STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING ______ B. WING ______	C 03/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/HERTFORD	**1300 DON JUAN ROAD HERTFORD, NC 27944**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint survey was conducted from 03/22/21 through 03/30/21. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tags F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 03/07/21 and was removed on 03/26/21. A partial extended survey was conducted.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff interviews, resident interview, and Medical Doctor (MD) interview, the facility failed to identify a hazardous construction area adjacent to the sidewalk leading to the 200 Hall entrance of the building used by one of one sampled resident (Resident #1). The area did not restrict access or have any visual caution signage. Resident #1 navigated his motorized wheelchair down the sidewalk. When he attempted to turn the motorized wheelchair around on the sidewalk,	F 689	F 689 Corrective action taken for those residents found to be affected by the alleged deficient practice: Resident #1 was admitted on 1/10/19 with a diagnosis that included Quadriplegia, unspecified lack of coordination, muscle weakness and muscle spasms.	4/5/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/16/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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one wheel fell off the pavement. Resident #1 fell into a construction trench filled with rocks and the wheelchair fell on top of him. Resident #1 was unable to telephone for help and laid in the trench until a passerby found him. Resident #1 was airlifted to the hospital where he was treated for fractures to his left femur and tibia which required surgery.

Immediate Jeopardy began on 3/7/21 when the facility failed to restrict resident access to an uneven sidewalk adjacent to a construction area and Resident #1 and his motorized wheelchair fell into a rock-filled construction trench. The resident was discovered by a passerby forty-five minutes after exiting the building and required emergency services and air lift to the hospital for treatment. The immediate jeopardy was removed on 3/26/2021 when the facility provided and implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level D (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) to ensure that the education and the monitoring systems put in place to remove the Immediate Jeopardy are effective.

Findings included:

Resident #1 was admitted to the facility on 1/10/19 with diagnoses including quadriplegia, lack of coordination, muscle weakness and muscle spasms.

Review of Resident #1's annual Minimum Data Set assessment dated 1/14/21 revealed the resident was cognitively intact and required total dependence with 2-person physical assistance

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On March 22, 2021, a complaint survey was conducted resulting in an allegation of immediate Jeopardy identified as a result of an accident that occurred on March 7. The investigation identified that Resident # 1 exited the facility shortly after 3:00 pm through the front door without notifying staff. Resident # 1 received a 36 pack of water and a bag of snacks from his sister who reportedly placed the items in his lap. The resident decided to attempt to reenter the facility through a non-designated entrance at the end of the 200 hall wing. When Resident # 1 determined that he could not enter the facility from the 200 hall exit door he began to turn his wheel chair around. During an interview on 3/12/2021 with the Administrator, Resident # 1 indicated that he was aware 200 hall exit was not an entrance and that he was aware of the drainage construction. Resident #1 indicated that he accidently moved the toggle on his electric wheel chair the wrong direction resulting in the chair moving forward off the sidewalk resulting in Resident # 1 and the chair tipping over onto the French drain next to the sidewalk.

A young boy rang the bell of the front entrance around 3:15 pm to alert the staff of a man that was turned over in his wheelchair on the facility grounds. The nurse immediately went to investigate and found resident #1 off the pavement, in the rocks with the wheelchair on top of him. 911 had already been dispatched by a passerby so EMT arrived onsite at 3:45

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with transfers. Resident #1 had range of motion impairment of upper and lower extremities, both sides. Resident #1 used a wheelchair for mobility.

A care plan initiated on 1/20/19 had a focus area of Resident #1 had limited physical mobility related to neurological deficits/quadriplegia/paraplegia with a goal that Resident #1 will maintain current level of mobility. Has motorized wheelchair. The interventions included safe to leave grounds with reflector on wheelchair and educate on safety on grounds.

A nurse note dated 3/7/21 revealed the nurse responded to a doorbell at the front entrance around 3:15PM. There was a young boy who told her a man turned over his wheelchair in the back of the building. The note further indicated the nurse went out to investigate, she found the resident off the pavement, in the rocks with the wheelchair on top of him. 911 had been dispatched at 3:33PM by the passerby, Emergency Medical Technician (EMT) arrived at 3:45PM. Four EMTs and fire department were needed to remove the wheelchair due to it weighing 400 pounds.

