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	175221	A. BUILDING _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVENA LIVING AT FOUNTAINVIEW	601 N ROSE HILL ROAD ROSE HILL, KS 67133

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS 183928. This 2567 was electronically sent to the facility on 11/27/23.	F 000		
F 600 SS=G	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 involuntary seclusion; This REQUIREMENT is not met as evidenced by: The facility reported a census of 44 residents with seven residents selected for review, including two residents reviewed for allegations of abuse. Based on observation, interview, and record review, the facility failed to ensure staff provided a safe environment, free from abuse for Resident (R)1 and R7. During cares on 10/26/23, Certified Nurse Aide (CNA) M grabbed R1 by the arm, which resulted in an injury to R1's left arm near her wrist, which required steri-strips (thin adhesive bandage used to close wounds or cuts) for wound closure. During cares for R7, CNA M	F 600		

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

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was verbally rude and physically forced a shirt on him, which he voiced he did not want to wear.

Findings included:

- The "Medical Diagnosis" tab for R1 included diagnoses of paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), myopathy (muscle weakness due to a dysfunction in the muscle fibers), general anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and major depressive disorder (major mood disorder).

The "Significant Change Minimum Data Set" (MDS) dated 06/20/23 assessed R1 with a Brief Interview of Mental Status (BIMS) score of 15, indicating intact cognition. R1 lacked any behaviors of rejection of care. She required extensive assistance of one staff for bed mobility and dressing, and total dependence of two or more staff for transfers.

The "Activities of Daily Living [ADL] Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 06/23/23, revealed R1 had generalized weakness and required assistance with ADL.

The "Quarterly MDS" dated 09/15/23, assessed R1 with a BIMS score of eight, indicating moderate cognitive impairment. R1 did not have any behaviors or rejection of care. She continued to require extensive assistance of one staff for dressing and bed mobility and continued to be totally dependent on two or more staff for transfers.

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The "Care Plan", initiated on 06/17/23 revealed R1 had a left above the knee amputation, required assistance of two staff for transfers, was dependent on staff for repositioning and turning, and had a colostomy present (surgical creation of an artificial opening on the stomach wall to excrete feces from the body).

The "Progress Notes" dated 10/26/23 at 08:04 PM by Licensed Nurse (LN) G revealed staff administered Ativan (medication for anxiety) to R1, due to her anxiety, crying, and emotional.

The "Progress Notes" dated 10/26/23 at 10:27 PM entered by LN G revealed at approximately 08:00 PM, Certified Nurse Aide (CNA) M assisted R1 with changing her shirt and R1 acquired a skin tear on her left arm, near her wrist. The skin tear measured 1.5 centimeters (cm) by 1.0 cm and required two steri-strips for wound closure.

The "Grievance/Concern Log Book" revealed a "Grievance/Complaint Report" dated 10/27/23 that concerned R1 and was reported to Social Services staff (SS) X and Administrative Nurse D. The report revealed R1 said a CNA (CNA M) tried to get her out of bed "forcefully." R1 did not want to get out of her bed. R1 reported CNA M grabbed her by the left arm and hurt her, and R1 kept stressing she did not want to get up and wanted to wait a little longer. R1 was so upset she was yelling at CNA M "I'm not going with you." R1 stated CNA M's "attitude was scary" and she "shouted" at CNA M who then "grabbed her." R1 stated she told her to "leave my house" and she did not want CNA M to touch her. R1 stated she reported this to her friend (R4). SS X asked R1 if she was scared and R1 stated "yes." The report included a skin tear noted on R1's left arm.

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The "Grievance/Concern Log Book" revealed "Grievance/Complaint Report" dated 10/27/23 that concerned R7, and was reported to SS X and Administrative Nurse D. The staff asked R7 if he saw or heard anything that may have occurred through the night and R7 reported he heard someone crying down the hall, so he wheeled out into the hall and saw R1 "crying really hard." R7 reported he tried to speak with R1 however, she was crying so hard he could not understand her and stated, "I've never seen her that upset before." R7 stated he did not know what happened.

