STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425145	A. Building B. Wing	09/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth- Aiken	830 Laurens Street North Aiken, SC 29801

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43050 Based on observation, interviews, and record reviews, the facility failed to ensure that the self-administration of medication by one resident (Resident (R) 51) out of a total of 22 sampled residents was properly stored to prevent access by other residents. Also, the facility failed to have an order in the electronic health record (EMR) for bedside storage and an EMR record form at the bedside. The facility also did not provide a sharps container for R51 to dispose of the needles being used to administer his insulin. Findings include: Review of a facility policy titled, Self-Administration of Medications by Patients/Residents, dated 01/28/20, stated that the following conditions are met for bedside storage to occur . the manner of storage prevents access by other patients/resident .the electronic health record medication administration record form is printed and maintained at the bedside and is reviewed on each nursing shift, and the administration information is transferred to the electronic medication record .attending Physician enters an order, on the EMR for bedside storage. Record review of the Face Sheet, located in the electronic medical record (EMR) revealed that R51 was admitted on [DATE] with primary diagnosis of Type 2 Diabetes with hyperglycemia (high blood sugar levels). Review of the Orders located in the EMR under the Orders tab revealed a current order for Novolog (fast acting insulin) 24 units; subcutaneous (injection under the skin) with meals at 9:00 AM, 1:00 PM, and 5:00 PM. R51 also has a current order for Toujeo (long-acting insulin), and Trulicity (injectable diabetes medication) once a week. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/19/21 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating R51 had no cognitive impairment Review of the Observation List Report-Self Administration of Medication, located under the Resident Documents tab in the EMR, revealed States that resident want to self-administer his own insulin. Resident has the daily decision-making ability where his decisions are consistent and reasonable. Resident can name dosage and tell time that medicine was taken. Evaluation of assessment reveals that based on answers, it is appropriate for resident to self-administer medication. Medications are to be stored on the Nursing Medication Cart. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the Orders located in the EMR under the Orders tab revealed that on 08/02/21, an order was signed by his physician to self-administer his Novolog insulin. Further review in the Documents tab of the EMR revealed a Self-Administration of Medication form, dated 07/15/21, that stated the self-administered medications were to be stored in the nursing medication cart. During an observation and interview on 09/14/21 at 10:19 AM, R51 verified he stores and self-administers his insulin. R51 stated that he feels that he can control his sugar if he oversees his insulin and when it should be taken. R51 stated that he educates himself about diabetes and what should take place with his care. R51 has a freestyle blood glucose monitoring system. R 51 stated that the nursing staff will come in and ask him for his blood glucose or if he is asleep, they will scan it themselves. When asked how R51 documents his blood glucose, he stated that it is stored in the device by that it does not always work. R51 stated sometimes forgets to document the results. Nursing will ask if he took his insulin, and he will tell them how many units he took. R 51 stated that hiss insulin is kept in a clear plastic pencil box that is not locked. Further observation revealed the needles from the insulin pen are kept in a plastic cup on his tray table. Further observation revealed no sharps container for the used needles and insulin pens located in his room. On 09/16/21 at 10:38 AM, interview with Licensed Practical Nurse (LPN) 10 revealed that R51 refused his insulin this morning. He was to take 24 units and stated that he would take 34 units at lunch. LPN10 stated that she then called his physician and documented the refusal to take his medication. LPN10 states that this is an ongoing issue with R51 and that he manipulates his dosing since he continuously checks his glucose level. This allows him to eat what he wants without his sugar levels going too high or too low. They presently ask him if he has taken his insulin and record this information in the EMR. Interview with the Director of Health Services (DHS) on 09/16/21 at 11:33 AM revealed that the