STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355069	A. BUILDING _____ B. WING _____	C 08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	**620 14TH AVE NE DEVILS LAKE, ND 58301**

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E 000	Initial Comments A COVID-19 Emergency Preparedness Survey was completed by the Centers for Medicare and Medicaid Services (CMS) on August 15-17, 2022. The facility was found in compliance with 42 CFR §483.73 related to E-0024(b)(6).	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control and Complaint Survey was conducted on August 15-17, 2022. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The facility had one COVID-19 positive resident in the facility at this time. The identified concerns expressed by the complainant were partially substantiated. Based on findings an Extended Survey was conducted on August 22, 2022.	F 000		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility	F 684	1. Corrective action for the resident who	9/26/22

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

Electronically Signed | 09/13/2022

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F 684	Continued From page 1 policies, incident reports, and staff interview, the facility failed to investigate a fall, report a change in condition to the physician in a timely manner, and promptly and thoroughly investigate an injury of unknown origin for 1 of 2 sampled residents reviewed for falls (Resident #1). These failures resulted in Resident #1 experiencing unnecessary pain, and placed all residents at risk for falls, abuse, neglect, lack of treatment and/or unnecessary pain. During an on-site facility incident investigation on 08/17/22, the surveyor determined a potential Immediate Jeopardy (IJ) situation existed. The IJ potential resulted from review of Resident #1's medical record regarding a fall and injury of unknown origin, the facility's failure to investigate the fall, the failure of staff to immediately inform the provider of Resident #1's significant change in status, an incomplete, and inconsistent facility investigation into the injury of unknown origin, and staff interview. These findings placed residents in immediate jeopardy due to a facility failure to determine how falls/injuries of unknown origin occurred and rule out potential abuse/neglect. Further immediate jeopardy existed due to lack of staff knowledge about notification and follow up with the provider on change of condition in residents that can lead to significant outcome. * 08/17/22 at 1:30 p.m. - The survey team contacted the management staff at the State Survey Agency (SSA) to report the findings and to discuss a potential IJ situation. * 08/17/21 at 2:30 p.m. - The SSA notified the regional office of the IJ situation.	F 684	has been affected include a root cause of the incident which included 3 areas. These areas consisted of the resident fall investigation, the resident change in condition notification and the final vulnerable adult investigation report. 2. The facility has identified that all residents who have fallen or are at risk of falling, require a provider change in condition notification, or have had a vulnerable adult report completed have the potential to be affected. Resident Care Managers have completed a comprehensive assessment of all residents who have fallen and needed a change in condition notification in the past three months. Executive Director has completed a review of all vulnerable adult reports that have been submitted in the last three months. 3. The Resident Falls policy, Change in Condition policy, and Vulnerable Adult policy have been reviewed and are appropriate. Education on these policies and procedures has been provided to the Director of Nursing, Resident Care Managers, and nurses. Work place investigation education has been completed by Executive Director, Director of Nursing, Resident Care Managers and Social Service staff.	

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F 684	Continued From page 2 * 08/17/22 at 3:05 p.m. - The survey team notified the Administrator of the IJ situation and requested they develop a plan for abatement of the IJ. * 08/18/22 at 1:58 p.m. - The facility provided a written plan (via email) of correction for the IJ. * 08/18/22 at 4:22 p.m. - The survey team reviewed and accepted the facility's written plan. * 08/22/22 at 5:00 p.m. - The survey team determined the IJ situation at a scope/severity of J was abated and reduced to a scope and severity of G. Findings include: Review of the facility policy titled, "Vulnerable Adult-North Dakota" occurred on 08/17/22. This policy, revised May 2022, stated, ". . . Neglect - failure to provide goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress . . . Abuse also includes the deprivation by an individual, including a care taker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being . . . Injury of unknown source - an injury should be classified as an injury of unknown source when both of the following conditions are met . . . The source of the injury was not observed . . . and . . . The injury is suspicious because of the extent of the injury . . . Examples of neglect . . . caretaker neglect - failure of the caretaker to provide necessary food, clothing, shelter, health care, or supervision . . . a resident falls and suffers injury .	F 684	4. The Director of Nursing or designee will audit falls investigations and documentation of change in condition to ensure a root cause was determined, individualized interventions are in place, and timely provider notification has been made. Audits will be completed on all falls/change of condition for 3 months, 4 per month for 6 months, and 2 per month for 3 months with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. Upon this this review, system revisions and/or staff education will be implemented if indicated. The Executive Director or Designee will audit all vulnerable adult reports to ensure report was thoroughly investigated and conclusions are consistent with investigation findings. Audits will be completed on all vulnerable adult reports for 3 months, 4 per month for 6 months, and 2 per month for 3 months with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. Upon this this review, system revisions and/or staff education will be implemented if indicated.	