The "Witness Statement" for 10/26/23 by CNA N revealed she answered R1's call light and when she walked into the room, R1 had her legs hanging out of the bed. R1 stated she wanted up and was not ready for bed. CNA N stated R1 was very distressed and emotional out in the dining area, telling staff and residents that she did not want "her" back in the room. The statement lacked who R1 referred to and what time this occurred.

The "Witness Statement" for 10/26/23 by CNA O revealed CNA O was "shadowing" an unidentified CNA (CNA M) and when walking into R1's room, CNA M stated they were there to lay her down, change her colostomy bag, and put on her pajamas. CNA O stated R1 repeatedly said she did not want to change into her pajamas and lay down, however CNA M finally convinced her to lay down to change the colostomy bag. R1 stated she did not want CNA M to do it but would allow CNA O to change it, to which CNA O agreed. CNA O stated after changing the colostomy, she went to put a different shirt on R1, instead of

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pajamas, and CNA M stated, "no it is time for bed" and we "need to put on the pajamas." CNA O stated CNA M "forced" the pajamas on R1, and R1 became a "little combative" because she did not want to wear the pajamas or stay in bed. R1 was upset and wanted to get out of bed and CNA M stated R1 "does this all the time and would be fine and go to sleep." When leaving the room, CNA O noticed R1's arm was bleeding, and she reported the bleeding to the nurse. The statement lacked a time of the incident occurrence.

The "Witness Statement" for 10/26/23 by LN G revealed R1 was upset and crying. When LN G asked her what happened, she said the CNA's giving her care were mean to her, she never wanted them in her room again, and they forced a shirt on her she did not want on. LN G stated R1 had a skin tear from her watch on her left lower arm near her wrist. LN G stated she confronted the CNAs (did not specify who) about this incident and they denied being mean or rough with R1. LN G called Administrative Nurse D and informed her of the situation, who told her to send CNA M home. LN G stated CNA M denied being mean and was questioning why she was being sent home and was trying to get confirmation from the other CNAs to prove her innocence. LN G stated the CNAs (did not specify who) that were in the room with CNA M had witnessed CNA M "forcing the shirt on" R1. The statement lacked what time the incident occurred.

On 11/13/23 at 03:26 PM, when questioned if staff had ever handled her roughly, R1 stated she "wasn't going to be here much longer and didn't want to do this."

On 11/13/23 at 04:13 PM, Administrative Staff A

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stated R4 saw R1 cry. Social Service staff (SS) X went into R1's room. R1 told SS X that a CNA made her mad and that was why she was crying. Administrative Staff A stated the CNA was from the agency, it occurred at the beginning of the shift, and he was not there at the time from what he understood. The CNA (CNA M) wanted to get R1 up and she did not want to get up at the time and then stated CNA M was being mean to her. R1 told the nurse that CNA M had an attitude and was being rough. Administrative Staff A stated CNA M was sent home due to her general attitude, it was not a positive attitude, and a few of the residents did not like the way CNA M talked and portrayed herself. Administrative Staff A stated the agency was aware of the incident and CNA M was not to return to the building.

On 11/13/23 at 04:20 PM Administrative Nurse D stated R1 identified CNA M, and LN G called her and said R1 was upset one of the aides had been rough with her and that is "where she left it." Administrative Nurse D told LN G to find out who it was and "send her home." Administrative Nurse D stated LN G called her around 09:00 PM. Administrative Nurse D stated she later called the CNA M's Agency she worked for and told them "she was not to come back."

On 11/13/23 at 04:28 PM Administrative Staff A stated from the way the information was given to him, the event was not reportable, and CNA M was sent home.

On 11/15/23 at 09:22 AM, the surveyor could not reach CNA M's agency by phone.

On 11/15/23 at 09:45 AM CNA O stated she worked from 06:00 PM to 06:00 AM on 10/26/23.