facility currently has two residents who self-administers medication. The DHS verified that R51 does store the medications in his room and that they were getting a locked box for the resident to keep his insulin by his bedside. When asked why per the facility policy does R51 not have his medication in a locked container, she replied that one is being purchased today. The DHS was asked why there is not a physician order for bedside storage, per facility policy and she had no response. Observation on 09/17/21 at 11:49 AM revealed that R51 had purchased his own locked container to keep at his bedside for his insulin. It uses a number code to open. R51 stated that administration is to bring a sharps container in his room along with a self-administration form that is to be filled out by the resident and staff for all self-administration of insulin.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 37245 Based on observation, interview, and record review, the facility failed to ensure privacy during delivery of personal care specifically by exposing resident's bare body to public view for one (Resident (R) 9) of one resident reviewed for privacy out of a total sample of 22 residents. Findings include: Observation on 09/16/21 at 12:41 PM revealed Certified Nursing Assistant (CNA)1 performing incontinence care on R9. At the time of observation, R9 was lying on her right side, hospital gown fully opened at the back, exposing R9's back and buttocks. R9 was in a private room but the bedroom door was fully open, exposing R9 to public's view. During an interview on 09/16/21 at 12:26 PM with CNA1, she confirmed the bedroom door was open while she was performing incontinence care and stated, I should have closed the door before I started care. During an interview on 09/16/21 at 12:57 PM with R9, she confirmed CNA1 did not close her door during her incontinence care. During an interview on 09/17/21 at 5:26 PM with the Director of Health Services (DHS), she stated the privacy expectations when performing care are pulling the curtain, closing windows, and closing doors.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30347 Based on observations and interview, the facility failed to ensure a clean and homelike environment for five rooms out of 30 sampled resident rooms. This failure had the potential for other resident rooms to not be maintained in a clean and homelike manner. Findings include: The following observations were made during an environmental tour with the Maintenance Director (MAD) on 09/16/21 that began at 2:45 PM and concluded at 5:30 PM. During this tour, the MAD confirmed these observations and stated, I was not aware of these problems. 1. Observations of room [ROOM NUMBER] revealed the wall behind the head of bed A to be scarred, scratched, and scraped. The wall between the bathroom and closet were scarred, cut and had paint peeling. The wall next to bed B had a loose external mount electrical receptacle box (not a safety hazard). 2. Observations of room [ROOM NUMBER] revealed the closet door was not attached and was off the track. The wall next to the bathroom was scarred and cut. 3. Observations of room [ROOM NUMBER] revealed the closet doors not hung properly and were loose. The electrical receptacle nest to the bathroom door was missing the cover, the toilet seat was missing. The wall next to bed B was scarred and cut. 4. Observations of room [ROOM NUMBER] revealed the wall between the closet and bathroom to be scarred and cut. The closet doors were not hung properly and were loose. 5. Observations of room [ROOM NUMBER] revealed the wall between the bathroom and closet to be scarred and cut. The closet doors were not hung properly and were loose.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26190 Based on staff interview, observation, and record review, the facility failed to ensure one resident (Resident (R) 105) was free from physical abuse by R41 out of total sample of 22 . This deficient practice had the potential to cause harm to R105. Findings include: Review of the facility's policy titled, Prevention of Patient Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Property revised 10/27/20 stated, .The Organization and its partners should assure that best efforts are made to prevent any occurrences of any form of abuse .Definitions: Abuse means the willful infliction of injury with resulting physical harm .Abuse also includes .physical abuse .Procedures: 1. Providers are to identify, correct, and intervenes in situations in which abuse .may occur .The assessment, care planning, and monitoring of patients with needs and behaviors that might lead to conflict .such as patients with a history of aggressive behaviors . Review of R105's undated Face Sheet, found in the electronic