective services.

On 12/5/22, during the course of a complaint investigation, Surveyor B determined through facility records that Resident #14's family member reported on 11/25/22, "3-11 shift CNA was pushing on patient's forehead." The facility's response was, "frequent rounding recommended by staff. Adhere and respond to patient and family concerns as soon as possible. Staff should identify themselves with name and how they can be of help. Staff instructed to be gentle with care and explain care proceeding before care."

On 12/6/22 at 4 PM, Surveyor B met with Resident #14. Resident #14 was asked about staff treatment. Resident #14 said, "They are rough, I tell them Hey I'm 75, be easy. I've had them push me on the back of my head to move me, they get frustrated. I feel safe but I don't know that I would recommend this place to anyone." Resident #14 was asked if she knew if the facility investigated her concerns, and

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Resident #14 said she was not aware.

Review of Resident #14's clinical record revealed she had an admission MDS/assessment completed 11/30/22. During this assessment Resident #14 had a BIMS score of 14, which indicated she was cognitively intact.

On 12/7/22 at 10:20 AM, during an interview with the facility Administrator, Director of Nursing and Corporate Clinical Specialist, several Resident reports were reviewed, to include Resident #14's allegation of a staff pushing on the patient's forehead. The Administrator was able to identify the staff member by name who was involved, and said it was during care she pressed against her forehead. When asked where documentation would be if it had been reported, and if an investigation was conducted, she said, "it would be on the grievance form." There were no such details on the grievance form to indicate any investigation had been conducted. No evidence was present to indicate the allegation had been reported to the state agency or adult protective services.

The facility staff provided no further evidence with regards to Resident #14's allegations prior to the survey exit and stated they had submitted all evidence they had.

On 12/6/22 at 10:49 AM, an interview was conducted with Employee G, a social worker. When asked to explain what abuse is, Employee G said, "It can be mental, physical, psychosocial, it comes in many forms." When asked what she does if someone reports abuse, Employee G said, "I contact my immediate supervisor, then I

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go into the room and follow-up on what they said." When asked if this conversation gets documented, Employee G said, "yes" and further explained it would be in the Resident's progress notes. When asked if a Resident or family must specifically use the word abuse for it to be considered abuse, Employee G said "no."

On 12/6/22 at 4:12 PM, an interview was conducted with the Social Services Director/Employee H. Employee H defined abuse and neglect and explained that anyone can report abuse, including the Resident, a family member, a staff member, or a visitor. Employee H stated that the facility Administrator investigates and will at times ask the Social Services Department to assist. Employee H was able to verbalize the reporting of allegations to the required entities and indicated that the facility Administrator handled that. Employee H said she maintains a folder with interview information and other investigation documents in her office. Employee H was asked to provide any such files she may have that took place from August 2022 to the present. On 12/6/22 at 4:24 PM, Employee H returned to Surveyor B and said she had not conducted any investigations and had no such documents for the requested time frame.

During an end of day meeting with the facility Administrator, Director of Nursing and Corporate Clinical Specialist, they were made aware of the above findings, and asked to provide any additional documents or evidence they may have to indicate that the allegations were reported to the state survey agency and adult protective services.

No further information was received, and the

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F 609	Continued From page 31 facility notified the survey team they had submitted all documentation they had to provide. Complaint related deficiency.	F 609		
F 610 SS=E	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: Based on Resident interview, staff interviews, clinical record review, facility documentation review and in the course of a complaint investigation, the facility staff failed to investigate allegations of abuse/neglect for 6 Residents (Resident #15, 11, 16, 13, 14 and 12) in a survey sample of 25 Residents. The findings included: 1. For Resident #15, who had an allegation of	F 610		

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abuse, the facility staff failed to conduct a complete and through investigation.