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F 684	Continued From page 3 . . Examples of unknown injuries . . . fractures with unknown cause . . . Reporting . . . Suggested content of reports to [State Health Agency] . . . Written Reports . . . Include copies of any other documents . . . resulting from the investigation . . ." Review of the facility policy titled, "Falls - Resident" occurred on 08/17/22. This policy, revised March 2022, stated, ". . . A comprehensive assessment will be completed with every fall in an effort determine the root cause and to develop individualized interventions. . . ." Review of the facility policy titled, "Change of Condition" occurred on 08/17/22. This policy, revised August 2021, stated, ". . . The provider will be notified as soon as an assessment is conducted in the following cases. . . . A significant change in the resident's physical, mental, or psychosocial status . . . A need to alter treatment . . ." Review of Resident #1's medical record occurred on 08/17/22. Diagnoses included dementia, anxiety, osteoporosis, and bone density disorder. A quarterly minimum data set dated 06/02/22 identified severely impaired cognition, no scheduled or as needed (PRN) pain medications taken, and that Resident #1 denied pain. The care plan, dated 08/01/22, stated, ". . . ADL [activities of daily living]/MOBILITY DEFICITS: Resident has self-care deficits AEB [as evidenced by] need for assistance with ADLs including bathing secondary to weakness, balance deficits, activity tolerance and Dx	F 684		

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F 684	Continued From page 4 [diagnosis] of dementia and R) [right] [sic] femur fx [fracture] . . . Interventions. . . Non-ambulatory. . . Has an immobilizer to Left leg for Dx of fracture of left femur [initiated 08/01/22] . . . TRANSFERS: Hoyer lift assist of 3 . . . One person must keep left leg stable during transfer at all times [initiated 08/01/22] . . . is at increased risk for falls r/t [related to] poor cognition and poor safety awareness. Scores at high risk for falls. She has fallen in the last 90 days . . . Interventions . . . Lipped mattress to bed [dated initiated 07/27/22] . . ." Resident #1's nurse's notes identified: * 07/12/22 at 9:13 p.m., "Time of fall: 2050 [8:50 p.m.] Description of event: Staff found her lying on left side by bed. Was the fall witnessed?: no, neuros [neurologic assessment] started [.] Did the resident hit their head?: unknown, no bruising noted . . . Pain location, description, & pain scale rating: Resident isnt [sic] able to rate pain or state where due to cognition. She is holding left knee. Small bruise noted to top of knee cap, no swelling. Physical Assessment (include any injuries & immediate care provided): She is able to move all extremities. no skin tears. How was the resident assisted up from the fall?: Hoyer of 2 [.] Action Plan/Intervention: Reminded staff to round on resident and to place into bed after supper. [Provider Name] stated to give tylenol, ice left knee, and she will be here in morning to assess. . . ." * 07/13/22 at 1:19 p.m., "Resident had bath and body audit today. No new skin concerns noted. . . ." * 07/13/22 at 5:57 p.m., "Resident is follow up fall charting. Vitals and neurochecks stable. No new injuries noted."	F 684		