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CNA O stated CNA M transferred R1 to the bed and R1 was mad and did not want to go to bed, but her colostomy bag needed cleaned up. R1 did not want CNA M to touch her, so CNA O stepped in. CNA O stated R1 did not want a pajama shirt on, so she found another one in her closet, and she turned around and CNA M was "yanking" another shirt on R1. CNA O stated she would "put this on" and CNA M said, "no she needs to put pj's on." CNA M stated she observed fresh blood on the resident's sheet and noticed R1's left wrist area had an opened, bleeding wound. After CNA O left R1's room, she reported the bleeding wound to the nurse, and CNA CNACNA P, and CNA N returned to the resident's room and transferred her into a wheelchair. CNA O stated when R1 arrived at the nurse's station, she was crying and upset. CNA O informed LN G about "a battle between the two of them" when R1 was trying to push the shirt off and CNA M was pulling it back down. When questioned if CNA M was abusive to R1, CNA O stated CNA M was verbally abusive to R1 and after watching her with the pajama shirt, CNA M was physically abusive with R1. CNA O stated the incident could have been prevented if CNA M would have allowed her to put the other shirt on.

On 11/15/23 at 10:11 AM, Certified Medication Aide (CMA) S stated she worked on 10/26/23. CMA S stated LN G told CNA M that R1 wanted to get up, and CNA M had "attitude and talking back" to LN G. CNA M stated she had just laid R1 down. CMA S said when staff got R1 up and brought her up to the desk, R1 was "crying and bawling her eyes out." CMA S stated while standing there R1 told LN G that CNA M was "rude and rough with her." Then CNA M walked by and R1 told staff to "get her away." CMA S

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stated R1 calmed down about an hour after CNA M left the facility and made aware that she was not coming back.

On 11/15/23 at 01:44 PM, LN G stated she worked 10/26/23 and CNA M "was rough" with R1. LN G stated R1 had a watch on and when CNA M changed R1's shirt, the shirt caught her watch, that resulted in a wound. LN G stated R1 was very upset and in tears and did not want the "girls" in the room, they had "forced" a shirt on her that she did not want to wear.

On 11/15/23 at 02:12 PM, Administrative Staff A stated Administrative Nurse D notified him of the incident on 10/26/23 at 08:30 PM when Administrative Nurse D text him, and he called her back and instructed her to get the aide out of there. Administrative Staff A stated he thought since he eliminated the problem right away by getting CNA M out of the building. Administrative Staff A stated it was portrayed to him that CNA M just had a negative attitude.

The facility policy "Abuse Prevention Program" dated October 2021, revealed the residents have a right to be free from abuse, neglect, misappropriation of property and exploitation. This includes but is not limited to verbal, mental, sexual, or physical abuse. As part of the resident abuse prevention, the administration will protect the residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual. Administration will identify and assess all possible incidents of abuse and investigate and report any allegation of abuse within

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timeframes as required by federal requirements.

The facility failed to ensure a safe environment free from abuse on 10/26/23 when CNA M grabbed R1's arm and forced a shirt on R1, resulting in a wound that required two steri-strips to close, made her stay in bed when she did not want to lay down, and made R1 emotionally upset and cry.

- The "Medical Diagnosis" tab for R7 included diagnoses of metabolic encephalopathy (the functioning of the brain is affected by some agent or condition such as a viral infection or toxins in the blood), cerebral infarction (stroke - damage to tissues in the brain due to a loss of oxygen to the area), mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, wanting to die were more intense and persistent than what may normally be felt from time to time), dementia (progressive mental disorder characterized by failing memory, confusion), and post-traumatic stress disorder (PTSD- psychiatric disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress).

The "Admission Minimum Data Set" (MDS) dated 08/20/23 assessed R7 with a Brief Interview of Mental Status (BIMS) score of 14, indicating intact cognition.

The "Activities of Daily Living [ADL] Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 08/23/23 revealed R7 required assistance with ADLs.