On 12/5/22, during the course of a complaint investigation it was determined that Resident #15 had reported on 10/25/22 that an assigned CNA (certified nursing assistant), CNA H, was very argumentative and unprofessional. Review of the grievance form revealed that LPN (licensed practical nurse) E had written a statement that read, "In the morning while passing medications standing in front of [room number redacted], I heard staff talking loud. I called him immediately to come outside which he [CNA H] did. I asked him what happened and told him I could hear him from outside and he said, 'Let me talk. This resident is alert, and let me tell her the truth.' This nurse went into resident's room to give her ...scheduled medications and resident told her that a staff was yelling at her for putting on her call light, when all she wanted was a cup of water, crying telling this nurse that staff doesn't know what she has been through. She continues, 'At 7 years of age I was sexually abuse by my own father and since then if anyone speaks to me in a loud voice I become frighten and my whole day is spoil...[sic].'"

Review of the grievance indicated, "associate is counselled and educated to be professional with our resident and treat them with respect and good customer service." There was no evidence that this allegation had been reported to the state survey agency or adult protective services.

On 12/5/22, in the afternoon, Surveyor B met with Resident #15. Resident #15 presented to be alert and oriented. Resident #15 verbalized that she was verbally, mentally, and sexually abused as a

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child and has PTSD (post-traumatic stress disorder) and bipolar. When asked if she has had any problems with staff mistreating her, she said, "There was one, but we have worked it out and he apologized."

Review of the clinical record for Resident #15 revealed that she had a quarterly MDS (minimum data set) (an assessment) conducted on 11/16/22. On this assessment Resident #15 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated she was cognitively intact. The progress notes were reviewed and had no documentation with regards to the report of abuse. Review of Resident #15's care plan revealed a focus area that read, "Behavior Concerns....misinterpreting the truth..." that was initiated 6/11/18 and revised on 9/9/20. Interventions for this care plan included but were not limited to: "...Observe for and report unusual or negative behaviors promptly, Observe/assess for triggers to negative behaviors. Report for further assessment..."

On 12/6/22, Surveyor B asked to review the employee file for CNA H. Upon review it was noted that CNA H had an "Associate Counseling Form" dated 10/26/22, that read, "First Incident-Verbal.". Detailed description of Incident: "Pt [patient] reported assigned CNA [CNA H name redacted] was very argumentative and unprofessional. Action Taken: Associate was counselled and education to be professional with our resident and treat them with good customer service...." There was no evidence that CNA H had been suspended during the course of an investigation.

On 12/7/22, Surveyor B met with the facility

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Administrator, Director of Nursing and Corporate Clinical Director and discussed this incident. The facility staff was advised there was no evidence of an investigation being conducted. The Administrator stated she would have the unit manager come talk to Surveyor B.

On 12/7/22 at 10:50 AM, RN B, the unit manager came to the conference room and spoke with Surveyor B about Resident #15's allegation. RN B said, "It happened during the 11 pm-7 am shift, when I came in, I heard about it. I went to talk to the Resident and apologize. When I talked to her, she had calmed down. She is bipolar and gets very upset and then after a while she calms down. She [Resident #15] put on her call light and said [CNA H's name redacted] said he was in another room, the way he is talks is loud and she felt like she wasn't respected. Sometimes he will be having a normal conversation and will be loud, he apologized- she said he apologized, and she feels he is a good CNA. I talked to him, and he was taken off the schedule for the rest of the week. I did an interview with the rest of the staff, so no one repeats it." RN B was asked if she talked to any witnesses or did an investigation, RN B stated she only talked to the Resident and the staff member, no one else. When shown the written statement from the nurse, LPN E and asked who wrote that, RN B stated it was the statement from CNA H. She was told that it was from a nurse that had witnessed the incident.

Review of the timecard for CNA H revealed that he worked the night of 10/24/22, when the incident happened and didn't return until 10/31/22. The facility Administrator confirmed that CNA H is prn (an as needed) employee and calls daily to see if there are shifts he can work

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when he is available, therefore his time card didn't reveal any scheduled shifts from 10/25-10/31. The facility Administrator did show Surveyor B a text message that was sent to the supervisor's cell phone on 10/31/22, asking if CNA H was able to work, as an indication that the scheduler knew he had been suspended and unable to work for a period of time.