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F 684	Continued From page 5 * 07/15/22 at 9:50 a.m., "Resident is on follow up fall monitoring with neuro checks. Neuro checks are negative at this time. No noted injury due to pain. No complaints of pain noted due to fall. Vitals obtained and within normal ranges for resident at this time. No noted concerns at this time. We will continue to monitor further and report any changes or concerns." * 07/16/22 at 2:41 a.m., "Resident is follow up fall with neuro checks. Neuro check was negative, VSS [vital signs stable], no noted pain or injury. Last neuro check completed, consider fall resolved." * 07/20/22 at 6:03 a.m., "Fax prepared and left for day shift to send. Resident's left knee was found to be swollen, with yellow bruising and fluid behind the knee cap. Knee cap on palpation was deviated down and to the right. Resident screamed in pain with repositioning. Area was warm to the touch. Ice pack applied and pillow placed between knees for support." The facility failed to initiate an investigation on an injury of unknown origin at this time. * 07/20/22 at 2:18 p.m., "Resident had bath and body audit this shift, some swelling noted to left knee, fax out to PMD [primary medical doctor]. No other new skin concerns noted nor reported." The facility failed to follow up with the provider regarding the fax and resident condition. * 07/27/22 at 7:52 a.m., "Late Entry: res [resident] had w/p [whirlpool]. while doing skin audit writer noted that res had a faded purplish/yellow bruise that went all the around above left knee. her leg above knee was swollen, warm to touch and hard. writer informed [nurse name], RN [Registered Nurse], charge nurse and she will be contacting [provider name]. . . ." * 07/27/22 at 10:12 a.m., "Writer called to	F 684		

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F 684	Continued From page 6	F 684		

tubroom to note that resident left leg/knee was swollen. Noted that the thigh was swollen and hard to the touch. No redness or warmth noted. Resident does have a lot of pain and does scream out with even the slightest touch. MD [medical doctor] updated and did order to send for xray."
* 07/27/22 at 3:29 p.m., "Writer and [provider name] called and spoke with residents daughter, [daughter's name] regarding xray results. Will place a brace on the leg to immobilize it. . . ."
* 07/27/22 at 5:04 p.m., "[provider name] did send orders for femur fracture."

Resident #1's Radiology Report, dated 07/27/22, stated, ". . . Displaced fracture of the distal left femur. . . ."

Review of Resident #1's physician's orders dated 07/01/22-08/17/22 showed:
* 07/27/22 "Tylenol Extra Strength Tablet . . . (Acetaminophen) Give 500 mg [milligram] by mouth two times a day for musculoskeletal pain"
* 07/27/22 "Tylenol Extra Strength Tablet . . . (Acetaminophen) Give 500 mg by mouth every 6 hours as needed for musculoskeletal pain"
* 07/09/22-07/27/22 "Acetaminophen Give 650 mg by mouth every 4 hours as needed for pain/fever do not exceed 3000 mg/ [per] 24 hours"
* 07/27/22 "HYDROcodone-Acetaminophen [narcotic pain reliever] Tablet 5-325 MG Give 0.5 tablet by mouth two times a day for musculoskeletal pain"
* 07/27/22 "HYDROcodone-Acetaminophen Tablet 5-325 MG Give 0.5 tablet by mouth every 6 hours as needed for musculoskeletal pain"

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F 684	Continued From page 7	F 684		

Review of Resident #1's Medication Administration Record from July 1, 2022 through August 17, 2022 showed the resident received the following as needed pain medications:
* Acetaminophen Give 650 mg - three times 07/12/22, 07/14/22, 07/20/22
* Tylenol Extra Strength Tablet 500 mg - one time
* Hydrocodone-Acetaminophen Tablet 5-325 mg - twelve times

During an interview with an administrative nurse (#1) on 08/17/22 at 12:10 p.m., she reported the facility investigated the fracture of Resident #1's left femur beginning 07/28/22. The administrative nurse provided the investigation documentation which consisted of a handwritten sheet of notes identified as nurse interview/documentation review, and a typed sheet identified as CNA [certified nursing assistant] interviews. Both documents lacked dates and times.