The Fall Report dated 3/7/21 by Nurse #1 indicated the incident location was outside. The report indicated Resident #1 did not alert staff prior to leaving the building. It appeared resident was meeting someone outside due to fact that the resident had a case of water on him when he fell outside the building. Resident went out the back door and wheels went off pavement into rocks and wheelchair fell on top of resident.

An observation, with the Administrator, on 3/22/21

pm. With EMT and the Fire department assistance, they were able to safely remove the wheelchair and the resident was air flighted to the hospital where he was diagnosed with a fracture to the shaft of his left femur and a spiral fracture of the left tibia. The resident was admitted to the hospital where with orthopedic consultation underwent surgical procedures to repair the left leg fractures. He tolerated the procedures well and was readmitted to the facility on 3/12/21. The resident□s care and services were provided post-operative in the facility as ordered. The Administrator interviewed resident # 1 and on 3/23/21, the resident was discharged by Transport services to live with his mother.

The facility failed to ensure that a construction area was visibly and adequately marked off as a danger zone and resident number 1 attempted to enter the 200-hall entrance since his room was just inside the door. The resident recognized that he was not going to be able to enter the 200-hall entrance and with an attempt to turn around his wheelchair, one wheel left the walkway and the wheelchair fell over on him.

Regarding this allegation, there were no other residents affected by this incident.

How the facility will address other residents having the potential to be affected by the same alleged deficient practice:

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at 2:50PM of the outside area where the fall occurred, revealed a sidewalk that was uneven which led to the side entrance (200-hall entrance) where Resident #1 had attempted to gain entrance into the facility. It was further observed there was a trench along the perimeter of the facility where construction was occurring. The trench was 2 feet in depth.

An observation on 3/23/21 at 9:00AM revealed caution tape was placed across the sidewalk construction site which prevented access to this area. This was not in place on 3/22/21.

An observation on 3/23/21 at 6:00PM of the location where the incident occurred revealed a sidewalk located 100' to the right of the main entrance. The sidewalk led to the 200-hall entrance. The concrete on the sidewalk was smooth for 35'. The concrete was uneven and jagged for 20' and then smooth for 10'. Along the inside perimeter of the uneven concrete, there were 2 pieces of Polyvinyl Chloride (PVC) pipe protruding 2' vertically from the ground. There was a drop off in this section of 2' which was layered with gravel. There was a caution tape at the beginning of the uneven concrete at 3' in height and another caution tape of the end of the uneven concrete at 1' in height. Resident #1 was found located in the trench 12' from the 200-hall entrance and 10' from the wire fencing gate which surrounded the 200-hall porch. The resident's wheelchair was resting partially on the PVC pipe and partially on the resident's right side.

During an interview with Resident #1 on 3/22/21 at 12:50PM he revealed he had exited through the front door of the facility to visit with his family member. He further revealed he attempted to

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Any resident who has the potential to exit the facility independently or any resident that is on the outside premises has the potential to be affected by the deficient practice as alleged for Resident # 1.

The facility has developed a policy on 3/25/21 to ensure construction sites are properly marked to prevent access and ensure resident, staff and visitor safety. The maintenance workplace safety policy was amended to include the following: Make sure that construction sites or work areas are designated and properly marked as such to prevent access and to ensure safety. Construction areas or work sites must visibly and adequately be marked as danger zones.

An Ad-hoc QAPI was held on 3/25/21 to review the policy with department managers and the Medical Director. The Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Unit manager s will utilize this policy in the all staff education as it relates to construction. Families and residents are being educated regarding the construction sites or work areas are designated and properly marked as such to prevent access and to ensure safety. Construction area or work sites will be visibly and adequately marked off as danger zones.

VP of Quality and Customer experience, provided an in-service to the Administrator, Director of Nursing, the District Director of Operations and The

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re-enter through the 200-hall door which had a keypad. The resident stated he knew the code to gain access independently. Resident #1 further stated the wheel of his wheelchair fell off the pavement into the ground and turned over. Resident #1 stated he went outside unaccompanied and indicated he was able to have outdoor visitation anytime he wanted without scheduling it.