A review of the facility policy, "Abuse Prevention," revealed, in part: "...V. Investigation: A. Designated staff will immediately review and investigate all reported incidents or allegations. B. Investigations will include collecting physical and documentary evidence which may include taking photographs, as necessary, interviewing residents and staff with personal knowledge of the incident or alleged incident, requesting witness statements, collecting relevant evidence, and documenting each step taken during the investigation. C. The Quality Assurance Committee will conduct analysis for trends. D. Outside investigative bodies, such as the local police will be contacted as directed by the Administrator in accordance with state and local law and Center policy. E. Investigations will be conducted and completed within 5 working days, if possible, of the incident or allegation. In the event the investigation has not been completed a report will be submitted to the state licensing and certification containing as much information as is possible. The Center shall continue investigations until complete...."

No further information was provided.

2. For Resident #11, whose spouse reported to facility staff an allegation of abuse, the facility

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staff failed to conduct an investigation.

On 12/5/22, during the entrance conference held with the facility Administrator and Director of Nursing, the facility staff were asked to provide any Facility Reported Incidents (FRI's) and investigations conducted from August to the present. The facility provided 2 FRI's, neither which involved Resident #11.

On 12/5/22, during the course of a complaint investigation, Surveyor B determined that Resident #11's spouse had reported to a facility staff member on 8/12/22, that he "is not happy with the way staff treat his wife." The complaint read, "Last night a staff told his wife to shut up when she want to ask question [sic]..." A grievance form was completed and contained no supporting evidence of any investigation being conducted. The "grievance official follow up" read, "review plan of care with staff and educated on good customer service and techniques with understanding verbalized. Educated on resident's rights as well. UM [unit manager] spoke with RP [responsible party]/spouse and patient at bedside and concerns addressed to satisfactory with all questions answered."

Resident #11 was discharged from the facility and was not able to be interviewed. Review of the clinical record revealed that on 8/17/22 and on 10/11/22, a MDS (minimum data set) (an assessment tool) was conducted, and Resident #11 had a BIMS (brief interview for mental status) score of 15 on both assessments. This score indicated that Resident #11 had answered all questions correctly and was cognitively intact. Both assessments were also coded as Resident #11 not having any symptoms of delirium. There

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was no documentation within the progress notes with regards to the above allegation. Resident #11 had a care plan initiated on 8/11/22, that read, "[Resident #11's name redacted] is adjusting to a new environment r/t [related to] new admission." The interventions associated with this care plan read, " Allow patient/resident to express/discuss feelings and provide reassurance and support, encourage family, friends and other support persons to visit., Introduce to staff and other patients/residents on the unit."

On 8/17/22, Resident #11's spouse reported another complaint that was recorded on a facility grievance form. The details of the complaint read, "On Monday 8/15/22 at 7 PM; CNA came into the room and changed my spouse's brief at 7PM & stated, 'This is the last change for the night.' CNA closed the door and didn't leave the call bell within reach. She was frightened. She did not get brief changed until the next day." The facility staff wrote on the grievance form that this grievance was resolved on 8/17/22, and the follow-up read, "CNA and staff on shift educated with good customer services and techniques, Patient's rights and communication skills with understanding verbalized. Resident has right to call for incontinence checks and assistance at all times." There was no evidence of the education provided to staff, any investigation into who the CNA was that told the Resident this and then neglected to provide any further care that night.

On the morning of 12/7/22, the facility Administrator was asked to provide any and all evidence of any investigations that had been conducted that had been conducted and had not been submitted with the FRI's. The Administrator

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stated she had called the former Administrator, who is out on leave, and they had no further documents to provide.

No evidence of an investigation was provided with regards to Resident #11's allegation of being told to "shut up" prior to the conclusion of the survey.

On 12/7/22 at 10:20 AM, during an interview with the facility Administrator, Director of Nursing and Corporate Clinical Specialist several Resident reports, to include Resident #11's allegation of being told "to shut up," were discussed. The facility Administrator acknowledged that this could be "emotional abuse" and an investigation should have been conducted. When asked, "What if a Resident's call bell is taken away or they are told that is the last change for the night?" The Administrator immediately said, "Oh that's abuse."