Review of CNA interviews completed by the facility on 07/28/22 identified the following regarding Resident #1:
* "legs were really puffy, knee looked out of place, told [nurse name] that she needs to look at [Resident #1] knee and its puffy. Knee looks as though its not together. Still puffy 2 weeks later, when [CNA name] worked with her again. . . .Difficult to get brief in between legs."
* "The night she fell she was in pain, nurse was informed and the nurse said she was fine. . . ."
* "2 weeks ago, helping [CNA name] with transfer, leg is not looking right,. . . Leg was looking shorter. The leg is hurting, swollen to the knee. . . . reported to the nurse, that it doesn't look right . . . gradually swell up, wasn't swollen right away."

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F 684	Continued From page 8 * "told the nurse that resident was crying in pain . . . Doing report, [CNA name] told her she [Resident #1] fell that's why her leg looks twisted. Doesn't look right. Trying to tell them on night shift but they keep bypassing it. A couple days ago told [nurse name] that the leg doesn't look right, . . . A lot of people had been saying things about it but it was just being bypassed, told that's just how her leg is." * ". . . When you lifted in the hoyer, she was in pain, would do her little cry that she does. Not sure if it was reported to the nurse that she was in pain . . ." Review of the handwritten notes, identified by administrative nurse (#1) as nurse documentation/interviews, dated 07/28/22, identified the following regarding Resident #1: * "No reports of pain/swelling/bruising - [didn't] look at it" * "[Didn't] look at knee - [no] complaints slept through night" * "[No] reports - didn't look at leg" * "[No] swelling - yelling in pain w[with]/transfer-assessed leg w/no concerns" * "Tues [Tuesday] night- pain w/repo [repositioning] - last week - increased swelling & [and] warmth - pain fax made for MD. * "[No] signs of pain" * "[No] signs of pain" * "Wed [Wednesday] body audit - [didn't] see anything - no increased pain - always looked same. looked different yesterday - Someone has called in everyday to look @ [at] leg. [No] increased." * "body Audit - Knee swollen - minimally - [nurse name] & I decided normal" * "PRN [as needed] Tylenol [pain relief	F 684		

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medication] - @ fall that night. yelling w/transfers. [illegible word] reported."
* [No] reports pain/swelling - sent fax for [nurse name]"

Review of the final report received by the State Agency on 08/04/22, stated, ". . . Nurse/DON [Director of Nursing] interview: Multiple CNAs, RNs [Registered Nurses], LPNs [Licensed Practical Nurses] interviewed that had worked with [Resident #1] over the course of two weeks. All denied any swelling to left thigh/knee. All denied resident crying out in pain with transfers or cares. Resident does resist cares/hoyer [mechanical lift]/bath at times. . . . Investigation: Staff, residents, and nurse were interviewed . . . Conclusion: Review team went over details and concluded allegation. Team determined no abuse seemed to have occurred. Facility assured residents and facility are safe. Resident does have diagnosis of osteoporosis and disorder of bone density. Resident was a hoyer transfer with assist of 2 staff, updated to 3 staff due to fracture. Suspected that fracture happened during resident transfer."

During an interview on 08/17/22 at 3:08 p.m., an administrative staff (#3) confirmed he failed to review the final investigation completed or the report submitted to the state agency.

The facility failed to initiate a fall investigation for the 07/12/22 fall. The facility failed to notify the provider of the change in condition to Resident #1's left knee/thigh, and increased pain level on 07/20/22. After the provider notification on 07/27/22 (7 days later) the resident went to the emergency department. Staff then initiated an