A subsequent interview with Resident#1 on 3/22/21 at 3:05PM revealed he had placed a call to his family member from his cell phone for the purpose of arranging a visit. When his family member arrived, an (Nursing Assistant) NA had let him out the front door. Resident #1 further stated he visited with his family member for 5-10 minutes. He stated the family member had provided him a case of water. After the visit, Resident #1 stated he decided to enter through the 200-hall entrance since his room was located just inside the door. Resident #1 stated when he started up the pavement, he observed the gate to the 200-hall to be closed, so he attempted to turn his wheelchair around. At that time, one wheel left the pavement and the wheelchair fell over onto him. Resident #1 stated he was unable to reach his cell phone to call for help. Resident #1 revealed he laid on the ground and waved his arms attempting to get the attention of a passerby, while yelling for help. Resident #1 indicated 4 cars had passed until someone saw him and stopped. Resident #1 revealed he was afraid he was going to lay out there and die.

An interview with Nurse #2 on 3/22/21 at 12:59PM revealed she was unaware how Resident #1 exited the facility. Nurse #2 stated she was notified when a young boy rang the

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District Director of clinical services on how to conduct root cause analysis so that effective interventions can be implemented to prevent reoccurrence on 3/25/21.

The facility Maintenance man and the Construction company marked off the construction sites so that the areas are visibly and adequately marked off as danger zones on 3/25/21.

The social services director called the current residents□ families on 3/25/21 to alert them of the continued construction on the grounds of the facility and of the danger zones that visitors and residents were to stay away from. The Social Worker informed resident families that resident room window visits or any other window visit location in the construction zone were suspended and prohibited during the construction period. A letter was also mailed to the responsible parties regarding the construction projects and safety advise, and of the ability to schedule visits by calling the facility.

The Administrator, Director of nursing, Assistant Director of nursing provided in-services to the current staff on 3/25/21. The in-service content included safe assistance to residents when outside, indoor and out door visitation, addressed identification of the construction zone and placement of construction zone signage, tape, ropes and barriers, in-serviced that no residents, visitors or unauthorized employees are be in the construction /

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doorbell. The young boy informed Nurse #2 there was a gentleman lying on the ground outside. Nurse #2 assessed Resident #1, Emergency Management Services (EMS) arrived and proceeded to care for the resident.

An interview on 3/22/21 at 8:20PM with Nurse #1, who was Resident #1's first shift nurse on 3/7/21, revealed she was notified by a co-worker that the resident was on the ground outside. She further stated EMS called the fire department to lift the wheelchair off the resident. She stated she observed a 32 pack of water and a bag of goodies on the ground. Nurse #1 revealed she was unaware Resident #1 was outside, nor was she aware how he got outside. Upon discovering the resident was on the ground outside, Nurse #1 revealed she had completed a mental assessment and stated he appeared to be his 'regular self'. Nurse #1 indicated the co-worker had completed vitals on Resident #1. She stated she observed the resident's leg was bent back. His head was lying in the rocks with the wheelchair laying on top of him.

An interview with the Director of Nursing (DON) on 3/22/21 at 10:55AM revealed Resident #1 exited the facility without notifying staff. Resident #1 knew the code to the 200-hall door which was where he exited. The DON stated the resident had been expecting items which were dropped off outside the 200-hall door. The DON further stated when Resident#1 exited the facility, the wheel of his wheelchair got off the curb and Resident #1 fell.

An interview on 3/23/21 at 11:30AM with NA #1 revealed she recalled Resident #1's family member was outside the facility when she was

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danger zone, addressed that violations should be reported to the Director of Nursing or Administrator immediately. The Director of Nursing, Assistant Director of nursing and Social worker informed all the residents on 3/25/21 that we are still in the process of our construction project on the facility grounds. We have contractors that are trying to complete the projects outside to help improve the drainage system as soon as possible. We have alerted your responsible part to please pay special attention to the marked off areas with caution tape and other danger zone signs for their safety. Due to the expansive construction projects at this time we will be temporarily suspending window visits but we can schedule outside and inside visitations with your families per the CMS guidelines. We are letting your families know about the visitation options and we are eager to provide you with an opportunity to visit with your loved one.