The facility staff provided no further evidence with regards to Resident #11's allegations prior to the survey exit and stated they had submitted all evidence they had.

3. For Resident #16 who reported a staff member was not gentle during care, the facility staff failed to investigate to determine if abuse had occurred.

On 12/5/22, during a complaint investigation, Surveyor B noted a grievance filed by Resident #16 on 9/8/22, who reported to a facility staff member, that "[CNA B's name redacted] was not gentle with her while changing her and the CNA had an attitude." The grievance form indicated that the Resident reported the same to the unit manager upon interview. The CNA was educated and provided with a counseling form that

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indicated "First Incident- In-service."

There was no evidence that the facility staff investigated the allegation to determine if other Residents had experienced the same behavior by CNA B, or any other staff.

On 12/5/22, in the afternoon, Surveyor B met with Resident #16 in their room. Resident #16 was asked about the above noted allegation. Resident #16 only responded to questions by nodding her head and indicated that no one had come to talk with her about her complaint. Review of Resident #16's clinical record revealed an MDS that was a quarterly assessment completed 11/29/22. Resident #16 had a BIMs score of 14, which indicated the Resident was cognitively intact. There were no progress notes with regards to the allegation.

On 12/7/22 at 10:20 AM, during an interview with the facility Administrator, Director of Nursing and Corporate Clinical Specialist, several Resident reports were reviewed, to include Resident #16's allegation of a staff not being gentle and having an attitude. The Administrator stated, "We would have to look into it and investigate."

The facility staff provided no further evidence with regards to Resident #16's allegations prior to the survey exit and stated they had submitted all evidence they had.

4. For Resident #13, who reported an allegation of abuse, the facility staff failed to conduct an investigation.

On 12/5/22, during the course of a complaint

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investigation, Surveyor B determined through facility records that Resident #13 reported on 10/27/22, "a male staff member was very rough while providing care. He was angry and very curt with patient." The facility's response was, "Staff was in-service on caring for resident." There was no evidence provided that an investigation was conducted.

Resident #13 had been discharged from the facility and was not able to be interviewed. Review of the clinical record revealed no documentation with regards to this reported incident. Resident #13 had an admission MDS/assessment completed 10/24/22. During this assessment Resident #13 had a BIMS score of 14, which indicated she was cognitively intact and a reliable historian.

On 12/7/22 at 10:20 AM, during an interview with the facility Administrator, Director of Nursing and Corporate Clinical Specialist several Resident reports were reviewed, to include Resident #13's allegation of a staff being "rough." The Administrator said, "we would have to interview and look at willfulness." When asked if this would mean an investigation would have to be conducted, the Administrator said, "Yes."

The facility staff provided no further evidence with regards to Resident #13's allegations prior to the survey exit and stated they had submitted all evidence they had.

5. For Resident #14, who had an allegation of possible abuse reported by a family member, the facility staff failed to conduct an investigation.

On 12/5/22, during the course of a complaint

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investigation, Surveyor B determined through facility records that Resident #14's family member reported on 11/25/22, "3-11 shift CNA was pushing on patient's forehead." The facility's response was, "frequent rounding recommended by staff. Adhere and respond to patient and family concerns as soon as possible. Staff should identify themselves with name and how they can be of help. Staff instructed to be gentle with care and explain care proceeding before care."

On 12/6/22 at 4 PM, Surveyor B met with Resident #14. Resident #14 was asked about staff treatment. Resident #14 said, "They are rough, I tell them Hey I'm 75, be easy. I've had them push me on the back of my head to move me, they get frustrated. I feel safe but I don't know that I would recommend this place to anyone." Resident #14 was asked if she knew if the facility investigated her concerns, Resident #14 said she was not aware.

Review of Resident #14's clinical record revealed she had an admission MDS/assessment completed 11/30/22. During this assessment Resident #14 had a BIMS score of 14, which indicated she was cognitively intact.

