STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

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F 000	INITIAL COMMENTS A Complaint investigation survey was conducted from 09/13/2021 through 09/22/2021. Event ID# ENV811. 1 of 28 complaint allegations was substantiated but did not result in a deficiency. 9 of 28 complaint allegations were substantiated resulting in deficiencies (F600, F626, F561 & F725). Immediate Jeopardy was identified at: CFR 483.12 at tag F 600 at a scope and severity (J) CFR 483.35 at tag F725 at a scope and severity (J) The tags F600 constituted Substandard Quality of Care. Immediate Jeopardy began on 08/08/2021 and was removed on 09/18/2021. A partial extended survey was conducted.	F 000		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and	F 561		10/19/21

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

Electronically Signed | 10/11/2021

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F 561	Continued From page 1 waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interview, the facility failed to honor a resident ' s choice to get out of bed each day for 1 of 20 residents sampled (Resident #9). Findings included: Resident #9 was admitted to the facility on 2/6/21 with heart failure. Resident #9 ' s care plan dated 8/12/21 documented he required assistance with all activities of daily living. The resident required transfer by mechanical lift. Resident #9 ' s quarterly Minimum Data Set dated 8/13/21 revealed the resident had an intact cognition. The resident was total dependence of 2 staff for transfer.	F 561	F 561 Self-Determination 1. Resident # 9 is a current resident of the facility and is receiving assistance out of bed at his request, confirmed by resident interview and record review, care plan updated to reflect this update in resident choice for care. 2. All residents who require assistance getting out of bed have potential to be effected. Social Services and Nursing Leadership will interview 100% of current interviewable residents by 10/19/2021 who require assistance to get out of bed to determine if their choice to get out of bed is honored routinely. 3. Education to be completed by	

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F 561	Continued From page 2 On 9/13/21 at 10:35 am an observation was done of Resident #9 in his bed. Nursing Assistant (NA) #1 entered the room and informed the resident she was still waiting for assistance from another NA to get the resident out of the bed. On 9/13/21 at 10:40 am an interview was conducted with Resident #9. He stated that transfer required 2 staff by the lift and there was frequently not enough staff to get him out of bed to his wheelchair. This problem had been going on for months because of the pandemic. On 9/13/21 at 10:50 am an interview was conducted with NA #1. She stated that Resident #9 required two staff to transfer him by lift device. There was only one NA assigned for each hall and all the NAs were busy providing morning and incontinence care. NA #1 stated that sometimes it was lunch before she could get Resident #9 out of the bed and other days there was no assistance, and the resident was not able to get out of bed. NA #1 stated that shortage of staff to provide 2-staff tasks were difficult. The NA had let the assigned nurse know she could not get Resident #9 out of bed several times. On 9/15/21 at 12:48 pm an interview was conducted with the Director of Nursing (DON). She stated that she was not aware Resident #9 was not able to get out of bed because there was not a second staff member to transfer by device. She said, "Residents should get out of bed each day as requested."	F 561	10/19/2021 by the Nursing Managers and Corporate Nurse for Licensed Nurses and Nurses Aids regarding Resident□s Rights, including their choice to determine when they wish to get out of bed. Education included alerting center leadership if there is a staffing situation that is impeding on honoring these choices. No staff shall work until the education has been received. This education will be included for all new hires. The Interdisciplinary Team (IDT, which includes the Admissions Director, Recreation Director, MDS Coordinator, Business Office Manager, Scheduler, Social Services, Human Resources Manager, Dietary Manager, Unit Managers, Medical Records and Central Supply) will complete Partner Rounds twice weekly for two weeks, and then once a week for four weeks. Partner Rounds to include all residents and all units. Results of Partner Rounds will be documented on the Partner Check-in Form. During their Partner Rounds the residents are interviewed regarding their choices and if they are honored. 4. Partner Round Check-in Forms are reviewed by the Administrator 2 x week. Any immediate concerns are brought to the Administrator and /or Director of Nursing to address. Results of these interviews are brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance.	

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F 561	Continued From page 3	F 561	5. Date of compliance: 10/19/21	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.	F 580		10/19/21

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F 580	Continued From page 4 (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interview of staff, residents, and the physician, the facility failed to inform the physician of one resident-to-resident altercation (Resident #2) and that there were resident concerns regarding Resident #2 ' s wandering behavior as a result of the resident ' s mental deterioration for 1 of 2 reportable episodes reviewed. Findings included: Resident #2 was admitted on 3/20/21 with diagnoses of metabolic encephalopathy and dementia. The quarterly Minimum Data Set dated 8/19/21 documented Resident #2 came from the hospital. The cognition was severely impaired. The behaviors were physical, verbal and toward self 1-3 days per week. Wandering was 4 to 6 days per week. The active diagnoses were medically complex, Alzheimer ' s disease with late onset, and non-Alzheimer ' s dementia. The resident	F 580	F 580 Notify of Changes 1. Resident # 2 no longer resides in the facility. 2. All residents who have behaviors have potential to be effected. Nursing leadership will complete an audit of all current residents with behaviors by 10/19/2021 to ensure that the Physician was made aware of their behaviors, and that the notification was documented in the resident□s record and care planned accordingly. 3. Education to be completed by 10/19/2021 by the Nursing Managers and Corporate Nurse for all licensed staff regarding requirement to notify the physician of residents changing conditions, to include ensuring that the physician is informed of residents with behaviors and changes in mental status. No staff shall work until the education has	

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F 580	Continued From page 5 received antipsychotic medication for 6 days. A nurses ' note dated 8/8/21 revealed Resident #2 was very agitated all morning, increasingly getting worse. Resident #2 going in other residents ' room (wandering) and taking others ' belongings, grabbing trash out of trash cans and throwing it all on the floor. Staff tried to calm resident down with no results. Resident #2 then went to a resident room doorway where Resident #18 was sitting, and he started jerking Resident #18 ' s wheelchair and tried to force her out of her room. Resident #18 began to yell, alerting staff to what was happening. Resident #2 then jerked resident #18 ' s arm. Nurse #1 was in the hallway as this was occurring and she tried to intervene and de-escalate the situation. Resident #2 then knocked the nurse backwards into the wall and onto the floor. At this point the Director of Nursing (DON) was notified as well as management. Emergency medical service (EMS) was called to transport Resident #2 to emergency room (ER). The hospital Emergency Room (ER) record dated 8/8/21 documented Resident #2 was sent to the ER for confusion and aggression. The resident had been awake for the past 24 hours believing his son was outside talking to him. "Short- and long-term memory deficit, anxious, delusional. Agitation due to dementia. Prescription Valium 2 mg three times a day as needed for anxiety/agitation. Return to facility with further physician care." The resident was not admitted and returned to the facility the next day. A review of Resident #2 ' s nursing notes from 8/8/21 to 9/13/21 did not reveal documentation that the physician was informed of the resident-to-resident altercation on 8/8/21.	F 580	been received. This education will be included for all new hires. The Nursing Leadership Team (Director of Nursing, Unit Managers, and the MDS Nurse) review the 24-hour report and nursing documentation daily for two weeks and then five times a week on-going in the Clinical Morning Meeting to determine if there were any resident behaviors and ensure that the physician has been notified accordingly. 4. The Director of Nursing is responsible for ensuring the Clinical Morning Review is conducted with appropriate follow up. The Director of Nursing shares the results of these reviews with the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of compliance: 10/19/21	

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F 580	Continued From page 6 On 9/13/2021 at 1:30 pm an interview was conducted with the Director of Nursing (DON). The DON stated that the first of two altercations of resident-to-resident on 8/8/21 with Resident #2 was not reported to the Medical Director because the DON was not aware the altercation was abuse (no further comment). The DON stated that she was aware of Resident #2 ' s wandering and that residents requested he be removed from their room. DON stated that there was no investigation of the altercation documented and it was not reported as a facility reported incident. On 9/14/21 at 10:55 am an interview was conducted with Nurse #1. Nurse #1 was present for the resident-to-resident altercation between Residents #18 and #2 on 8/8/21. Nurse #1 stated she informed the DON of the altercation and had not informed the resident ' s physician (who is also the Medical Director). On 9/14/21 at 2:30 an interview was conducted with the Medical Director (MD)[also the resident ' s physician]. The MD stated he was not informed of Resident #2 ' s first resident-to-resident altercation on 8/8/21. He was informed of the altercation on 8/30/21. The MD also stated that he was not informed that Resident #2 ' s wandering caused resident complaints/concern and affected resident privacy. The MD wanted to be informed and to have had the opportunity to discuss with the DON.	F 580		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation	F 600		10/19/21