As a result of this portion of the facilities plan of correction the immediate jeopardy was removed on 3/26/2021.

What measures or systematic changes that will be put in place to assure the deficient practice will not recur:

On 3/25/2021, the Administrator and Maintenance Director did an exterior facility safety assessment to identify potential risk around the facility in or out of

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leaving at 3:00PM. NA #1 stated she let Resident #1 out the locked front entrance to an area between 2 doors as she was leaving for the day. She further stated the outer door didn't lock.

A subsequent interview with NA #1 on 3/24/21 at 2:50PM revealed she did not think it was a problem to leave Resident #1 because he was meeting his family member outside. NA #1 stated she did not think about the fact that Resident #1 could not physically get back into the building. NA #1 stated Resident #1 had his cell phone on him and the resident never went anywhere without his phone.

During an interview with Resident #1's family member on 3/23/21 at 12:00PM, she stated she had visited with Resident #1 on 3/7/21. She further stated she arrived at the facility around 2:50PM and visited for 15 minutes. The family member revealed Resident #1 came out the front door by himself to her car, which was parked along the side of the building, about midway down the sidewalk. She stated she had stopped to bring him water and snacks. She indicated there were no staff members outside during the time she visited with Resident #1. The family member expressed her concern that no one was there to assist Resident #1 in getting back into the building. She stated she had offered to assist Resident #1; however, he had declined, stating she was not permitted in the building. The family member stated when she left, Resident #1 was maneuvering his wheelchair toward the front entrance.

During a telephone interview with the facility's Medical Director (MD) on 3/30/21 at 12:30PM, he revealed Resident #1 had functional quadriplegia.

the construction zone. The facility assessment was updated on 3/25/2021 to reflect the assessment.

The Administrator or Maintenance Director conduct daily construction area audits. The audits will occur when any part of the facility or property is under construction

The Safety assessment completed by the Administrator and Maintenance Director on 3/25, and review of the 3/7 incident for Resident # 1, was reviewed on 3/25/2021 by the management team / Safety committee members for consideration of findings and recommendations. Root Cause Analysis education was provided to the Administrator and Director of Nurses by the District Director of Clinical Services on 3/25/21. This Root Cause Analysis education was conducted for the meeting members on 3/25/21 by the Administrator and Director of nurses. The meeting members on 3/25/2021 included the Maintenance Director, the Director of Nursing, Dietary Manager, Housekeeping / Laundry Director, Business Office Manager, MDS Coordinator, Central Supply and Medical Records Coordinator, Social Worker and the Administrator.

On 3/25/2021, all residents and their RP□s were informed of construction safety awareness and guidelines including recognition of danger zones and the requirement to stay out the construction areas as marked. On 3/26/2021 a surveyor visited the facility and through

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The MD stated Resident #1 had a fair amount of use of his arms as he was able to use his cell phone and to play video games. The MD stated he never saw Resident #1 outside other than in the designated smoking area. The MD stated Resident #1 required assistance from staff for all his care needs.

The EMS report dated 3/7/21 at 4:05PM, stated, "Resident found in isolation construction entrance in the gravel off the walkway, approximately 2 feet below the concrete walkway. The wheelchair was supported by blue Polyvinyl Chloride (PVC) pipe which was noted across right lower extremity. Left lower extremity was noted to be angulated backwards above the knee. Requested assist from Fire Department to safely remove wheelchair noted to be over 400lbs from patient. Visualized left leg, distal femur deformity, noted with crepitus, skin of lower extremity noted to be ashen in color. Resident was air-flighted to the hospital due to nature of injuries."

A telephone interview with EMS #1 on 3/23/21 at 2:22PM revealed the wheelchair was partially off the walkway resting partially on the Polyvinyl Chloride pipe and Resident #1's right lower extremity.