The "Quarterly MDS" dated 09/26/23 revealed R7

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continued to have a BIMS score of 14.

The "Care Plan" initiated on 08/22/23 revealed R7 could have a behavior problem and caregivers were to provide opportunity for positive interaction and attention and he would be assured that mutual respect would be given and received from mutual parties. R7 required minimum to moderate assistance of one staff for dressing.

The "Grievance/Concern Log Book" revealed "Grievance/Complaint Report" dated 10/27/23, that concerned R7 and reported to Social Services staff (SS) X and Administrative Nurse D. The report revealed R7 reported a Certified Nurse Aide (CNA), (CNA M) had "lots of attitude" and "got mad" when asked to help place a long sleeve shirt on him. R7 said CNA M was even "madder" when she had to come back in to take the shirt off, because he "got too hot." R7 reported the second time CNA M entered the room she "threw his shirt at the nightstand" and "stormed out of the room."

The "Witness Statement" for 10/26/23 by CNA P revealed she entered the room with CNA N to answer R7's call light and he was upset his needs were not met and stated a CNA (CNA M) was verbally "rude."

The "Witness Statement" for 10/26/23 by CNA N revealed she answered R7's call light and he stated CNA M was "rude" to him, she would not put his shirt on, and he was going to file a complaint." CNA N stated she assisted placing the shirt on and let the nurse know he was upset.

The "Witness Statement" for 10/26/23 by CNA O revealed she was in R7's room with CNA M when

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she took off his long sleeve shirt. CNA O stated she proceeded to grab a short sleeve shirt from the closet to put on him and CNA M told her not to because "he does this all night long" and took the shirt from her and sat it on the nightstand.

The "Witness Statement" for 10/26/23 by Licensed Nurse (LN) G revealed R7 had his call light on and when she answered it, he stated CNA M had "forced" a shirt on him when he wanted a short sleeve shirt on.

On 11/13/23 at 04:13 PM, Administrative Staff A stated CNA M was sent home on 10/26/23 "due to her general attitude" and "it was not positive." Administrative Staff A stated a few of the residents "did not like the way she was talking and portraying herself" including the "nurses." Administrative Nurse A stated the agency was made aware of the incident and she was not to return to the building.

On 11/13/23 at 04:20 PM, Administrative Nurse D stated LN G called her about another resident that was upset and one of the aides (CNA M) had been rough with her, and that is "where she left it". Administrative Nurse D told LN G told her to find out who it was and "send her home." Administrative Nurse D stated LN G called her around 09:00 PM, as she was not in the building when the incident occurred. Administrative Nurse D stated she later called CNA M's Agency she worked for and told them "she was not to come back."

On 11/14/23 at 01:50 PM, R7 stated he had a concern with an "agency aide" a few weeks ago. R7 stated he wanted to change shirts and when the "gal" (CNA M) threw his long sleeve shirt on

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the floor and was "rude." When asked if she was abusive, R7 responded "yes, I thought the girl was." R7 stated he filed a grievance about it.

On 11/15/23 at 09:45 AM CNA O stated she worked on 10/26/23 from 06:00 PM to 06:00 AM. CNA O stated R7 complained he was hot, and while getting a short sleeve shirt out of the closet to replace his long sleeve one he wore, CNA M took the shirt away from her and tossed it to the nightstand stating "we are not going to play this game." CNA O stated it was about two hours into her shift when this happened.

On 11/15/23 at 10:11 AM, CMA S stated she entered R7's room with LN G to answer his call light. CMA S stated R7 said to not let CNA M in his room, she was "rude" and "disrespectful" to him. CNA M stated LN G then called Administrative Nurse D to report CNA M's behavior and incident she had with another facility resident.

On 11/15/23 at 01:44 PM LN G stated she worked on 10/26/23 and CNA M refused to give him care or go in his room after an incident about his shirt. When contacting Administrative Nurse D about CNA M's behavior, she was instructed to send CNA M home.