medical record (EMR) under the Face Sheet tab revealed R105 was admitted to the facility on [DATE], with the diagnoses of delusional (false beliefs) disorder, unspecified dementia with behavioral disturbance, chronic pain, muscle weakness, and unsteadiness on feet. Review of R105's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/16/21, located in the EMR under the RAI tab, revealed R105 was unable to complete the Brief Interview for Mental Status (BIMS) and staff assessed her with severe cognitive impairment. R105 needed one-person physical assistance for bed mobility, toileting, transfers, and dressing. Review of R105's EMR, under the Care Plan tab stated, Problem Behavioral Symptoms, Approach: Maintain a calm environment and approach to R105, Remove R105 from other resident's rooms and unsafe situations, Utilize non-medicinal interventions such as music, diversional activities and/or snacks to reduce anxiety . Review of R41's undated Face Sheet, found in the EMR under the Face Sheet tab revealed R41 was admitted to the facility on [DATE], with the diagnoses of Alzheimer's disease, dementia with behaviors, anxiety disorder unspecified, and restlessness and agitation. Review of R41's quarterly MDS with an ARD of 07/19/21, located in the EMR under the RAI tab revealed, R41 had a BIMS score of -three out of 15 which indicated severe cognitive impairment. R41 needed one-person physical assist for bed mobility, toileting, transfers, and dressing. Review of R41's EMR, under the Care Plan tab stated, Problem Behavioral Symptoms .07/22/21 R41 had an incident where she pushed another Resident down causing her to fall. R41 was sent out to emergency department and was diagnosed with an UTI (urinary tract infection) .Approach: Avoid overstimulation, maintain a calm environment, redirect with a snack or activity such as talking about animals, Staff to allow R41 to calm down and attempt to redirect when she is physically aggressive towards staff . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of R105's EMR under the Progress Notes tab, indicated on 07/22/21, R105 had a physical altercation with R41 and was knocked to the floor hitting her head. R105 was assessed by nursing and was found to not have a laceration to her head and was placed on neurology checks. R105 did not verbalize any complaints of pain. Record review of R41's EMR under the Progress Notes tab, indicated on 07/23/21 R41 was transferred to a local emergency room due to becoming violent with staff .with the discharge plan of following up with psychiatry and treatment with antibiotics for a urinary tract infection. R41 was placed on one to one supervision for a period of 12 days and did not exhibit any aggressive behaviors toward R105 or any other resident during that time period. Both residents reside on the locked memory care unit. Record review of the facility's investigation, Five-Day Follow-Up Report, dated 07/26/21, revealed .Details of Reportable Incident: R41 walked up to R105 and touched her on the chest. R105 put her hand on R41's arm. After that, R41 pushed R105 off into the door frame .Immediate corrective action/assessment .Residents were separated, neuro checks started and completed, increased observation monitoring and behavior monitoring put into place .Interventions by facility to prevent future Injury/Alleged Abuse: Resident is on behavior monitoring and increased observations completed on the residents, as well as, redirection occurs to prevent future incidences from occurring . During an interview on 09/16/21 at 4:32 PM with the Director of Health Services (DHS), she stated one to one care was defined as a staff member being within arm's reach of the resident 24 hours a day seven days a week. During an interview on 09/16/21 at 4:55 PM with the Unit Manager, Registered Nurse (RN) 19 for the Memory Care Unit, she stated R41 was on one to one observation from 07/22/21 through 08/02/21. RN19 stated that R41 has not exhibited any additional violent behaviors toward other residents since that time. During an observation on 09/17/21 at 10:15 AM, on the memory care unit, R105 was sitting in the activities area holding her doll and R41 was in her room. During observations on the memory care unit, throughout the survey week, no resident to resident or resident to staff altercations were witnessed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43050 Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan for one of 22 sampled residents (Resident (R)51). R51 self-administers insulin and the consequences of not having a care plan could negatively impact the resident's quality of life, as well as the quality of care and services received. The facility failed to develop a care plan that reflected measurable goals, objectives, and