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F 600	Continued From page 7 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: Based on observation, record review, and interview of staff, resident, and medical staff, the facility failed to protect residents ' right to be free from abuse (Residents #1 and #18) as evidenced by Resident #2 grabbed Resident #18 ' s arm and Resident #2 placed his arm around resident #1 ' s neck in a choke hold. Both altercations required staff to physically remove Resident #2 from both Resident #1 and Resident #18. Resident #1 sustained a neck injury. Both altercations resulted in Resident #2 being sent to an acute care setting for evaluation. This deficient practice affected 2 of 3 sampled residents reviewed for abuse. Immediate Jeopardy began on 8/8/2021 when Resident #2 abused Resident #18 and the facility did not put effective interventions in place to prevent further occurrences of abuse. Resident #2 ' s behavior continued through 8/30/21 when he abused Resident #1. Immediate jeopardy was removed on 9/18/2021 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of	F 600	F 600- Abuse 1. Resident # 1 no longer resides in the facility, so no further corrective action can be completed. Resident #2 was transferred to the hospital on 9/16/2021, since then, the family decided on alternative placement within a Memory Care Unit to which he has discharged to, so no further corrective action can be completed. Resident # 18 is currently residing in the facility and is free from abuse. Resident is alert and oriented and is interviewed twice per week by facility leadership to ensure that she is having no concerns. 2. All residents in the center have the potential to be affected. The Director of Nursing and Unit Managers completed skin checks for residents with BIMs 8 and under on 9/16/2021. No signs or symptoms of abuse were noted. Facility Social Worker completed safety	

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F 600	Continued From page 8 compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service and resident education. Findings included: Resident #2 was admitted on 3/20/21 with diagnoses of metabolic encephalopathy and dementia. The quarterly Minimum Data Set (MDS) dated 6/24/21 documented that the resident had a severely impaired cognition. There were physical and verbal behaviors 1-3 days per week. Wandering was blank. The resident received 6 doses of antipsychotic medication. A nurses ' note dated 7/13/21 documented behaviors were present. Resident #2 was noted wandering through building, entering rooms without permission of others. Resident #2 was redirected and given breakfast, but the wandering continued. Staff noted awareness and redirected back toward nurses ' station 1, when necessary. A nurses ' note dated 8/8/21 revealed Resident #2 was very agitated all morning, increasingly getting worse. Resident #2 went in other residents ' room and took others ' belongings, grabbed trash out of trash cans and threw it all on the floor. Staff tried to calm resident down with no results. Resident #2 then went to a resident room doorway where Resident #18 sat, and he started jerking Resident #18 ' s wheelchair and tried to force her out of her room. Resident #18 yelled and alerted staff to what was happening.	F 600	interviews with Residents with a BIMs 9 and above on 9/16/2021 to ensure residents felt safe in the Facility. No residents voiced concerns over their safety within the Facility. In addition, the Director of Nursing and Unit Managers completed an audit on 9/17/2021 of all nursing documentation within the last 30 days to ensure that any episodes of psychosis were care planned. 3. On 9/16/2021 education was completed with Center Leadership (Administrator and Director of Nursing) on OPS 300: Abuse Prohibition (Identification, Prevention, Reporting, and Investigating) by Senior Administrator. A Post Test was completed. On 9/16/21 education was initiated for all current staff to include FT, PT, PRN, and Agency Staff (Licensed Nurses, Nurses□ Aides, therapy, Dietary, Housekeeping, laundry, maintenance and department heads) on OPS 300: Abuse Prohibition by the Administrator, Director of Nursing, Nurse Practice Educator and Unit Managers. No staff shall work until Abuse Prohibition education has been received. This education will be included for all new hires. A Post Test was completed for all staff. Education to be completed by 10/19/2021 by the Nursing Leadership, Corporate Nurse, and Corporate Memory Support Coordinator, for Nursing Staff, on Resident Behaviors, Dementia training and de-escalation of behaviors.	

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F 600	Continued From page 9 Resident #2 then jerked Resident #18 ' s arm. Nurse #1 was in the hallway as this occurred and she tried to intervene and de-escalate the situation. Resident #2 then knocked Nurse #1 backwards into the wall and onto the floor. At this point the Director of Nursing (DON) was notified as well as management. Emergency medical service (EMS) was called to transport Resident #2 to emergency room (ER). Resident #18 was admitted to the facility on 8/23/19 with diagnoses of stroke. The quarterly MDS dated 8/27/21 documented adequate hearing, clear speech, understood/understands. Cognition was intact. On 9/13/21 at 4:15 pm, Resident #18 was interviewed. Resident #18 remembered when a male resident tried to get in her room. Resident #18 was sitting in her wheelchair in her room doorway blocking the entrance. The male resident (#2) was angry, grabbed her arm and shook her wheelchair. Resident #18 was scared, but not hurt. Since then, when the male resident had tried to get into her room again, she shut her door. On 9/14/21 at 10:55 am an interview was conducted with Nurse #1. Nurse #1 was present for the resident-to-resident altercation with Residents #18 and #2 on 8/8/21. Nurse #1 stated she observed Resident #2 standing over Resident #18 while she was sitting in her wheelchair at her room doorway. Resident #2 attempted to enter Resident #18 ' s room by yelling and shaking Resident #18 ' s wheelchair while she was sitting in it. Nurse #1 stated she tried to reorient Resident #2 and offered to assist him. Resident #2 thought his son was in	F 600	Facility implemented a shift-to-shift report which includes review of residents with new or worsening behaviors. All new or increasing behaviors will be discussed with physician notification and care planned as appropriate. Education to be completed by 10/19/2021 by the Nursing Leadership for all Licensed Staff on the new shift-to-shift report. 4. The Director of Nursing and Unit Managers will monitor nursing documentation daily for four weeks, weekly times four weeks, and monthly thereafter for new or increasing behaviors, and implementation of care plans. Any deviation from procedure will be addressed upon identification. The Administrator will report and investigate all allegations of abuse to authorities. The Clinical Quality Specialist will monitor daily for two weeks, weekly for four weeks, and monthly thereafter. All audit results will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of compliance: 10/19/21	

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F 600	Continued From page 10	F 600		

Resident #18 ' s room. Nurse #1 stated that her attempts to reorient and redirect the resident were not effective and he was still shaking the resident ' s wheelchair. Resident #2 pushed Nurse #1 to the floor. Other staff arrived to separate the two residents. Nurse #1 stated Resident #2 had a history of wandering throughout the building and taking things that do not belong to him. Resident #2 also wandered into other resident ' s rooms and would take items. Resident #2 ' s wandering was a current behavior. Nurse #1 stated that there was no 1:1 supervision for the resident or additional supervision when he came back (from the ER) 8/31/21.

On 9/13/21 at 11:00 am an interview was conducted with Nurse #5 who was assigned to Resident #2. Nurse #5 stated Resident #2 had a history of resident-to-resident abuse (physical). Nurse #5 was the assigned nurse on shift for the first incident (8/8/21) with Resident #18 about a month ago. Nurse #5 stated Resident #2 assaulted Resident #18 in the doorway of her room by grabbing her arm and shaking her wheelchair.

On 9/14/21 at 11:20 am an interview was conducted with Nurse #5 who was present on 8/8/21 for the resident-to-resident altercation. Nurse #5 stated she was on the hall where Resident #18 was sitting in her wheelchair in her room doorway. Resident #2 approached Resident #18 and grabbed her arm to pull her out of the way and then grabbed the wheelchair and began to shake it. Resident #18 placed her feet on the floor and pushed back to prevent the movement of her wheelchair. The wheelchair continued to shake but was not able to move

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from the doorway. Resident #2 attempted to gain access to Resident #18 ' s room. Nurse #1 was near and attempted to verbally redirect Resident #2 while he was still shaking Resident #18 ' s wheelchair with her in it. Resident #2 then pushed Nurse #1 to the floor. Additional staff arrived and the two residents were separated. The resident was known to wander in and out of the resident ' s rooms and takes their things and had assaulted staff. Nurse #5 had heard residents (including female) call out into the hall from their room to "get this man (Resident #2) out of my room, he does not belong here." Nurse #5 stated that Resident #2 ' s behavior escalated on 8/8/21 instead of accepting redirection and assaulted a staff member. Nurse #5 was concerned that if the staff had not intervened and attempted to redirect and remove the resident, Resident #18 could have been further assaulted and injured.