On 11/15/23 at 02:12 PM, Administrative Staff A stated Administrative Nurse D notified him of the incident on 10/26/23 at 08:30 PM when Administrative Nurse D text him, and he called her back and instructed her to get the aide out of there. Administrative Staff A stated he thought since he eliminated the problem right away by getting CNA M out of the building. Administrative Staff A stated it was portrayed to him that CNA M

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F 600	Continued From page 12 just had a negative attitude. The facility policy "Abuse Prevention Program" dated October 2021, revealed the residents have a right to be free from abuse, neglect, misappropriation of property and exploitation. This includes but is not limited to verbal, mental, sexual, or physical abuse. As part of the resident abuse prevention, the administration will protect the residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual. Administration will identify and assess all possible incidents of abuse and investigate and report any allegation of abuse within timeframes as required by federal requirements. The facility failed to prevent abuse on 10/26/23 when CNA M physically forced a shirt on R7 and was verbally rude to him.	F 600		
F 609 SS=D	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, 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	F 609		

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abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 44 residents with seven residents selected for review including two residents reviewed for allegations of abuse. Based on interview and record review, the facility failed to report allegations of abuse to the State Survey Agency when an allegation was made by Resident (R)1 and R7 against Certified Nurse Aide (CNA) M on 10/26/23. R1 reported CNA M tried to get her out of bed forcefully, grabbed her by the arm and hurt her and R7 reported CNA M forced a long sleeve shirt on him when he wanted a short sleeve shirt on and CNA M treated R7 with verbal abuse by being rude.

Findings included:

- The "Medical Diagnosis" tab for Resident (R)1 included diagnoses of paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), myopathy (muscle weakness due to a dysfunction in the muscle fibers), general anxiety disorder (mental or

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emotional reaction characterized by apprehension, uncertainty and irrational fear), and major depressive disorder (major mood disorder).

The "Significant Change Minimum Data Set" (MDS) dated 06/20/23 assessed R1 with a "Brief Interview of Mental Status" (BIMS) score of 15 indicating intact cognition. She required extensive assistance of one staff for bed mobility and dressing and required total dependence of two or more staff for transfers. R1 had range of motion impairment to both sides of her lower extremities and required a wheelchair for mobility.

The "Activities of Daily Living [ADL] Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 06/23/23 revealed R1 had generalized weakness and required assistance with ADL's.

The "Quarterly MDS" dated 09/15/23 assessed R1 with a "BIMS" score of eight, indicating moderate cognitive impairment.

The "Care Plan" initiated on 06/17/23, revealed R1 had a left above the knee amputation, required assistance of two staff for transfers, dependent on staff for repositioning and turning and had a colostomy present (surgical creation of an artificial opening on the stomach wall to excrete feces from the body).

The "Progress Notes" dated 10/26/23 at 10:27 PM entered by LN G revealed at approximately 08:00 PM, certified nurse's aide (CNA) M assisted R1 with changing her shirt and R1 acquired a skin tear on her left arm near her wrist. The skin tear measured 1.5 centimeters (cm) by 1.0 cm and required two steri-strips strips

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(thin adhesive bandage used to close wounds or cuts) for closure.

The "Grievance/Concern Log Book" revealed "Grievance/Complaint Report" dated 10/27/23, that concerned R1 and reported to Social Services (SS) X and Administrative Nurse D. The report revealed R1 reported a CNA (CNA M) tried to get her out of bed "forcefully." R1 reported the CNA M grabbed her by the left arm and hurt her, when R1 did not want to get up. R1 stated she was upset and yelled at the CNA (M) "I'm not going with you" the CNA's "attitude was scary" and R1 "shouted" at the CNA and CNA M "grabbed her."

The "Witness Statement" revealed on 10/26/23, CNA N revealed she answered R1's call light and when she walked into the room. R1 had her legs hanging out of the bed and stated she wanted up and was not ready for bed. CNA N stated R1 was very distressed and emotional out in the dining area, telling staff and residents that she did not want "her" back in the room. The statement lacked who R1 referred to and lacked a time of the alleged occurrence.