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F 684	Continued From page 10 investigation of injury of unknown origin. The facility investigation of Resident #1's left femur fracture lacked dates, times, and completeness. The facility investigation showed CNAs identified changes in Resident #1's left leg and pain level, reported the changes to the nurses, and that nurses assessed and contacted the provider via fax. This contradicted the final report submitted to the State Agency which stated CNAs and Nurses reported no changes to Resident #1's left leg and pain level in the two weeks prior to the discovery of the fracture on 07/27/22. The facility failed to ensure the staff followed the systems in place to protect Resident #1 and all residents from potential abuse, neglect, and unnecessary pain.	F 684		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the physician completed	F 711	1. The facility is unable to obtain signed and dated progress notes for Resident #1	9/26/22

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F 711	Continued From page 11 and/or the facility obtained the progress notes for 2 of 4 sampled residents (Resident #1 and #4) reviewed for required provider visits. Failure to write, sign, and date a progress note with the required every 30 or 60-day visit and/or failure to include the progress note in a resident's record does not ensure a review of the resident's total program of care and current condition or foster continuity of care with other health care providers. Findings include: - Review of Resident #1's medical record occurred throughout the survey. The record lacked completed progress notes, signed and dated by the physician, in correlation with the physician's 30 or 60-day visits on 12/30/21, 01/25/22, 03/01/22, 04/28/22, and 06/28/22. - Review of Resident #4's medical record occurred on 08/22/22. The record lacked completed progress notes, signed and dated by the physician, in correlation with the physician's 60-day visits on 12/30/21, 03/01/22, 4/28/22, and 06/28/22. During an interview on 08/22/22 at 5:15 p.m., two administrative nurses (#1 and #5) stated Resident #1 and #4's physician visited assigned residents every 60 days and dictated the progress notes into the hospital electronic medical record system. Either the physician sends the progress notes to the facility, or the facility staff who have access to the hospital electronic medical record print off the progress notes and scan them into the facility's electronic medical record system for each resident. The	F 711	for the following dates: 12/30/21, 01/25/22, 03/01/2022, 04/28/2022, and 06/28/2022 or for Resident #4 for the following dates: 12/30/21, 03/01/22, 04/28/22, and 06/28/2022 as the provider responsible is no longer providing services at Eventide. 2. The facility has identified that all residents in the facility that are followed by the provider responsible have the potential to be affected by this practice but we are unable to correct as she is no longer providing services at Eventide. 3. Education will be provided to the Director of Nursing, Resident Care Managers, Unit Secretaries and all the facilities practicing Primary Care Physicians regarding the requirements of 30-and 60-day signed and dated progress notes. 4. The Director of Nursing or designee will audit to ensure that signed and dated progress notes are completed and/or obtained for required provider visits. Audits will be completed on all provider visits x 3 months, on 4 visits per month x 3 months, and on 2 visits per month x 6 months with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. Upon this review,	

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	355069	A. BUILDING _____ B. WING _____	C 08/22/2022

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F 711	Continued From page 12 nurses agreed the facility failed to obtain and enter the above progress notes into the residents' electronic medical records.	F 711	system revisions and/or staff education will be implemented if indicated.	
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT CITATION FROM THE STANDARD SURVEY ON 11/18/21.	F 725	1. Nurse Manager spoke with Residents #6 and #7 assured them that their needs are important to staff and that staff would	9/26/22

