| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| N 000 | Initial Comments<br><br>On 10/09/2023, Surveyor conducted 2 complaint investigations at Anitas Gardens.<br><br>Two deficiencies were identified.<br><br>Two complaints were substantiated.<br><br>Census: 19 | N 000 | | |
| N 388 | 83.35(3)(c) Implement, follow the individual service plan<br><br>Implementation. The CBRF shall implement and follow the individual service plan as written.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure Caregiver D followed Resident 1's individual service plan (ISP) as written when Caregiver D improperly transferred Resident 1 resulting in bruising.<br><br>Findings include:<br><br>On 07/26/2023, the department received a complaint that alleged concerns with a resident transfer.<br><br>On 10/06/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 07/02/2023 with diagnoses including limb girdle muscular dystrophy and anxiety. Resident 1 was their own legal decision maker.<br><br>Resident 1's ISP dated 07/13/2023 documented, "Mobility and Transferring- [Resident 1] is independently mobile via [his/her] electric wheelchair. [S/he] is currently being assisted with transfers via a slide board 2 assist & gait belt. | N 388 | | |

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

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[S/he] has [his/her] own unorthodox system and is able to verbalize and self-direct. Instruct caregivers with transfers. Essentially, when resident is in bed, staff assist [him/her] to a sitting position. Resident then leans forward and the gait belt is applied down below [his/her] hips and under the buttocks, the slide board is then slid under the resident. With [his/her] electric wheelchair, which is positioned next to [his/her] bed, staff is then able to slide Resident in to [his/her] chair by putting on the gait belt and guiding [his/her] legs and feet over the mattress and into position over the footrest. Transfers from wheelchair to bed is opposite of above. Transfers to & from toilet are also complete in the same manor. Two staff will assist Resident daily with all transfers via slide board and gait belt. Staff will use above started method and as directed by Resident."

Resident 1's incident report dated 07/18/2023 documented:
"Describe Incident: On 07/19/2023, [Resident 1] let a second shift caregiver know that [s/he] had bruises on [his/her] arm from the way [Caregiver D] transferred [him/her] the day before.
Contributing factors: Aggressively grabbing [Resident 1's] arm during transfer.
Injury: Bruise on right arm."

The provider's self-report dated 07/24/2023 for the above incident documented:
"On July 19, 2023, [Resident 1] made an allegation of abuse by a caregiver at the provider. [S/he] was a recent admission on 7/2/23. [S/he] has a diagnosis of muscular dystrophy and is dependent for [his/her] cares but is cognitively intact. [S/he] stated that a caregiver did not follow [his/her] instructions on how to assist [him/her] in getting up and was verbally disrespectful. This

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was reported to supervisor, who reported it to the administrator. The resident also called [his/her] case manager to report the problem. ... The employee was put on suspension subject to the investigation. The caregiver [Caregiver D] had previously been talked to for not speaking respectfully to the resident. We were able to verify [his/her] report with a picture of the finger-tip bruising on [his/her] arm. The staff member denied the allegations and continues to deny the allegations. However, as we believe the resident and had photographic proof, the employee [Caregiver D] was terminated. We will be forwarding the information to caregiver misconduct. We will be working on re-training staff on resident rights and individual service plans."

Witness statements reviewed by Surveyor on 10/06/2023 documented:
"On 07/20/2023, I [Former Administrator E] spoke with [Resident 1] and [s/he] stated that [Caregiver D] aggressively grabbed [his/her] arm while transferring [him/her] and when [s/he] tried to explain to [him/her] how [s/he] is supposed to be transferred, [Caregiver D] told [him/her] [s/he] has been doing this for 20 something years [s/he] knows what [s/he] is doing."

Manager B's witness statement dated 07/19/2023 stated, "Staff reported bruising on [Resident 1's] arms. It was stated that [Caregiver D] transferred [him/her] by grabbing [his/her] arms. Manager went to talk to resident in regard to bruising. [Resident 1] stated that [Caregiver D] grabbed [him/her] by the arms instead of gait belt and was rough with the transfer ... Resident stated that [Caregiver D] is rude to [him/her] frequently, also stated that [s/he] was told [his/her] clothes where old and [s/he] needs to replace them. [Resident 1]

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is very upset at how [s/he] was treated by [Caregiver D]."