The "Witness Statement" on 10/26/23 by Licensed Nurse (LN) G revealed R1 was upset and crying and when asked her what happened, she said the CNA's giving her care were mean to her, she never wanted them in her room again, and they forced a shirt on her she did not want on. LN G stated R1 had a skin tear from her watch on her left lower arm near her wrist. LN G stated she called Administrative Nurse D and informed her of the alleged occurrence and was instructed to send CNA M home.

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The "Witness Statement" on 10/26/23 by CNA O revealed CNA M "forced" pajamas on R1 after R1 had stated she did not want her pajamas on or to lay down. CNA O stated R1 was upset and did not want to stay in bed or wear the pajamas.

On 11/13/23 at 04:13 PM, Administrative Staff A reported SS X had entered R1's room and was informed an aide was making her mad and that was why she was crying. Administrative Staff A reported the aide was from the agency, it occurred at the beginning of the shift, and he was not there at the time. The allegation was that CNA M wanted to get R1 up and she did not want to get up at the time and the stated CNA M was mean to her. R1 reported CNA M had an attitude. Administrative Staff A stated the CNA was sent home due to her general attitude, it was not a positive attitude, and a few of the residents did not like the way she talked and portrayed herself. Administrative Staff A stated the agency was made aware of the allegation and CNA M was not to return to the facility.

On 11/13/23 at 04:20 PM, Administrative Nurse D stated LN G called her and said R1 was upset and one of the aides had been rough with her, and that is "where she left it" so LN G was told to find out who it was and "send her home." Administrative Nurse D stated LN G called her around 09:00 PM, she was not in the building when the incident occurred. Administrative Nurse D stated she later called the agency CNA M worked for and told them "She was not to come back."

On 11/15/23 at 02:12 PM, Administrative Staff A stated he did not feel the event was reportable to the State agency when he informed staff to

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remove CNA M from the facility, however, he realized later he should have "taken different steps" and should have reported it to the State Agency.

The facility policy "Abuse Investigating and Reporting" dated October 2021, revealed all alleged violations involving abuse, neglect, exploitation, mistreatment, including injuries of unknown source . . . will be reported by the facility Administrator, or his/her designee, to the following persons or agencies:
1. The State licensing/certification agency responsible for surveying/licensing the facility.
2. The local/State Ombudsman.
3. The Resident's Representative of Record.
4. Adult Protective Services (where state law provides jurisdiction in long-term care).
5. Law enforcement officials.
6. The resident's attending physician.
7. The facility Medical Director.
An alleged violation of abuse, neglect, exploitation, mistreatment (including injuries of unknown source) . . . will be reported immediately, but not later than two hours if the alleged violation involves abuse or has resulted in serious bodily injury; or 24 hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury.

The facility failed to report the alleged violations on 10/26/23 between CNA M and R1 to the State Survey Agency and other appropriate entities.

- The "Medical Diagnosis" tab for Resident (R)7 included diagnoses of metabolic encephalopathy (the functioning of the brain is affected by some agent or condition such as a viral infection or

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toxins in the blood), cerebral infarction (stroke - damage to tissues in the brain due to a loss of oxygen to the area), mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, wanting to die were more intense and persistent than what may normally be felt from time to time), dementia (progressive mental disorder characterized by failing memory, confusion), and posttraumatic stress disorder (PTSD)- psychiatric disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress, such as natural disaster, military combat, serious automobile accident, airplane crash or physical torture).

The "Admission Minimum Data Set" (MDS) dated 08/20/23 assessed R7 with a "Brief Interview of Mental Status" (BIMS) score of 14, indicating intact cognition.

The "Activities of Daily Living [ADL] Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 08/23/23 revealed R7 required assistance with ADL's.

The "Quarterly MDS" dated 09/26/23 revealed R7 continued to have a "BIMS" score of 14.