The hospital emergency room (ER) record dated 8/8/21 documented Resident #2 was sent to the ER for confusion and aggression. The resident had been awake for the past 24 hours believing his son was outside talking to him. The record indicated, "Short- and long-term memory deficit, anxious, delusional. Agitation due to dementia. Prescription Valium 2 mg (milligrams) three times a day as needed for anxiety/agitation. Return to facility with further physician care." Resident #18 was not admitted to the hospital and returned to the facility the next day.

On 9/13/2021 at 1:30 pm an interview was conducted with the DON. The DON stated she was aware that a staff member tried to intervene and separate the residents (Residents #2 and 18) and the staff member was pushed to the floor.

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The DON stated the facility does not have the staffing to provide 1:1 supervision of Resident #2 and increased level of care and supervision that the resident required.
A nurses' note dated 8/11/21 revealed, "Very agitated (Resident #2) at first of shift fussing with nursing assistant (NA). Resident #2 was redirected easily and sat in a chair at nursing desk most of shift. This note was written by Nurse #2.

A nurses' note dated 8/12/21 revealed "Resident #2 up and down all shift in and out of residents rooms. He was redirected but continued to go in residents ' rooms." This note was written by Nurse #2.

A nurses' note dated 8/14/21 revealed Resident #2 was observed exhibiting bizarre, disruptive behavior in the dayroom. Resident was observed moving chairs and tables around, the resident began to throw chairs and other stationary objects (dayroom is where the resident was placed to supervise, and other residents had access). This writer, Nurse #2, attempted to redirect residents ' behavior but was unsuccessful. There were no other residents present. Resident presented to be harmful to himself, the staff, and other residents. The on-call physician was contacted via telephone and made aware of the situation. An order was received to send the resident to the hospital for evaluation. Emergency medical service (EMS) arrived at the facility, spoke briefly with nursing and resident. The resident walked out of the facility with EMS refusing to sit on the stretcher. At 11:00 pm the resident returned to the facility via EMS. The resident arrived at the facility asleep on a stretcher. The ER physician stated that there

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were no abnormal findings with the resident. The resident was resting in bed with eyes closed, will continue to monitor for behaviors. This note was written by Nurse #2.

On 9/13/21 at 11:00 am an observation was done of Resident #2. The resident was sitting alone in his wheelchair in the common room behind the nurses ' station but was not a 1:1 supervision or increased supervision.

On 9/13/21 at 11:00 am an interview was conducted with Nurse #5 who was assigned to Resident #2. Nurse #5 stated Resident #2 was also known to wander into random resident ' s rooms and take their belongings and was throwing furniture in the unit dining room behind the nurses ' station. Nurse #5 stated that the facility had not made any changes to the resident ' s routine to prevent further assaults to other residents. The facility had tried to place the resident in another facility that had a locked dementia unit with increased level of care and no other facility would take the resident due to his behavior. Nurse #5 stated that the resident gets up on his own and tries to ambulate. The resident entered the other resident ' s rooms and was stopped and redirected by staff. Nurse #5 stated that she had informed the DON of the resident ' s behaviors and antipsychotic (Risperdal and Seroquel) medication refusal.

The quarterly MDS dated 8/19/21 documented Resident #2 came from the hospital. Cognition was severely impaired. There were physical and verbal behaviors 1-3 days per week. Wandering was 4 to 6 days per week. The active diagnoses included Alzheimer ' s disease with late onset, and non-Alzheimer ' s dementia. The resident

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received 6 doses of antipsychotic medication.

A nurses' note dated 8/27/21 revealed Resident #2 wandered throughout the night try to redirect several times and got agitated with staff. Continued to monitor. This note was written by Nurse #2.

A nurses' note dated 8/29/21 revealed Resident #2 was going in and out of other residents ' rooms bothering the resident in the first bed. The resident refused to come out of room stating, "This is my son, and you can't make me get out." Resident #2 became increasingly agitated and aggressive with staff. Resident held on to call light, pulled the call light from the wall and started wrapping it up in his hand. Resident #2 tore call light in two. Staff were able to safely remove Resident #2 from another resident ' s room and redirected him to his own room. This note was written by Nurse #4.

A nurses' note dated 8/29/21 revealed Resident #2 continued to be combative to staff and attempted to attack other residents. Difficult to redirect. Resident #2 refused all noon time meds. This note was written by Nurse #4.

Nurse #4 was attempted to be contacted for interview, but contact was unsuccessful.

On 9/14/21 at 12:55 pm an interview was conducted with Nurse #2 who was assigned to Resident #1 on 8/30/21 at the time of a resident-to-resident altercation at her medication cart. Resident #1 was sitting in her wheelchair at the medication cart and Nurse #2 took her blood for glucose testing. Resident #2 came over to Resident #1 and was mumbling something.

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Resident #2 thought Resident #1 was someone else and was confused. The two residents were arguing. Nurse #2 turned away to draw up insulin and heard Resident #1 yell. Nurse #2 turned back and observed Resident #2 with his arm around Resident #1 ' s neck. Nurse #2 called for help and Nurse #6 arrived and both staff removed Resident #2 ' s arm from around Resident #1 ' s neck. The residents were separated. Resident #2 was placed on 1:1 supervision until EMS and police arrived to take Resident #2 to the ER. Resident #1 complained of pain in her neck. Physician was notified and a neck x-ray was ordered.

Resident #1 was admitted to the facility on 2/6/21. Her quarterly MDS dated 7/6/21 documented adequate hearing, understood/understands and clear speech. She had no memory problems.

Resident #1 ' s statement dated 8/31/21 documented she was sitting in the hallway on 8/30/21 next to the medication cart getting her blood sugar checked. Resident #1 was choked by Resident #2. Nurse #2 and Nurse #6 had to get Resident #2 ' s arm off Resident #1 ' s neck. The nurses checked Resident #1 to make sure she was okay. Resident #2 was removed up the hall with the NA.

A radiology report dated 8/31/21 for Resident #1 resulted in a neck x-ray after injury of mild degenerative changes and straightening of the cervical spine. This could be due to muscle spasm, ligamentous injury, or simply positional. Advise was for cat scan or magnetic resonance imaging (pictures of inside the body) if clinical ambiguity remains. Cat scan or magnetic resonance imaging (outside of the facility) was

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not completed while the resident was in the facility.

Psychiatry note dated 8/30/21 documented by the psychiatric family nurse practitioner (FNP) "resident worsening agitation and aggressiveness. Resident will not take medications. Recommend inpatient admission for behaviors aggressiveness and combativeness are worsening. Unable to treat due to resident refusing medication and will more than likely require forced medication protocol that cannot be done in an outpatient environment. The FNP spoke to the social worker and administrator about the resident ' s behavior."

On 9/15/21 at 11:10 am an interview was conducted with FNP psych. FNP stated that she documented in her note that because of Resident #2 ' s behavior, diagnoses and what staff has documented regarding the resident ' s behavior, the resident was recommended to be placed at a facility that can provide forced medication.

Summary of investigation submitted with the 5-day report for resident-to-resident altercation dated 8/30/21 documented that Resident #2 placed his arm around the neck of Resident #1 and choked her. Two staff separated the residents in altercation. Resident #1 was assessed for injury and received a neck x-ray. Resident #2 had a history of dementia with behavioral disturbances.

Hospital Emergency Department (ED) record dated 8/30/21 documented Resident #2 was sent from the facility to be evaluated for altercation with another resident (#1) and behaviors/acting out. Medical exam was negative. "History of

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acute mental changes, unknown cause. Cat scan (xray) of the head revealed report for no acute abnormality. Moderate to severe apparent old ischemic white matter disease. Medication administered intramuscular (IM): Ativan 1 mg (anxiety) 8:19 pm; Seroquel (antipsychotic)100 mg by mouth (PO) 10:39 pm; and Ativan 1 mg IM 10:39 pm. On 8/31/21 at 8:15 am Ativan 1 mg IM was administered and at 8:35 am Ativan 1 mg IM was given. Neurological assessment revealed he was disoriented x 4. Poor judgement, attention/concentration, short term memory loss, poor safety awareness, and restlessness. Normal motor response. Resident was admitted to a room for observation for 24 hours. Dementia with behavioral disturbance, unspecified dementia type: new and requires workup. Diagnosis management comments: Resident pleasantly demented, but later became agitated wanting to go home when he was to have CT scan or lab work. He was still upset and was given Seroquel with improvement of symptoms. CT scan resulted atrophy (of the brain). The resident did not have an abnormal gait. The resident likely had an episode of behavioral outburst secondary to worsening dementia. The resident was clinically stable for discharge back to the facility. Seroquel 50 mg at bedtime for agitation prescription provided for as needed. Recommend physician follow-up and assess for medication adjustments." The resident was not admitted and returned the next morning.