Former Administrator E's witness statement dated 07/20/2023 stated, "On 07/19/2023, [Manager B] called me [Former Administrator E] stating that a caregiver told [him/her] that it was bruises on [Resident 1's] arm, and that [Resident 1] told [him/her] that it happened when [Caregiver D] transferred [him/her] by grabbing [his/her] arm aggressively. After talking to [Manager B], I [Former Administrator E] called [Caregiver D] to get a statement from [him/her]. [Caregiver D] stated that [s/he] did not do any transfers that day and that [s/he] did not know what happened. I [Former Administrator E] let [Caregiver D] know that I [Former Administrator E] had to suspend [him/her] so that I [Former Administrator E] could complete an investigation."

On 10/06/2023, Surveyor reviewed Caregiver D's employee record. Caregiver D was hired on 05/24/2023. Caregiver D's employee orientation documented Caregiver D initialing s/he was trained in Care Plans. "All new employees will be shown the resident care plans and explained their importance. Staff will be required to read each reisdent's care plan prior to completing any cares for that resident. They will also be shown where to find updates to the care plans."

On 10/06/2023 at 11:41, Surveyor interviewed Manager B. Manager B confirmed Caregiver D was terminated due to ongoing communication concerns with residents and not following Resident 1's care plan. Manager B stated s/he saw the fingertip like bruising on Resident 1's arm.

On 10/06/2023 at 2:02 PM, Surveyor interviewed

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| N 388 | Continued From page 4<br><br>Resident 1. Resident 1 confirmed Caregiver D did not follow his/her care plan and would not accept guidance from Resident 1 during the transfer on 07/18/2023. Resident 1 stated Caregiver D grabbed his/her arms instead of the gait belt and slide board. Resident 1 stated s/he frequently had concerns with Caregiver D on how s/he treated residents and was rough during cares.<br><br>On 10/06/2023 at 2:12 PM, Surveyor interviewed Administrator A and Manager B regarding Resident 1's ISP not being followed that resulted in bruising. Administrator A stated s/he started in August 2023, but could confirm resident rights and ISP training was completed. Administrator A confirmed Caregiver D no longer worked at the provider. Manager B did not know why Caregiver D did not follow Resident 1's ISP. No further information was shared. | N 388 | | |
| N 396 | 83.36(1)(a) Adequate staff to meet resident needs.<br><br>The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure there were sufficient number of employees on a 24-hour basis to meet the needs of all residents.<br><br>Findings include:<br><br>On 08/31/2023, the department received a complaint that alleged concerns related to staffing. | N 396 | | |

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| N 396 | Continued From page 5<br>On 10/06/2023, Surveyor conducted a complaint investigation and identified the following:<br><br>The provider is licensed to care for up to 19 residents in the client groups of advanced age, irreversible dementia/Alzheimer's physically disabled, traumatic brain injury, and terminally ill.<br><br>On 10/06/2023, Surveyor reviewed the resident roster. There were 19 residents. At 9:35 am, Administrator A identified Resident 1, Resident 2, and Resident 3 as requiring 2 staff assist with cares.<br><br>A review of the provider's employee schedule dated July, August, September, and October 2023 documented:<br>July: 3rd shift (10pm-6a): The scheduled documented 18 of 31 days where only 1 caregiver was working. The following dates only 1 caregiver was scheduled on the 3rd shift (10p-6am): 07/02/2023, 07/04/2023-07/07/2023, 07/10/2023-07/13/2023, 07/15/2023-07/16/2023, 07/20/2023-07/21/2023, 07/24/2023, 07/26/2023-07/27/2023, 07/29/2023-07/30/2023.<br><br>August: 3rd shift (10pm-6am): The scheduled documented 14 of 31 days where only 1 caregiver was working. The following dates only 1 caregiver was scheduled on the 3rd shift (10p-6am): 08/01/2023, 08/03/2023, 08/10/2023, 08/12/2023-08/13/2023, 08/16/2023-08/17/2023, 08/21/2023-08/24/2023, 08/26/2023-08/27/2023, 08/29/2023.<br><br>September: 3rd shift (10pm-6am): The scheduled documented 6 of 30 days where only 1 caregiver was working. The following dates only 1 caregiver was scheduled on the 3rd shift (10p-6am): 09/01/2023, 09/12/2023-09/14/2023, | N 396 | | |