The "Care Plan" initiated on 08/22/23 revealed R7 could have a behavior problem and caregivers were to provide opportunity for positive interaction and attention and he would be assured that mutual respect would be given and received from mutual parties. R7 required minimum to moderate assistance of one staff for dressing.

The "Grievance/Concern Log Book" revealed "Grievance/Complaint Report" dated 10/27/23,

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that concerned R7 and reported to Social Services (SS) X and Administrative Nurse D. The report revealed R7 reported a Certified Nurse Aide (CNA), (CNA M) had "lots of attitude" and "got mad" when asked to help place a long sleeve shirt on him and was even "madder" when she had to come back in to take the shirt off because he "got too hot." R7 reported the second time she entered the room she "threw his shirt at the nightstand" and "stormed out of the room."

The "Witness Statement" for 10/26/23 by CNA P revealed she entered the room with CNA N to answer R7's call light and he was upset his needs were not met and stated a CNA (CNA M) was verbally "rude."

The "Witness Statement" for 10/26/23 by CNA N revealed she answered R7's call light and he stated CNA M was "rude" to him, she would not put his shirt on, and he was going to file a complaint." CNA N stated she assisted placing the shirt on and let the nurse know he was upset.

The "Witness Statement" for 10/26/23 by CNA O revealed she was in R7's room with CNA M when she took off his long sleeve shirt. CNA O stated she proceeded to grab a short sleeve shirt from the closet to put on him and CNA M told her not to because "he does this all night long" and took the shirt from her and sat it on the nightstand.

The "Witness Statement" for 10/26/23 by Licensed Nurse (LN) G revealed R7 had his call light on and when she answered it, he stated CNA M had "forced" a shirt on him when he wanted a short sleeve one on.

On 11/13/23 at 04:13 PM, Administrative Staff A

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stated CNA M was sent home on 10/26/23 "due to her general attitude" and "it was not positive." Administrative Staff A stated a few of the residents "did not like the way she was talking and portraying herself" including the "nurses." Administrative Nurse A stated the agency was made aware of the incident and she was not to return to the building.

On 11/13/23 at 04:20 PM, Administrative Nurse D stated LN G called her about another resident that was upset and one of the aides (CNA M) that had been rough with her, and that is "where she left it" so LN G was told to find out who it was and "send her home." Administrative Nurse D stated LN G called her around 09:00 PM, she was not in the building when the incident occurred. Administrative Nurse D stated she later called the agency CNA M worked for and told them "She was not to come back."

On 11/14/23 at 01:50 PM, R7 stated he had a concern with an "agency aide" a few weeks ago. R7 stated he wanted to change shirts and when the "gal" (CNA M) threw his long sleeve shirt on the floor and was "rude." When asked if she was abusive, R7 responded "yes, I thought the girl was." R7 stated he filed a grievance about it.

On 11/15/23 at 02:12 PM, Administrative Staff A stated he did not feel the event was reportable to the State agency when he informed staff to remove CNA M from the facility, however, he realized later he should have "taken different steps" and should have reported it to the State Agency.

The facility policy "Abuse Investigating and Reporting" dated October 2021, revealed all

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F 609	Continued From page 21 alleged violations involving abuse, neglect, exploitation, mistreatment, including injuries of unknown source . . . will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: 1. The State licensing/certification agency responsible for surveying/licensing the facility. 2. The local/State Ombudsman. 3. The Resident's Representative of Record. 4. Adult Protective Services (where state law provides jurisdiction in long-term care). 5. Law enforcement officials. 6. The resident's attending physician. 7. The facility Medical Director. An alleged violation of abuse, neglect, exploitation, mistreatment (including injuries of unknown source) . . . will be reported immediately, but not later than two hours if the alleged violation involves abuse or has resulted in serious bodily injury; or 24 hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury. The facility failed to report the alleged violations on 10/26/23 between CNA M and R7 to the State Survey Agency and other appropriate entities.	F 609		