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F 725	Continued From page 13 Based on information from the complainant, observation, resident interviews, and review of facility Alarm Response Report, the facility failed to ensure sufficient nursing staff to meet resident needs for 2 of 9 sampled residents (Resident #6 and #7), and three confidential residents (Residents A, B, and C) who required staff assistance. Failure to provide sufficient staffing and answer call lights in a timely manner does not promote a resident's right to physical, mental, and psychosocial well-being. Findings include: The complainant indicated long call light wait times and call lights being turned off without resident needs being met or staff returning as stated. The facility failed to provide a call light policy. Resident interviews identified the following: * 08/15/22 at 1:23 p.m., Resident A indicated he/she waited up to an hour for staff to answer the call light and stated, "They're [staff] just too busy, but we all need help." He/she identified the worst time is between 5:30 p.m. and 6:00 p.m. * 08/15/22 at 3:25 p.m., Resident C reported he/she has often waited up to an hour or hour and a half for staff to answer the call light when needing the bathroom, and the wait time is worse around supper. * 08/15/22 at 3:56 p.m., Resident B stated he/she has waited up to 30 minutes for staff to answer the call light. * 08/15/22 at 4:00 p.m., Resident #6 stated, "I do still have to wait at times, especially when they are shorthanded like they were today. I had to	F 725	be leaving the call light on until their needs were met. 2. All residents have the potential to be affected. 3. The facility has hired replacement staff members as well as additional travel staff. Nursing leadership and staffing coordinator will meet daily to develop a staffing plan for the following day, ensuring that all positions are filled. All staff will be educated on the expectation that it is everyone□s responsibility to answer call lights. All staff will be educated that call lights should remain on until the residents need has been met. Daily rounds on all residents have been initiated by the leadership team. 4. Audits will be completed to ensure that call lights are being answered in a timely manner and resident□s needs are being met in a timely manner. The DON or designee will observe ten residents weekly for one month, then residents monthly for three months, and then 10 audits will be completed at least quarterly for one year with additional audits are recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. Upon this review system revisions and/or staff education will be implemented.	

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wait for 30 or 40 minutes for help, then I started yelling to get some help."
* 08/16/22 at 8:55 a.m., Resident #7 stated, "I put the call light on for help to the bathroom and it takes up to an hour for them [the staff] to answer, I've wet through my clothing and need to change clothing."

Observations on 08/16/22 showed the following:
* 6:36 p.m., call light in a resident room answered by administrative staff (#4). Administrative staff (#4) exited room, call light remained on, spoke into walkie talkie radio asking for nursing staff to assist resident to bed. Response over the walkie talkie stated, "Someone will assist as soon as all residents are cleared out of the dining room." Administrative staff (#4) asked for an estimate of time. No response returned. Administrative staff (#4) approached two certified nursing assistants (CNAs) (#7 and #9) and asked if they could assist the resident. The CNA (#7) stated, "Can't you see I'm going in here to feed?" and indicated the room he/she was about to enter. The CNA (#9) stated, "We have to make sure everyone is out of the dining room before we put them to bed."
* 6:40 p.m., a CNA (#6) walked past the administrative staff #4 into the resident room and stated, "What does she want?" The administrative staff (#4) explained the resident wished to go to bed, to which the CNA (#6) stated, "We can't help them to bed until the dining room is empty." The CNA turned the call light off and walked out of the room. The administrative staff (#4) entered the room, spoke to the resident, explained someone would be back to assist her after the dining room was cleared.
* 6:39 p.m., A CNA (#8) entered a resident room,

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asked the resident "You need the bathroom?" to which the resident answered yes. The CNA (#8) stated, "Ok, I can't take you right now, I have to get people out of the dining room before I can help you. I just wanted to let you know." And exited the room without cancelling the call light.
* 6:43 p.m., A CNA (#4) entered the same resident room, cancelled the call light, did not ask the resident what he/she needed, did not assist the resident, and exited the room.

Review of a random sampling of the facility Alarm Response Reports identified the following:
* 07/20/22 From 12:01 a.m. - 11:59 p.m.:
Assist/Nurse Call Response time of 20-30 minutes occurred 16 times
Assist/Nurse Call Response time of 30-60 minutes occurred 8 times
Assist/Nurse Call Response time of greater than one hour occurred 3 times.

* 08/15/22 From 12:01 a.m.-11:59 p.m.:
Assist/Nurse Call Response time of 20-30 minutes occurred 32 times
Assist/Nurse Call Response time of 30-60 minutes occurred 24 times
Assist/Nurse Call Response time of greater than one hour occurred 7 times.

During an interview on 08/17/22 at 10:00 a.m., an administrative staff (#3) and an administrative nurse (#1) stated they expected all staff to answer call lights in "a reasonable amount of time". They stated they expected staff to assist residents at all times including before, during, and after meals, and that they had no expectation of staff to "clear the dining room" before assisting residents.

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