### F 000 INITIAL COMMENTS

On 6/15/2020 an unannounced Complaint Investigation survey entry was conducted. There were 3 intakes and 8 allegations. 7 of the 8 allegations were unsubstantiated. 1 of the 8 allegations was substantiated. See Event ID #VXMU11

### F 563 Right to Receive/Deny Visitors

<table>
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<th>CFR(s): 483.10(f)(4)(ii)-(v)</th>
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§483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident.

(ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time;

(iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time;

(iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and

(v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for doing so.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
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<tr>
<th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
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<tbody>
<tr>
<td>345442</td>
<td>A. BUILDING __________________________</td>
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specifying no visitation due to COVID-19.

On 06/07/20 Nurse #1 and Nurse #2 documented that one of Resident #1’s family members (Family member #2) made verbal threats toward the staff during her visit with the resident. Nurse #2 was interviewed on 6/16/2020 at 1:45 pm via telephone. Nurse #2 stated, prior to the 06/07/20, Resident #1 had declined and was placed on palliative care. The resident’s family could have in-person, one-hour visits with the resident. On 06/07/20 she called 911 due to threats made by Family Member #2 and the she was asked to leave the facility. After this incident on 06/07/20, all the resident’s family members were not allowed to have in person visits with the resident. Nurse #2 stated that she was unaware of any problems that Family member #1 had caused when she visited the resident.

An interview was attempted with Nurse #1, but he was not available.

The Administrator was interviewed on 6/15/2020 at 11:24 am. He stated on 6/5/20, Resident #1 physically declined, and the resident’s family members were allowed to come inside the facility, one at a time, to have one-hour end of life visits with the resident. He explained that on 06/07/20, Family Member #1 and Family member #2 visited the resident at separate times. During Family member #2’s 06/07/20 visit she informed Nurse #1 that she was “going to get you outside of this facility.” The family member continued to yell, and the staff called 911 for police to have her escorted out of the facility. Family Member #2 informed the staff at the nurses’ station that “I’m going to return and burn this whole building.

4. The Director of Nursing/Administrator will complete quality monitoring of current residents receiving end of life services weekly x 12 weeks then monthly x 3 to ensure visitation is allowed, scheduled and communicated to the resident’s responsible party. Opportunities of improvement will be corrected by the DON and Administrator as identified during these quality monitoring audits. The Director of Nursing will report on the results of the quality monitoring audits to the Quality Assurance Performance Improvement Committee. Findings will be reviewed by the QAPI committee and quality monitoring updated as indicated.
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down too.” Nurse #1 was assigned to the resident and Nurse #2 was present and in charge. The family were asked not to visit until the police investigation was completed. The Administrator explained that on 6/8/2020, Family member #1 was observed by staff trying to open a facility window and door and was asked to leave; the family member claimed she was not aware she could not visit. The family were called on 6/8/2020 and informed not to visit due to threats made by Family member #2 and ensuing police investigation. The resident was unresponsive as of 6/5/2020 and there was a plan for Hospice evaluation with Family member #1 to be involved on 6/10/2020, but the resident expired during the morning of 6/10/20 before the meeting could take place.

Family Member #1 was interviewed on 6/19/2020 at 3:34 pm via telephone. The family member stated Resident #1 had declined on 6/5/2020, was unresponsive because of pneumonia, and the facility Administrator allowed the family to visit one at a time for an hour. Family member #1 stated she last visited the resident during the afternoon of 6/7/2020 and Family member #2 last visited during the evening of 6/7/2020. Family member #1 commented that she received a call from the Administrator late in the evening on 6/7/2020 to inform her while Family Member #2 was visiting the resident she made threats toward staff and threatened to burn the building and the entire family would no longer be allowed to visit the resident. Family member #1 stated she made several calls to the Director of Nursing on 6/8/2020 and 6/9/2020 with no answer or return calls. She explained the nursing staff informed her that she would be allowed to make window visits with the resident at the facility. On
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6/8/2020, when came to visit the resident at her window she was unable to visit because the curtain to the window was closed. She stated she went to the main door, which was locked, to ask about the curtain to the resident’s window being closed and was informed that she could not enter the facility. Family member #1 stated on 6/10/20 she received a call from the facility around noon and was informed that Resident #1 had passed away during the morning. Family member #1 stated she felt it was unfair that she could not see the resident during her last days because of Family Member #2’s behavior.

On 6/19/2020 at 12:30 pm an interview was conducted with the Administrator. The Administrator stated he decided to keep the resident’s family away from the building until he could resolve some concerns regarding Family member #2’s threats. The Administrator explained there were no concerns with the visitation or behavior of Family Member #1, but he made the decision to keep all the family members out of the facility due to threats made by Family member #2.