A review of the nurses ' notes from 8/8/21 through 9/13/21 documented that the resident frequently refused his medication or spit them out (documented as refusal).

A review of Resident #2 ' s medication

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administration record (MAR) for August 2021 revealed documentation of the following:

Sertraline HCL (hydrochloride) (antidepressant) 10 mg (milligram) ordered for 8 days was refused 4 times from 8/16/21- 8/23/21.

Sertraline HCL 10 mg ordered twice a day was refused 11 times from 8/1/21 - 8/24/21.

Namenda 10 mg (for anxiety) twice a day was refused on 12 occasions and 2 doses had no documentation from 8/1/21- 8/30/21.

Valium 2 mg (for anxiety) every 8 hours as needed 14 days for agitation. There was no documentation of administration.

Resident #2 ' s behavior was documented on each of 3 shifts for 30 days and had 16 occurrences of behavior and 6 shift assessments had no documentation.

Seroquel 50 mg (antipsychotic) every 24 hours as needed for agitation at bedtime for 14 days was documented as started on 8/31/21. There was no documentation as given.

Risperidone 0.25 mg (antipsychotic) twice a day mix with liquid of choice was refused on 8 occasions and no documentation on 2 occasions for time period 8/1/21 - 8/24/21. The medication was changed to in the evening only and scheduled for 8/24/21 - 8/30/31 received 6 of 8 doses.

Risperidone 0.25 mg liquid mix with drink of choice each morning for time period 8/25/21 - 8/30/21 administered all days (6).

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The facility physician adjusted medications as follows: Physician order dated 9/2/21 and again on 9/8/21 Seroquel 5 ml (1 mg = 1 ml) each morning in drink of choice.

Physician order dated 9/7/21 Seroquel 5 ml (milliliter) each evening in any drink. Physician order dated 9/7/21 Seroquel 50 mg every 12 hours as needed for psychosis/agitation for 14 days.

A review of Resident #2 ' s MAR for September 2021 documented the following:

Namenda 10 mg twice a day for anxiety. There were 5 refusals and there were 4 times Resident #2 was sleeping and none given. The timeframe was 9/1/21 - 9/16/21.

Seroquel 50 mg every 24 hours for 14 days as needed for agitation. None were documented as given. The timeframe was 8/31/21 - 9/3/21.

Seroquel 50 mg every 12 hours for 14 days as needed for agitation documented with 2 doses, given on 9/5/21 and 9/6/21. The timeframe was 9/3/21 - 9/7/21.

Seroquel 50 mg every 12 hours for 14 days as needed for agitation/psychosis. None were documented as given out of 14 days. The timeframe was 9/7/21 - 9/21/21.

Risperidone 1 mg/ml give 0.5 ml in the evening mix with drink of choice. Documented the resident refused on 9/1/21 and was discontinued.

Risperidone 1mg/ml give 0.5 ml in the morning

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mix with drink of choice for time period 9/3/21 - 9/16/21. The resident refused 1 dose out of 11.

Risperidone 1 mg/ml give 0.5 ml in evening mix with drink of choice for time period 9/2/21 - 9/13/21. The resident refused 1 dose and 2 not given resident was sleeping out of 11.

The resident was monitored each shift for behavior and wandering episodes from 9/1/21 - 9/12/21 and had documented behaviors on 5 occasions. Behaviors were documented for day shift 9/1 and 9/10/21, evening shift 9/1 and 9/12/21, and night shift 9/1/21.

On 9/13/2021 at 1:30 pm an interview was conducted with the DON. The DON stated she had been seeking placement for Resident #2 at three other facilities with a locked unit on 8/31/21 (2) and 9/6/21 (1) but had not been successful (no available bed). The DON stated that the resident does wander in the halls and sometimes entered a resident ' s room and must be removed/ redirected. The resident was being observed in the hall dining room and had no 1:1 supervision. The DON was aware that the resident had refused and spat out his psychotropic and antipsychotic medication prescribed for his behaviors during the month of August 2021 and that the psychiatric FNP recommended the resident have forced medication administration that could not be provided in the facility and would need to be transferred on 9/30/21.

On 9/14/2021 at 3:20 pm an interview was conducted with the Medical Director (MD). The MD stated that he was aware of the second (Resident #1) resident-to-resident altercation by

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Resident #2 but not the first altercation (Resident #18) until yesterday when he spoke to the DON. The MD was aware the resident was not taking his medication. The MD was aware that the resident entered other residents ' rooms, but not that there were resident complaints of unwanted entry until now. The MD stated that he had not committed the resident because he was concerned that they would just send him back. The MD stated that there was nowhere to send the resident to meet his needs. The facility cannot force medication. The resident would have a better quality of life if he was receiving his medication. The MD stated that interventions were needed to protect the other residents from harm. The MD stated that he would work with the DON to order intramuscular and sublingual medication to improve medication compliance and send the resident out to the ED when behaviors begin to escalate and not try to manage at the facility.

On 9/15/21 at 9:15 am an interview with the DON was conducted. The DON went to the County Court before the Magistrate for involuntary commitment on 9/15/21 with comprehensive documentation and two physician letters. Magistrate stated "I have seen this for years, you should be able to handle the resident in your facility, denied. The resident will just wind up returning to the facility." The DON stated that she does not have the staff to continue with 1:1 supervision.

On 9/15/21 at 10:05 am interview with the DON was conducted. She stated that a referral was sent to a psychiatric facility on 9/15/21. A second psychiatric facility also declined the resident on 9/15/21 due to county boundaries of where they

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will accept.
The Administrator was notified of immediate jeopardy on 9/16/21 at 2:03 pm.

Facility respectfully submits the below allegation of Immediate Jeopardy removal for F600.

? Identify those residents who have suffered, or are likely to suffer a serious adverse outcome as a result of the noncompliance:

On 8/8/2021, Resident #2 grabbed Resident #18 ' s wheelchair and arm that was unwanted and unexpected. Center Staff immediately separated residents. Center Staff immediately sent Resident #2 out for evaluation. Upon Resident #2 ' s return to the Center, he was evaluated Psych Services and a medication review was completed. On 8/30/2021, Resident #2 placed his arm around Resident #1 ' s neck. Center Staff immediately separated residents. Center Staff immediately placed Resident #2 on one-on-one supervision until Resident #2 was sent out for evaluation. Upon Resident #2 ' s return to the Center, he was evaluated Psych Services and a medication review was completed.

Once the current Center Executive Director was notified on 9/14/2021 of the altercations, he immediately placed the resident on one-on-one supervision. Resident #2 remained on one-on-one supervision until resident #2 was sent to the emergency room for an unrelated medical condition on 9/16/2021 where he remains.

Resident #1 was immediately assessed by the nursing staff for injuries following the incident on 8/30/2021. Approximately thirty minutes later,

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Resident #1 had complaints of pain. As a result, the Physician was notified and an X-Ray was ordered. Results of the X-Ray on 8/30/2021 were inconclusive for injury (X-Ray did show degenerative changes, but no fracture was identified) and the Physician ordered an MRI due to the Resident ' s inability to cooperate with the lateral view of the X-Ray. Resident #1 discharged from the facility against medical advice prior to the completion of the MRI.

Resident #18 was immediately assessed by nursing staff on 8/8/2021 for any injuries with none noted. Resident remains at the Center at this time. Safety interviews were completed with Resident #18 on 8/9/2021, 8/30/2021, and 9/16/2021 in which the Resident stated she felt safe and had not been harmed by a staff or resident. Physician advised the nursing staff to continue to monitor Resident #18 for any changes and to notify Physician if changes occurred. Resident #18 has been evaluated by a Physician on 8/24/2021 with no change since last physician visit or acute findings noted, with no new orders received.