On 12/7/22 at 10:20 AM, during an interview with the facility Administrator, Director of Nursing and Corporate Clinical Specialist several Resident reports were reviewed, to include Resident #14's allegation of a staff pushing on the patient's forehead. The Administrator was able to identify the staff member by name who was involved and said it was during care she pressed against her forehead. When asked about the location of documentation if an investigation was conducted,

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she said, "it would be on the grievance form." There were no such details on the grievance form to indicate any investigation had been conducted.

The facility staff provided no further evidence with regards to Resident #14's allegations prior to the survey exit and stated they had submitted all evidence they had.

6. For Resident #12, whose family reported the Resident felt harassed by nursing staff and treated like an animal, the facility staff failed to conduct an investigation.

On 12/5/22, during the course of a complaint investigation, Surveyor B noted in facility documentation that Resident #12's family reported to facility staff on 8/18/22, that the Resident "felt harassed by nursing staff and treated like an animal." The grievance form was written by Employee H, the social services director. However, there was no grievance follow-up noted on the form. Attached was a second grievance form dated the same day, completed by another staff member. The allegations of the Resident feeling that she was harassed by nursing staff and treated like an animal were not noted on the second form. Therefore, this allegation had no follow-up/investigation, etc.

Review of the clinical record for Resident #12 revealed that she had been discharged from the facility and therefore, was not able to be interviewed. Review of the progress notes revealed an entry on 8/18/22 at 15:19, that read, "UM [unit manager] along with care team met with resident and family to discuss concerns

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along with plan of care as ordered. Patient concerns were acknowledged and addressed, pain management and bowel regimen were reviewed and order changes initiated per md order and consultation. plan of care reviewed with staff nurses and aides. all parties involved verbalized understanding of plan of care and care concerns as well. resident remains stable." The note made no mention of the report of "feeling harassed and treated like an animal."

Resident #12's clinical chart revealed that a Medicare/5 day assessment/MDS (minimum data set) was conducted 8/12/22. During this assessment, Resident #12 scored a 12 out of 15 on the brief interview for mental status, which indicated moderately impaired cognition.

On 12/7/22 at 10:20 AM, during an interview with the facility Administrator, Director of Nursing and Corporate Clinical Specialist several Resident reports, to include Resident #12's allegation of feeling harassed and treated like an animal. The Administrator said, "There is definitely an emotional component. It would prompt an investigation and based on the findings we would send a FRI [facility reported incident]." The facility staff were asked to provide any additional information they may have to indicate that an investigation had been conducted with regards to Resident #12.

No additional information was provided.

On 12/6/22 at 10:49 AM, an interview was conducted with Employee G, a social worker. When asked to explain what abuse is, Employee G said, "It can be mental, physical, psychosocial, it comes in many forms." When asked what she

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does if someone reports abuse, Employee G said, "I contact my immediate supervisor, then I go into the room and follow-up on what they said." When asked if this conversation gets documented, Employee G said, "yes" and further explained it would be in the Resident's progress notes. When asked if a Resident or family must specifically use the word abuse for it to be considered abuse, Employee G said "no."

On 12/6/22 at 4:12 PM, an interview was conducted with the Social Services Director/Employee H. Employee H defined abuse and neglect and explained that anyone can report abuse, including the Resident, a family member, a staff member, or a visitor. Employee H stated that the facility Administrator investigates and will at times ask the Social Services Department to assist. Employee H said she maintains a folder with interview information and other investigation documents in her office. Employee H was asked to provide any such files she may have that took place from August 2022 to the present. On 12/6/22 at 4:24 PM, Employee H returned to Surveyor B and said she had not conducted any investigations and had no such documents for the requested time frame.

During an end of day meeting with the facility Administrator, Director of Nursing and Corporate Clinical Specialist, they were made aware of the above findings and asked to provide any additional documents or evidence they may have to indicate that investigations were conducted.

No further information was received, and the facility notified the survey team they had submitted all documentation they had to provide.

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F 610	Continued From page 45 Complaint related deficiency.	F 610		