outcomes. Findings include: Review of the policy titled Care Plans dated 12/31/96 indicated .it is the policy of the health care center for each resident to have a person centered baseline care plan followed by a comprehensive care plan . the comprehensive person-centered care plan is developed to include measurable goals and timeframes to meet a resident's medical, nursing and psychosocial needs, the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial needs that are identified in the comprehensive assessment . in consultation with the resident- the resident's goals for admission and desired outcomes . the resident's preference and potential for future discharge . the care plan will contain 4 main components: problem, goal, approaches, and role or accountability . problems should be written as actual problems or conditions . the goal is an expected outcome the resident should achieve by implementing specific interventions . the care plan approach serves as instructions for the resident's care and provides continuity of care by all partners. Record review of the Face Sheet, located in the electronic medical record (EMR) revealed that R51 was admitted on [DATE] with primary diagnosis of Type 2 Diabetes with hyperglycemia (high blood sugar levels). Review of the Orders located in the EMR under the Orders tab revealed a current order for Novolog (fast acting insulin) 24 units; subcutaneous (injection under the skin) with meals at 9:00 AM, 1:00 PM, and 5:00 PM. R51 also has a current order for Toujeo (long-acting insulin), and Trulicity (injectable diabetes medication) once a week. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/19/21 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating R51 had no cognitive impairment Review of the Orders located in the EMR under the Orders tab revealed a current order for Novolog (fast acting insulin) 24 units; subcutaneous (injection under the skin) with meals at 9:00 AM, 1:00 PM, and 5:00 PM. R51 also has a current order for Toujeo (long-acting insulin), and Trulicity (injectable diabetes medication) once a week. Further review of the Orders located in the EMR under the Orders tab revealed that on 08/02/21, an order was signed by his physician to self-administer his Novolog insulin. Further review in the Documents tab of the EMR revealed a Self-Administration of Medication form, dated 07/15/21, that stated the self-administered medications were to be stored in the nursing medication cart. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 09/14/21 at 10:19 AM, R51 verified he stores and self-administers his insulin. R51 stated that he feels that he can control his sugar if he oversees his insulin and when it should be taken. R51 stated that he educates himself about diabetes and what should take place with his care. R51 has a freestyle blood glucose monitoring system. R 51 stated that the nursing staff will come in and ask him for his blood glucose or if he is asleep, they will scan it themselves. When asked how R51 documents his blood glucose, he stated that it is stored in the device by that it does not always work. R51 stated sometimes forgets to document the results. Nursing will ask if he took his insulin, and he will tell them how many units he took. R 51 stated that hiss insulin is kept in a clear plastic pencil box that is not locked. Further observation revealed the needles from the insulin pen are kept in a plastic cup on his tray table. Further observation revealed no sharps container for the used needles and insulin pens located in his room. On 09/16/21 at 10:38 AM, interview with Licensed Practical Nurse (LPN) 10 revealed that R51 refused his insulin this morning. He was to take 24 units and stated that he would take 34 units at lunch. LPN10 stated that she then called his physician and documented the refusal to take his medication. LPN10 states that this is an ongoing issue with R51 and that he manipulates his dosing since he continuously checks his glucose level. This allows him to eat what he wants without his sugar levels going too high or too low. They presently ask him if he has taken his insulin and record this information in the EMR. Observation and interview on 09/14/21 at 10:19 AM with R51 revealed that the resident self-administers his insulin. R51 feels that he can control his sugar if he oversees his insulin and when it should be taken. Resident educates himself about diabetes and what should take place with his care. R51 has a freestyle blood glucose monitoring system. The nursing staff will come in and ask him for his blood glucose or if he is asleep, they will scan it themselves. When asked how R51 documents his blood glucose, he stated that it is stored in the device by that it does not always work. He