All residents in the center have the potential to be affected. Center Nurse Executive and Unit Managers completed skin checks for residents with BIMs 8 and under on 9/16/2021. No signs or symptoms of abuse were noted. Center Social Worker completed safety interviews with Residents with a BIMs 9 and above on 9/16/2021 to ensure residents felt safe in the Center. No residents voiced concerns over their safety within the Center. In addition, the Center Nurse Executive and Unit Managers completed an audit by 9/17/2021 of all nursing documentation within the last 30 days to ensure that any episodes of

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F 600	Continued From page 24	F 600		

psychosis were care planned.

? Specify action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when action will be complete:

Upon Resident #2 ' s return to the Center, Resident #2 will be placed on one-on-one supervision until Resident #2 is safely transferred to another location which specializes in behavioral management.

On 9/16/2021 education was completed with Center Leadership (Center Executive Director and Center Nurse Executive) on Genesis Abuse Prohibition Policy (Identification, Prevention, Reporting, and investigating) by Senior Executive Director. A Post Test was completed. Prevention strategies to include utilization of additional agency staff and utilizing staff from sister-Centers to meet sufficient numbers of staff to implement any additional supervision needed.

On 9/16/21 education was initiated for all current staff to include Full Time, Part Time, Per Diem, and Agency Staff (Licensed Nurses, Nurses ' Aides, therapy, Dietary, Housekeeping, laundry, maintenance and department heads) on Genesis Abuse Prohibition Policy by the Center Executive Director, Center Nurse Executive, Nurse Practice Educator and Unit Managers. No staff shall work until Abuse Prohibition education has been received. This education will be included for all new hires. A Post Test was completed for all staff. Prevention strategies to include utilization of additional agency staff and utilizing staff from sister-Centers to meet sufficient numbers of staff to implement any additional supervision needed.

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F 600	Continued From page 25	F 600		

Education to be completed for all staff by 9/17/2021.

Center instituted on 9/16/2021, in addition to the shift-to-shift report already being completed, residents with new or worsening behaviors that possibly could threaten the safety or be an allegation of abuse are evaluated. All new or increasing behaviors and allegations of abuse will be discussed with physician notification and care planned as appropriate. Update to process was communicated to all Licensed Nurses on shift-to-shift report including new or worsening behaviors, up and to include allegations of abuse. Center Nurse Executive is responsible for implementation and monitoring.

The Center Nurse Executive and Unit Managers will monitor nursing documentation for all residents daily for two weeks, weekly times four weeks, and monthly thereafter for new or increasing behaviors, and implementation of care plans. Any deviation from procedure will be addressed upon identification, reviewed with the Clinical Team (Center Nurse Executive, Nurse Practice Educator, and Unit Managers) and referred to the Physician for additional guidance. All residents ' progress notes will be reviewed as specified and the review documented on the Morning Clinical Meeting Sheet.

The Center Executive Director will report and investigate all allegations of abuse to authorities.

Alleged date Immediate Jeopardy was removed, 9/18/2021. Center Executive Director is responsible for the implementation of this plan.

The credible allegation was validated on 9/22/21.

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F 600	Continued From page 26 Interviews were conducted to confirm abuse/neglect education was provided. On 9/20/21, a review of two in-services ' documentation for abuse and neglect was done. The in-service education completed on 9/16/21 included wandering. Oriented residents were interviewed, and audits documented that no residents had concerns for abuse or general concerns completed by 9/18/21. On 9/22/21 at 11:45 am an interview was conducted with alert and oriented residents, individually, to determine if facility staff interviewed them regarding abuse/neglect, residents wandering into their room, and to whom to report concerns. The residents recalled being interviewed this past week regarding abuse and/or resident wandering. On 9/22/21 at 12:10 pm an interview was conducted with the Administrator. The Administrator stated that staff was hired 9/16/21 and provided 1:1 supervision of Resident #2. The resident was currently in the hospital from an unrelated cause and supervision would be initiated upon return until placement in a facility that could meet his needs. Staff in-service had been completed for abuse and resident wandering. The immediate jeopardy was removed on 9/18/21.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse,	F 609		10/25/21

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F 609	Continued From page 27 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 abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview of staff and resident, the facility failed to report allegations of resident to resident abuse to the State agency for 1 of 2 allegations of abuse reviewed (Resident #2). Findings included: Resident #2 was admitted on 3/20/21 with diagnoses of metabolic encephalopathy and	F 609	F 609 - Reporting of Alleged Violations 1. Resident # 2 no longer resides in the facility. The Center did not report the event to the state for the incident on 8/8/2021, on 10/25/2021 the Center has submitted the report for the event. Resident #2 was transferred to the hospital on 9/16/2021, since then, the family decided on alternative placement	

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F 609	Continued From page 28 dementia. The quarterly Minimum Data Set (MDS) dated 6/24/21 documented that the resident had a severely impaired cognition. There were physical and verbal behaviors 1-3 days per week. Wandering was blank. A nurses ' note dated 8/8/21 revealed Resident #2 went to a resident room doorway where Resident #18 was sitting, and he started jerking Resident #18 ' s wheelchair and tried to force her out of her room. Resident #18 began to yell, alerting staff to what was happening. Resident #2 then jerked resident #18 ' s arm. This note indicated that Nurse #1 was in the hallway as this was occurring and she tried to intervene and deescalate the situation. Resident #2 then knocked the nurse backwards into the wall and onto the floor. At this point the Director of Nursing (DON) was notified as well as management. Emergency medical service (EMS) was called to transport Resident #2 to the emergency room (ER). Review of the facility ' s 24-hour and 5-day investigation reports for the months of August and September 2021 revealed no reports were documented/filed regarding the incident with Resident #2 and Resident #18 on 8/8/21. On 9/14/21 at 11:20 am an interview was conducted with Nurse #5 who was present on 8/8/21 for the resident-to-resident altercation between Resident #2 and Resident #18. Nurse #5 stated she was on the hall where Resident #18 was sitting in her wheelchair in her room doorway. Resident #2 approached Resident #18 and grabbed her arm to pull her out of the way	F 609	within a Memory Care Unit to which he has discharged to, so no further corrective action can be completed. Resident # 18 is currently residing in the facility and is free from abuse. Resident is alert and oriented and is interviewed twice per week by facility leadership to ensure that she is having no concerns. 2. All residents in the center have the potential to be affected. Director of Nursing and Unit Managers completed skin checks for residents with BIMs 8 and under on 9/16/2021. No signs or symptoms of abuse were noted. Facility Social Worker completed safety interviews with Residents with a BIMs 9 and above on 9/16/2021 to ensure residents felt safe in the Facility. No residents voiced concerns over their safety within the Facility. These audits were completed to ensure that no other allegations or instances of abuse violations had occurred that required reporting. No additional areas were identified. 3. Education was completed for the Administrator and Director of Nursing by the Corporate Nurse regarding reporting requirements. This education included required reporting of Resident to Resident events. Education was provided to all current staff, including agency staff regarding identifying and reporting requirements of abuse. No staff shall work until the education has been received. This education will be included for all new hires.	