According to the hospital discharge summary record, Resident #1 was admitted on 3/7/21 with diagnoses that included closed nondisplaced spiral fracture of shaft of left tibia, closed displaced oblique fracture of shaft of left femur, and trauma. On 3/9/21, Resident #1 underwent an operative procedure which included an open treatment, fracture, femur, shaft, with retrograde intramedullary implant insertion, left retrograde femoral nail. The lower left fracture to the tibia

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document review, resident interviews and family phone calls validated that staff, resident and family education was completed on 3/25/2021

How the facility plans to monitor its performance to make sure that solutions are sustained:

The Construction Area Audit will be submitted to the QA/QAPI committee monthly for review for three months or at any time when any part of the facility or property is under construction

The updated Construction Safety Assessment will be submitted to the QA/QAPI committee monthly for three months or any time in the future if construction is occurring to any part of the facility or property. An ad-hock QAPI meeting will be conducted for any construction delays or changes to a construction plan.

The QA/QAPI committee will review and make recommendations to the Administrator as needed. Any new construction will be Audited for safety concerns in a similar way and findings reported to the QA/QAPI committee.

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was treated using a Rooke boot, a boot that provided complete offloading of the heel while naturally warming the limb. Resident #1 discharged on 3/12/21 from the hospital to the Nursing home. Discharge instructions included non-weight bearing lower left extremity for 12 weeks post-operatively, range of motion as tolerated, antibiotics and chemoprophylaxis for 6 weeks post-operatively.

An interview with the Administrator on 3/24/21 at 12:13PM revealed the facility had no policy regarding blocking off construction areas.
An interview with the Maintenance Manager on 3/23/21 at 11:23AM revealed the caution tape along the sidewalk had been blown away and not been replaced.

The Administrator was notified of Immediate Jeopardy on 3/25/21 at 10:20AM. On 3/26/21 at 11:42AM the facility provided the following credible allegation of Immediate Jeopardy removal.

The credible allegation of immediate jeopardy removal indicated:

Hertford Health and Rehabilitation IJ Abatement Plan

Hertford Health and Rehab IJ Credible Allegation for F 689 for removal of Immediate Jeopardy completed on March 25, 2021

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as result of noncompliance.

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Resident #1 was admitted on 1/10/19 with a diagnosis that included Quadriplegia, unspecified lack of coordination, muscle weakness and muscle spasms. On 3/7/21 a young boy rang the bell of the front entrance around 3:15 pm to alert the staff of a man that was turned over in his wheelchair on the facility grounds. The nurse immediately went to investigate and found resident #1 off the pavement, in the rocks with the wheelchair on top of him. 911 had already been dispatched by a passerby so EMT arrived onsite at 3:45 pm. With EMT and the Fire department assistance, they were able to safely remove the wheelchair and the resident was air flighted to the hospital where he was diagnosed with a fracture to the shaft of his left femur and a spiral fracture of the left tibia. The resident was admitted to the hospital where with orthopedic consultation underwent surgical procedures to repair the left leg fractures. He tolerated the procedures well and was readmitted to the facility on 3/12/21. The resident's care and services were provided post-operative in the facility as ordered and on 3/23/21, the resident was discharged by Transport services to live with his mother.

The facility failed to ensure that a construction area was visibly and adequately marked off as a danger zone and resident number 1 attempted to enter the 200-hall entrance since his room was just inside the door. The resident recognized that he was not going to be able to enter the 200-hall entrance and with an attempt to turn around his wheelchair, one wheel left the walkway and the wheelchair fell over on him.

Every resident that is on the outside premises has the potential to be affected.

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BRIAN CENTER HEALTH & REHAB/HERTFORD	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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Immediate action the Facility will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring.

The facility has developed a policy on 3/25/21 to ensure construction sites are properly marked to prevent access and ensure resident, staff and visitor safety. The maintenance workplace safety policy was amended to include the following: Make sure that construction sites or work areas are designated and properly marked as such to prevent access and to ensure safety. Construction areas or work sites must visibly and adequately be marked - as danger zones.

An Ad-hoc QAPI was held on 3/25/21 to review the policy with department managers and the Medical Director. The Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Unit managers will utilize this policy in the all staff education as it relates to construction. Families and residents are being educated regarding the construction sites or work areas are designated and properly marked as such to prevent access and to ensure safety. Construction area or work sites will be visibly and adequately marked off as danger zones.

VP of Quality and Customer experience, provided an in-service to the Administrator , Director of Nursing, the District Director of Operations and The District Director of clinical services on how to conduct root cause analysis so that effective interventions can be implemented to prevent reoccurrence on 3/25/21.