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| N 396 | Continued From page 6<br>09/23/2023-09/24/2023.<br><br>October: 3rd shift (10pm-6am): The scheduled documented 1 of 5 days where only 1 caregiver was working. The following dates only 1 caregiver was scheduled on the 3rd shift (10p-6am): 10/02/2023.<br><br>On 10/06/2023, Surveyor reviewed resident records and identified the following:<br><br>Example 1-Resident 1<br><br>Resident 1 was admitted to the provider on 07/02/2023 with diagnoses including limb girdle muscular dystrophy and anxiety. Resident 1 was their own legal decision maker.<br><br>Resident 1's individual service plan (ISP) dated 07/13/2023 documented:<br>"Mobility and Transferring- [Resident 1] is independently mobile via [his/her] electric wheelchair. [S/he] is currently being assisted with transfers via a slide board 2 assist & gait belt. [S/he] has [his/her] own unorthodox system and is able to verbalize and self-direct. Instruct caregivers with transfers. Essentially, when resident is in bed, staff assist [him/her] to a sitting position. Resident then leans forward, and the gait belt is applied down below [his/her] hips and under the buttocks, the slide board is then slid under the resident. With [his/her] electric wheelchair, which is positioned next to [his/her] bed, staff is then able to slide resident in to [his/her] chair by putting on the gait belt and guiding [his/her] legs and feet over the mattress and into position over the footrest. Transfers from wheelchair to bed is opposite of above. Transfers to & from toilet are also complete in the same manor. Two staff will assist resident daily with all | N 396 | | |

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transfers via slide board and gait belt. Staff will use above started method and as directed by resident."

Example 2-Resident 2

Resident 2 was admitted on 08/04/2020 with diagnoses including atrial fibrillation, COPD, and foot/knee pain. Resident 2 is their own legal decision maker.

Resident 2's ISP dated 08/31/2023 documented: "Mobility and Transferring: [Resident 2] requires assist of 2 staff along with EZ stand lift for all transfers.
Toileting: Resident is able to make [his/her] needs known but requires assist of 2 along with EZ stand mechanical lift to use the bathroom to have bm's due to being confined [his/her] wheelchair."

Example 3-Resident 3

Resident 3 was admitted on 12/17/2022 with diagnoses including type 2 diabetes, bilateral leg edema, and cognitive impairment. Resident 3 is their own legal decision maker.

Resident 3's ISP dated 07/27/2023 documented: "Toileting: [Resident 3] is able to make [his/her] needs known and alert staff when [s/he] needs to use the bathroom. Resident requires assist from staff due to being confined to [his/her] wheelchair and transferring with an EZ stand and 2 assist."

On 10/06/2023 at 1:25 PM, Surveyor interviewed Director C. Director C acknowledged s/he was told from management staffing the 3rd shift was of concern. Director C stated administrators oversee scheduling staff and know they must ensure 2 staff work each shift due to resident

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| N 396 | Continued From page 8<br>needs. Director C did not provide any further information.<br><br>On 10/06/2023 at 2:02 PM, Surveyor interviewed Resident 1. Resident 1 stated when requesting help on the 3rd shift, it's frequently staffed by only 1 person. Resident 1 stated often his/her cares are completed by 1 staff member.<br><br>On 10/06/2023 at 2:12 PM, Surveyor interviewed Administrator A and Manager B regarding staffing concerns. Administrator A confirmed Resident 1, Resident 2, and Resident 3 all required 2 staff to assist with cares. Surveyor noted after reviewing the CBRF's staff schedule, only 1 caregiver was scheduled during the 3rd shift for many days of the month, during the months of July, August, September, and October 2023. Manager B confirmed the staff schedules were accurate for the months July-October 2023. Administrator A and Manager B stated they were continuously hiring staff. | N 396 | | |