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F 609	Continued From page 29 and then grabbed the wheelchair and began to shake it. Resident #18 placed her feet on the floor and pushed back to prevent the movement of her wheelchair. The wheelchair continued to shake but was not able to move from the doorway. Resident #2 attempted to gain access to Resident #18 ' s room. Nurse #1 was near and attempted to verbally redirect Resident #2 while he was still shaking Resident #18 ' s wheelchair with her in it. Resident #2 then pushed Nurse #1 to the floor. Additional staff arrived and the two residents were separated. On 9/13/2021 at 1:30 pm an interview was conducted with the Director of Nursing (DON). The 8/8/21 resident to resident altercation involving Resident #2 and Resident #18 was reviewed with the DON. She stated that since Resident #2 did not "touch" Resident #18, the altercation was not abuse, was not investigated, and was not reported to the state. The DON was informed that only the wheelchair was shaken not that the arm was grabbed. The DON stated that she reported allegations of abuse to the state authority, "I report everything."	F 609	The Nursing Leadership Team (Director of Nursing, Unit Managers, MDS Nurse) review the 24-hour report and nursing documentation in the Clinical Morning Meeting to determine if there were any resident behaviors and ensure that self-reporting is initiated as indicated. The Interdisciplinary Team (IDT, which includes the Admissions Director, Recreation Director, MDS Coordinator, Business Office Manager, Scheduler, Social Services, Human Resources Manager, Dietary Manager, Unit Managers, Medical Records and Central Supply) complete Partner Rounds twice weekly. During their Partner Rounds the residents are interviewed regarding and concerns. The Administrator reviews all Partner Rounds to ensure no concerns rise to the level of an abuse allegation. 4. The Administrator and/or Director of Nursing will report and investigate all allegations of abuse to authorities. The Clinical Quality Specialist will monitor all reported allegations of abuse for proper reporting daily for two weeks, weekly for four weeks, and monthly thereafter. All audit results will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of compliance: 10/25/21	

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F 626 SS=E	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by:	F 626		10/19/21

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F 626	Continued From page 31 Based on record review, review of facility's policy on admission, transfer and discharge, and interview with the hospital and facility staff, the facility failed to permit a resident to return to the facility after hospitalization for 1 of 3 sampled residents reviewed for admissions and discharges (Resident #8). Findings included: The facility's policy on discharge, and transfer with the revision date on 2/1/19 was reviewed. The policy did not address permitting residents to return to the facility after hospitalization. Resident #8 was admitted to the facility on 4/23/21 with multiple diagnoses including injury at cervical spine cord and paralysis of all limbs. Resident #8 has doctor's orders dated 4/23/21 for tracheostomy care every day and evening shift and as needed and for tracheostomy suctioning as needed for increase secretions. The nurse's note dated 4/23/21 at 5:41 PM revealed that Resident #8 was alert and oriented to person, time, place, and self. The note further indicated that the resident was very time consuming and demanding to have a deep suction often. The nurse's note dated 4/24/21 at 2:29 AM revealed that Resident #8 has been very demanding and continually on call light. The resident kept stating that he could not breath and needed to be suctioned. He was suctioned couple of times, but the resident wanted it done every 10 to 15 minutes. It was explained to him that suctioning too much would irritate and cause	F 626	F 626 Permitting Residents to Return to the Facility 1. Resident # 8 no longer resides in the facility, so no further corrective action can be completed. 2. All residents who are discharged to the hospital have potential to be effected. Admissions Director will complete an audit by 10/19/2021 of all hospital transfers for the last 30 days to determine if they had been readmitted to the facility. 3. Education completed on 10/12/2021 by the Corporate Nurse with the Administrator, Director of Nursing, Social Service Director and Admissions Coordinator regarding requirement to permit a resident to return to facility after hospitalization. Education also included close review of potential admissions to ensure that they meet Genesis Admission Criteria and the Facility is capable of managing their needs prior to admission acceptance. 4. Director of Nursing or Social Services will review all residents who are transferred to the hospital to ensure appropriate return to the facility. This review will include that the facility is able to meet the resident needs upon return and that they are medically and/or mentally stable prior to discharge from hospital setting. The review will be completed daily for two weeks and then five times a week for four weeks. Results of these reviews will be reviewed by the	

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F 626	Continued From page 32	F 626		

bleeding. Resident was breathing normal with no distress. The note further indicated that the resident was sent to the hospital per his request at 3 AM.

The nurse's note dated 4/24/21 at 6:35 AM revealed that Resident #8 returned to the facility on 4/24/21 at 6:30 AM.

The nurse's note dated 4/28/21 at 8:35 AM revealed that the third shift nurse reported that Resident #8 had been calling all night to be suctioned. He called 911 around 7 AM or so requesting to be transported to the hospital. Resident #8 was sent to the emergency room via ambulance this morning.

The nurse's note dated 4/28/21 at 3:18 PM revealed that Resident #8 returned to the facility at 11:05 AM with no new orders. Resident called and wanted to be suctioned. Resident's oxygen saturation was 98% on room air. Resident was very anxious, wanted the nurse to stay with him, scared and did not want to be at the facility. He indicated that he wanted to be sent out to another hospital in wake county. The Social Worker (SW) and Director of Nursing (DON) were in to speak with the resident. He was suctioned numerous times per his request. Resident #8 continued to state that he didn't want to stay at the facility and wanted to be sent out to the hospital in wake county. The doctor was informed and ordered to send the resident to the hospital per his request. Resident was sent via non-emergency transport in stable condition. This note was written by Nurse #7.

The note dated 4/29/21 at 8:35 AM revealed that the Administrator spoke with the case worker at

Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance.

5. Date of compliance: 10/19/21

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F 626	Continued From page 33	F 626		

the wake county hospital. The case worker indicated that Resident #8 stated that he would come "back to the center and figure something else out". The Administrator reviewed with the case worker the concerns the facility had with Resident #8 (specifically calling 911, stating he did not feel safe at the center, the requests for suctioning multiple times per hour, requests to be closer to home as he was confused why he was so far from his family, and other behaviors) and that the facility also informed the hospital that their clinical acceptance criteria for admission is allowing to only suction twice per 8 hour shift which they were aware of prior to admittance from their facility.

The note dated 4/29/21 at 9:25 AM revealed the DON had received a phone call from the case worker at wake county hospital this am, DON and Administrator were present during the call. The case worker informed them that the hospital wished to discharge Resident #8 to the facility. The Administrator and the DON had discussed the events leading up to resident's discharge on 4/28/21 and informed them that because the facility cannot meet the resident's physical and mental needs per his statements, we are unable to accept the resident at this time. We offered him assistance in finding appropriate placement, as we have been in contact with the Ombudsman previously for this resident, who was already looking into closer placement to his family in Raleigh and this offer was declined.

The hospital Case Worker at wake county hospital was interviewed on 9/14/21 at 11:00 AM. The Case Worker indicated that she had called the facility on 4/28/21 and talked to the DON. She informed the DON that Resident #8 was

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ready for discharge and Resident #8 was willing to return to the facility. The DON stated that the facility was unable to readmit Resident #8 since the facility was unable to meet his needs/desires. The Case Worker further reported that another case worker had also called the facility and talked to the Administrator and DON who refused to readmit the resident based on his behavior. The Case Worker reported that Resident #8 was still at the hospital.

The DON was interviewed on 9/14/21 at 11:35 AM. The DON verified that she had talked with the case worker at the wake county hospital. She confirmed that it was her and the Administrator's decision not to readmit Resident #8 back to the facility since the facility was unable to meet resident's needs, he had been calling 911 and demanding to be suctioned 8-10 times per hour.

Nurse # 7 was interviewed on 9/14/21 at 12:43 PM. She stated that she was assigned to Resident #8 on 4/28/21. The resident had been requesting to be suctioned so often, claiming that he was short of breath. He was very anxious that day and wanted to be sent out to the hospital in wake county. He refused to go to the hospital in Randolph county. The doctor was informed, and he ordered to send the resident out per his request.

The Administrator was interviewed on 9/14/21 at 1:08 PM. He reported that he just started as Administrator of the facility on 9/8/21. He stated that he looked and was unable to find any policy that address permitting residents to return to facility after hospitalization. The Administrator stated that his expectation was to permit resident to return to the facility if the facility can meet the

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F 626	Continued From page 35 resident's needs.	F 626		
F 725 SS=J	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: Based on observation, record review, resident and staff interview, the facility failed to have sufficient nursing staff to supervise a confused ambulatory resident (Resident #2) which resulted in two resident-to-resident altercations (Resident	F 725	F 725 □ Sufficient Nursing Staff 1. Resident # 2 no longer resides in the facility. Resident # 9 is a current resident of the facility and is receiving assistance	10/19/21