The facility Maintenance man and the Construction company have marked off the construction sites so that the areas are visibly

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and adequately marked off as danger zones on 3/25/21.

The social services director called the current residents' families on 3/25/21 to alert them of the continued construction on the grounds of the facility. The scripted conversation is as follows: The facility is calling to update you that we are still in the process of our construction project on the facility grounds. We have contractors that are trying to complete the projects outside to help improve the drainage system as soon as possible. When you come to the facility, please pay special attention to the marked off areas with caution tape and other danger zone signs for your safety. Due to the expansive construction projects at this time we will be temporarily suspending window visits, but we are committed to schedule indoor and outdoor visitation per CMS guidelines. Of course, visitation may change based on COVID cases, so when you call for a visit arrangement, we will discuss with you the options at the time. We appreciate your patience and support over the last year. Thank you in advance for paying close attention if you are on the premises for your safety. Please call the facility and ask to speak with our social worker, as we are eager for you to come and visit with us.

A letter was also mailed to the responsible parties regarding the construction projects and safety advise, and of the ability to schedule visits by calling the facility.

The Administrator, Director of nursing, Assistant Director of nursing started provided in-services to the current staff on 3/25/21. The in-service content is as follows:

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All staff have the responsibility to assist a resident as needed to exit the facility safely and remain in a safe location while outside of the facility. The facility will honor indoor and outdoor visitation per the CMS guidelines. No employee, Resident or resident Responsible Party / Visitor should enter any part of a construction area as identified by "Caution tape, signs, ropes, gates or cones. All construction areas are off limits to all employees accept those assigned duties within a construction area by the Administrator or designated corporate manager. All construction areas are off limits to Residents and any visitor they may have. The scope of the construction area is around the entire facility perimeter where there has been a French drain and a down spout for roof/water runoff. Due to installation of new drain lines, all of the resident room windows are inside the construction danger zone area. An employee who becomes aware of any kind of potential for a breach of the construction areas as identified by caution tape, signs, ropes, barriers or cones should intervein as needed to prevent any safety concerns and or violation to our policy. Any concerns of any violation of employees, residents or visitors not complying with this guideline / policy is responsible to report the concern/incident to the Director of Nursing or Administrator immediately.

The Director of Nursing, Assistant Director of nursing and Social worker informed all the residents on 3/25/21 that we are still in the process of our construction project on the facility grounds. We have contractors that are trying to complete the projects outside to help improve the drainage system as soon as possible. We have alerted your responsible part to please pay

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F 689	Continued From page 13 special attention to the marked off areas with caution tape and other danger zone signs for their safety. Due to the expansive construction projects at this time we will be temporarily suspending window visits but we can schedule outside and inside visitations with your families per the CMS guidelines .We are letting your families know about the visitation options and we are eager to provide you with an opportunity to visit with your loved one. The Facility alleges the removal of the immediate jeopardy on 3/26/2021. The credible allegation was verified on 3/27/21 at 11:00AM as evidenced by record review, observation, staff, resident, and responsible party interviews. Interviews were conducted with a sample of staff members to verify education was conducted for all employees regarding construction site safety, resident safety, and visitation during the construction. Interviews were conducted with a sample of residents to verify education was provided regarding on-going construction at the facility, to include construction site safety, supervision of residents when outside the facility, and visitation policy during the construction. Interviews were conducted with a sample of resident's responsible parties verified education was provided regarding construction site safety and visitation during the construction. The change in visitation affected window visits only which were temporarily suspended.	F 689		

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Observation of the construction site revealed all construction areas were marked with 'caution, danger zone' signage, caution tape, construction barriers and orange barrier walls.

Observation of notice posted inside the facility regarding construction sites.

Documentation of in-service records were reviewed.

Review of the letter sent to families and residents.

Review of the updated policy on Maintenance Workplace Safety Policy revised March 2021 revealed all construction sites and designated work areas were to be properly marked as such to prevent access and to ensure safety. These areas must visibly and adequately be marked off as danger zones.

Review of the QAPI Ad-Hoc Meeting and the Risk Assessment Tool revealed education of Administrative Staff and development of a Risk Assessment Tool.

All of the evidence indicated the facility had removed the immediate jeopardy by March 26, 2021.