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F 725	Continued From page 36 #18 and #1) on 8/8/21 and 8/30/21 with injury to Resident #1, and failed to provide staff assistance to get a resident out of bed daily (Resident #9) for 3 of 20 residents sampled. Immediate Jeopardy began on 8/8/2021 when Resident #2 abused Resident #18 and the facility did not put effective interventions in place to prevent further occurrences of abuse. Immediate Jeopardy was removed on 9/18/2021 when the facility implemented a credible allegation of Immediate Jeopardy removal. Example 2 will remain out of compliance at severity level of E (no actual harm with a potential for minimal harm that is not Immediate Jeopardy). The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service. Findings included: Cross Referred to tag: F600: Based on observation, record review, and interview of staff, resident, and medical staff, the facility failed to protect residents ' right to be free from abuse (Residents #1 and #18) as evidenced by Resident #2 grabbed Resident #18 ' s arm and Resident #2 placed his arm around resident #1 ' s neck in a choke hold. Both altercations required staff to physically remove Resident #2 from both Resident #1 and Resident #18. Resident #1 sustained a neck injury. Both altercations resulted in Resident #2 being sent to an acute care setting for evaluation. This deficient practice affected 2 of 3 sampled residents reviewed for abuse.	F 725	out of bed at his request, confirmed by resident interview and record review, care plan updated to reflect this update in resident choice for care. 2. All residents in the facility have the potential to be affected. Nursing Leadership completed an audit of current residents with behaviors to ensure that staffing levels were meeting the needs to appropriately supervise residents. Social Services and Nursing Leadership interviewed 100% of current residents who require assistance to get out of bed to determine if their choice to get out of bed is honored routinely. 3. On 9/16/2021, education was completed with the Scheduler and Director of Nursing on Sufficient Nursing Staff by the Administrator. Education included maintaining adequate staffing levels to provide care and supervision that meet every resident's needs. On 9/16/2021 Education was initiated for all current clinical staff to include FT, PT, PRN, and Agency Staff (Licensed Nurses, Nurses□ Aides, Therapy) on ensuring that resident needs are being met by the Administrator, Director of Nursing, Nurse Practice Educator and Unit Managers. Education included ensuring the needs of all residents are met and notification to the Administrator and/or Director of Nursing regarding any potential staffing concerns and/or resident needs. No staff shall work until this education is received. This education will be included for all new	

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F 725	Continued From page 37 The Administrator was notified of the immediate jeopardy on 9/16/2021 at 2:03 pm. On 9/18/2021 the facility provided an acceptable credible allegation for immediate jeopardy removal that included the following: Facility respectfully submits the below allegation of Immediate Jeopardy Removal Plan for F725 ? Identify those residents who have suffered, or are likely to suffer a serious adverse outcome as a result of the noncompliance: The current Center Executive Director was notified on 9/14/2021 of Resident #2 ' s unwanted entry into other Resident rooms and two physical resident-to-resident altercations. The Center Executive Director immediately placed Resident #2 on one-on-one supervision. Resident remained on one-on-one supervision until the resident was sent to the emergency room for an unrelated medical condition on 9/16/2021 where he remains. All residents in the Center have the potential to be affected. Center Nurse Executive and Unit Managers completed an audit on 9/17/2021 of all nursing documentation for the past thirty days to ensure that staffing levels were adequate to provide care and supervision that meet every resident's needs. Upon review of the documentation, no other resident incidents requiring additional staffing coverage were identified. ? Specify action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and	F 725	hires. The Administrator will meet with the Director of Nursing, The Workforce Manager, and Scheduler daily (Monday-Friday) to ensure sufficient staffing to meet the needs of the residents. 4. Director of Nursing and Unit Managers will monitor nursing documentation and shift-to-shift reports daily for two weeks, weekly times four weeks, and monthly thereafter to ensure that all residents' needs are met. Director of Nursing will report to the Administrator any concerns identified. Upon identification of staffing concerns, the Administrator will evaluate the schedule and adjust accordingly to ensure that resident needs are being met. All audit results will be brought before Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance 10/19/21	

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when action will be complete:

On 9/16/2021, education was completed with the Center Scheduler and Center Nurse Executive on Sufficient Nursing Staff by the Center Executive Director. Education to include maintaining adequate staffing levels to provide care and supervision that meet every resident's needs.

When the need for staff is identified, increased agency requisitions are fulfilled to fit the Center ' s current need. Additionally, the Center utilizes local sister-Centers to provide staffing support as needed. The Center has the capability to place a hold on admissions based on staffing needs of the Center. Center implemented nursing on-call program effective 9/17/2021. Facility Assessment will be reviewed by the Quality Assurance and Performance Improvement Committee on 9/17/2021 through an Ad-hoc QAPI Meeting and monthly thereafter as part of the QAPI Meeting schedule.

On 9/16/2021 Education was initiated for all current clinical staff to include Full Time, Part Time, Per Diem, and Agency Staff (Licensed Nurses, Nurses ' Aides, Therapy) on ensuring that resident needs are being met according to the numbers of staff needed to implement the care plan and prevent abuse by the Center Executive Director, Center Nurse Executive, Nurse Practice Educator and Unit Managers. Education to include ensuring the needs of all residents are met and notification to Center Executive Director and/or Center Nurse Executive regarding any potential staffing concerns and/or resident needs. No staff shall work until this education is received. This education will be included for all new hires.

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The Center Executive Director will meet five days a week and every Friday to include weekend coverage review beginning 9/17/2021 with the Center Nurse Executive, Center Workforce Manager, and Center Scheduler to ensure adequate staff levels daily for two weeks, weekly times four weeks, and monthly thereafter to ensure sufficient staffing to meet the needs of the residents.

Alleged date Immediate Jeopardy was removed, 9/18/2021. Center Executive Director is responsible for the implementation of this plan.

Credible allegation was validated on 9/22/21:

On 9/22/21 a review of morning meetings for census and acuity to determine staffing levels for staffing documentation was done.

On 9/22/21 at 12:45 pm an interview was conducted with the Administrator. The Administrator stated that he increased staff for 1:1 supervision of Resident #2 by facility usage of agency nursing staff and planned to obtain nursing assistant staff from the organization ' s sister facilities to meet staffing needs. The Administrator also stated and provided documentation on 9/22/21 that was validated of each morning huddle meeting that evaluated the staffing according to the census and acuity.

Cross referred:
F561: Based on observation, record review, staff and resident interview, the facility failed to honor a resident ' s choice to get out of bed each day for 1 of 20 residents sampled (Resident #9).

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F 727	Continued From page 40	F 727		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide Registered Nurse (RN) coverage for at least 8 consecutive ours per day, 7 days a week for 2 out of 28 days reviewed. The findings included: A review of the posted daily Nurse Staffing forms from 8/15/2021 to 9/11/2021 revealed the facility had not had the required Registered Nurse (RN) coverage (at least 8 consecutive hours per days, 7 days a week) on the weekend of 8/28/2021 and 8/29/2021. On both days the facility's census was 96 and no RN coverage was documented. On 9/14/2021 at 3:00pm an interview was conducted with the Director of Nursing (DON) and the Administrator. The DON stated she was aware there were weekends they did not have RN coverage. She further stated the facility was using	F 727	F 727- RN 8 hours/ 7 days/ week 1. Facility is currently maintaining eight hours of RN coverage 7 days per week. Facility will ensure compliance with eight hours of RN coverage 7 days per week through utilization of the nursing on-call program and increased agency if needed. 2. All residents have the potential to be effected. The Administrator reviewed staffing for the last 30 days to ensure the Facility had maintained RN coverage a minimum of eight hours per day. 3. Education completed on 10/12/2021 by the Corporate Nurse with the Administrator, Director of Nursing, and Facility Scheduler regarding requirement to maintain a minimum of eight hours of	10/19/21

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F 727	Continued From page 41 agency staff and rearranging the schedules of current RNs who served in administrative roles to ensure weekends will have RN coverage going forward. The Administrator stated he took the position less than a week ago. He further stated it was his expectation the facility meet the regulation of RN coverage 8 hours a day, 7 days a week.	F 727	RN coverage per day. Licensed Nurses were educated on this regulation and their responsibility to notify the Administrator and/or Director of Nursing of any changes to the schedule from call offs or staff leaving early that impact the eight hours of RN coverage. The Administrator will meet with the Director of Nursing, The Workforce Manager, and Scheduler daily (Monday-Friday) to ensure sufficient staffing to meet the needs of the residents. The RN Nurse on call will be required to cover any variances in the schedule to ensure 8 hours per day of RN Coverage is maintained. 4. The Administrator will audit RN coverage for eight hours per day, 7 days per week, daily for two weeks, weekly times four weeks, and monthly thereafter to ensure sufficient staffing to meet the needs of the residents. 5. Date of compliance: 10/19/21	
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records.	F 842		10/19/21

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§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches

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F 842	Continued From page 43 legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure residents' medical records were complete and accurate as evidenced by lack of documentation of insulin administration for 1of 3 sampled resident reviewed for medications (Resident #10). Findings included: Resident # 10 was admitted to the facility on 9/24/20 with multiple diagnoses including diabetes mellitus (DM). The quarterly Minimum Data Set (MDS) assessment dated 1/1/21 indicated that Resident #10's cognition was intact, and she had received insulin injections for 7 days during the last 7 days. Resident #10 had a doctor's order dated 9/24/20 for Humalog insulin (used to treat DM) sliding scale before meals and at bedtime (6:30 AM, 11:30 AM, 4:30 PM and 9 PM) - inject 2 units for blood sugar (BS) 151-200; 4 units for BS 201-250; 6 units for BS 251-300; 8 units for BS	F 842	F 842 □ Resident Records 1. Resident # 10 no longer resides in the Facility. 2. All residents who have orders for insulin have potential to be effected. Nursing Leadership will complete an audit by 10/19/2021 of all current residents with insulin orders for documentation of administration for the last 30 days, any discrepancies resulted in physician notification and medication error reports completed. 3. Education to be completed by 10/19/2021 by the Nursing Managers for licensed staff on the importance of maintaining an accurate and complete medical record, to include the documentation of insulin administration on the eMAR. No staff shall work until the education has been received. This	

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F 842	Continued From page 44 301-350 and 10 units for BS 351-400 and to notify the doctor if greater than 400. Resident #10 has doctor's orders dated 11/24/20 for Humalog 75/25 - inject 56 units subcutaneous (SQ) daily at 6 AM and 54 units SQ daily at 6 PM for DM. On 12/24/20, Humalog 75/25 was changed to 58 units daily at 6 AM and 56 units daily at 6 PM. On 1/6/21, Humalog 75/25 was changed to 58 units twice a day at 6 AM and 6 PM. Resident #10's Medication Administration Records (MARs) were reviewed. The December 2020, January 2021 and February 2021 MARs did not have nurse's initials on 12/1/20 (6AM), 12/20/20 (6PM), 12/26/20 (6PM), 1/10/21 (6AM), 1/23/21 (6PM) and 1/30/21 (6AM) to indicate that the Humalog 75/25 was administered. On 12/1/20 (6:30AM), 1/10/21 (6:30 AM), 1/30/21 (6:30 AM), 2/7/21 (6:30 AM) and 2/14/21 (6:30 AM), the boxes for Humalog insulin sliding scale did not have nurse's initials to indicate the blood sugar was checked and the Humalog insulin was administered per sliding scale. Attempted to call Nurse # 8, assigned to Resident #10 on 12/20/20 and 12/26/20 and Nurse # 3, assigned to the resident on 1/10/21 but was unsuccessful. The Director of Nursing (DON) was interviewed on 9/15/21 at 10:29 AM. The DON reported that the nurse assigned to Resident #10 on 1/23/21 no longer works at the facility. She also stated that the nurse assigned to the resident on 12/20/21 and 12/26/21 was sick. The DON verified that she had seen several holes on Resident #10's MARs. She reported that she	F 842	education will be included for all new hires. The Nursing Leadership Team (Director of Nursing, Unit Managers, and MDS Nurse) will review the medication administration compliance report daily in the Clinical Morning Meeting to determine if there are any omissions in the eMAR. Any variances noted are addressed with the licensed staff individually for resolution. 4. The Director of Nursing will audit all residents with orders for insulin weekly X 4 weeks and then randomly thereafter. In addition, the Director of Nursing will audit 5 random residents per week for eMAR compliance with documentation weekly X 4 weeks then randomly thereafter. Results of these audits are brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of compliance: 10/19/21	

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F 842	Continued From page 45 truly believed that the Humalog 75/25 was administered, and the blood sugar was checked but the nurses forgot to put their initials on the MARs. She added that she would in-serviced the nursing staff on the importance of documentation.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		10/19/21

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F 880	Continued From page 46 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to don personal protective equipment (PPE) before entry into two quarantined resident ' s rooms (Resident #19 and	F 880	F 880- Infection Prevention and Control 1. Resident # 19 currently resides in the center, is free of infection, and no longer	

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F 880	Continued From page 47 Resident #20) and failed to keep the quarantined room door closed for 2 of 2 rooms on the 200 hall observed (Rooms #214 and 216) for infection control practices. Findings included: A review of the facility signage/policy personal protective equipment (PPE) was reviewed on 9/14/21. The signage documented that an "N-95 respirator (mask), gown, gloves and face shield were required before entry to the room. The door was to remain closed." On 9/13/21 at 12:45 pm an observation on Hall 200 (residents that were on quarantine) of meal tray pass for quarantined residents in rooms #214 and #216 was done. The doors were open and there was signage for droplet precaution on each door. The signage instructions were to keep the door closed and to don a mask, and place goggles, gloves, and gown. Nursing Assistant (NA) #2 entered room 216 with a meal tray without donning PPE as written on the door signage (was wearing a mask N-95). Resident #19 was residing in room 216, was a new admission on quarantine and had signage on the door for droplet precautions to include mask, gown, gloves, and goggles before entry. NA #3 attempted to enter room 214 carrying a meal tray without donning PPE (was wearing a mask N-95) and was asked to stop. Resident #20 was residing in room 214, was a new admission on quarantine, and had the same signage on the door. Both NA #2 and #3 were asked to stop for an interview. On 9/13/21 at 12:43 pm an interview was conducted of NAs #2 and #3. NA #2 stated she	F 880	is under quarantine. Resident # 20 no longer resides in the Facility. 2. All residents who are on quarantine / resident specific precautions have potential to be effected. Nursing Leadership completed an audit on 10/12/2021 of all current residents on quarantine/ resident specific precautions for any potential negative outcome to staff not wearing proper PPE, none were identified. This audit included assessment for symptoms and routine Covid testing per protocol. 3. Education will be completed by 10/19/2021 by the Director of Nursing or Infection Preventionist for all staff on the appropriate use of PPE to include the use of gowns, gloves, N95 masks and eye protection for residents on quarantine / resident specific precautions and ensuring that this is donned and doffed on each entry/exit of these rooms. Education also included ensuring that the doors to these quarantine/ resident specific precautions resident rooms are kept closed. No staff shall work until the education has been received. This education will be included for all new hires. The Director of Nursing or Infection Preventionist will complete Infection Prevention Rounds daily (Monday-Friday) to observe for compliance with the Infection Prevention and Control Program and address any areas of opportunity with immediate coaching on correct process.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 48 was not aware PPE was required and had not noticed the signage on the door (open) [was not informed which rooms were quarantine]. NA #3 stated she had not seen the signage on the door (open) until she was carrying the resident ' s meal tray into his room and was stopped. NA #3 was aware to look for signage, but the door was open and signage was hard to see. Both NAs acknowledged the requirement to follow the PPE signage when residents were on quarantine. On 9/13/21 12:49 pm an interview was conducted with Nurse #10. Nurse #10 stated Resident #19 in Room #216 ' s family stated the resident was vaccinated but had not provided proof and the resident was placed on quarantine upon admission until the proof was provided. Nurse #10 stated that Resident #20 in Room #214 was not vaccinated. Nurse #10 stated all NAs should don PPE before entry and keep the door closed, follow the precautions for quarantine, and follow the signage. On 9/14/21 at 8:50 am an interview was conducted with Nurse #10. She reviewed Resident #19 ' s medical record and determined that he was not vaccinated. Nurse #10 reviewed Resident #20 ' s medical record and a copy of the vaccine card had been obtained from the family today. Nurse #10 stated that all staff were required to don PPE when there was signage until the family provided proof of vaccination and the resident would no longer be on quarantine and signage be removed. NAs #2 and #3 should have donned PPE on 9/13/21 before entering the resident ' s room. On 9/15/21 at 11:30 am an interview was conducted with the Director of Nursing (DON).	F 880	4. The Interdisciplinary Team (IDT, which includes the Admissions Director, Recreation Director, MDS Coordinator, Business Office Manager, Scheduler, Social Services, Human Resources Manager, Dietary Manager, Unit Managers, Medical Records and Central Supply) will complete random audits daily of residents on quarantine/resident specific precautions to ensure that the doors to the rooms are closed and that staff entering these rooms are donning and doffing appropriate PPE. These audits will continue daily X 4 weeks and then 3 X week thereafter. Results of these reviews are brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of compliance: 10/19/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 49 She stated that all staff were required to follow the infection control signage posted (don PPE) on the resident door and to keep the doors closed while on quarantine. The DON was the Infection Preventionist for the facility.	F 880		