sometimes forgets to document the results. Nursing will ask if he took his insulin, and he will tell them how many units he took. R 51 stated that he does not always tell them the truth. R51 stated, I have an uncontrollable sweet tooth. I will not take my insulin and watch what I eat, and my sugar will stay low. Then at night, I can eat my twinkies and hostess cupcakes. On 09/16/21 at 10:38 AM, interview with Licensed Practical Nurse (LPN) 10 revealed that R51 refused his insulin this morning. He was to take 24 units and stated that he would take 34 units at lunch. LPN10 stated that she then called his physician and documented the refusal to take his medication. LPN10 states that this is an ongoing issue with R51 and that he manipulates his dosing since he continuously checks his glucose level. This allows him to eat what he wants without his sugar levels going too high or too low. They presently ask him if he has taken his insulin and record this information in the EMR. Review of the Care Plan, dated 09/10/20, found in the EMR under the Care Plan tag revealed that under the Category: (Other) was mentioned that R51 is at risk for hyper/hypoglycemia related to diabetes mellitus. Resident has a history of noncompliance with taking his insulin and prefers to self-administer insulin and does not always administer his scheduled dose. Long term goal is for R51 to be free from hypo/hyperglycemia. Further review of the care plan revealed no specific for self-administering insulin. Interview with the Director of Nursing (DON) on 09/16/21 at 11:33AM revealed that when asked why R51 does not have a specific care plan for self-administering insulin, she had no response.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on facility policy and procedure review, record review, observations, and resident and staff interviews, the facility failed to ensure six residents (Residents (R) 75, R124, R12, R24, R35, R74, R118, R122, and R108) who were reviewed for Activities of Daily Living (ADLS) received adequate assistance from staff to complete their ADLS on a consistent basis in a total sample of 22. Findings include: Review of the facility's policy titled, Documentation: Charting Activities of Daily Living (ADLs) revised 02/18/21 stated, Policy Statement: It is required for ADL care given by Certified Nursing Assistants and Nurses to be documented under Care Assist in the .resident's Electronic Healthcare Record . The facility's Shower Procedure, dated 2009, read, in pertinent part, Procedure: Document procedure per facility policy/protocol. The facility's Shower/ADL policy was requested by the survey team and was not provided prior to survey The Shower List for Unit 3 indicated residents on that unit were to receive showers twice weekly, and R75 was to receive showers on Mondays and Thursdays on the evening shift, R108 was to receive showers on Mondays and Thursdays on the night shift, and R124 was to receive showers on Tuesdays and Fridays on the day shift. 1. Review of the undated Resident Face Sheet found in the electronic medical record (EMR) revealed R75 was admitted to the facility on [DATE] with diagnoses including history of stroke and generalized muscle weakness. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/04/21 indicated R75 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of eight out of 15 and was totally dependent upon staff to complete his bathing/showering ADLS. Review of R75's ADL Care Plan, dated 12/21/20 and found in the EMR under the Care Plan tab, indicated R75 required extensive assistance to total assist to complete all of his ADLs. Approaches included: Bath/shower as scheduled per (R75's) preference. Review of the Point of Care ADL Category Report, dated 08/01/21 through 09/16/21, revealed R75 received bed baths on 08/02/21 and then not again until 09/08/21. Partial bathing was indicated for R75 on 08/11/21, 08/14/21, 08/15/21, 08/17/21, 08/19/21, 08/23/21, 08/28/21, 08/29/21, 09/11/21, 09/13/21, and 09/15/21. 2. Review of the undated Resident Face Sheet located in the EMR revealed R124 was admitted to the facility on [DATE], with diagnoses including history of stroke and hemiparesis/hemiplegia (paralysis and weakness) following a stroke. Review of the MDS with an ARD of 08/25/21 indicated R124 was cognitively intact with a BIMS score of 14 out of 15 and required physical help from staff in part of his bathing activity. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R124's ADL Care Plan, dated 10/21/20 and found in the EMR under the Care Plan tab, indicated R124 required supervision to extensive assistance with his ADLs due to his history of stroke. Approaches included: Bath/shower as scheduled per (R124's) preference. Review of the Point of Care ADL Category Report, dated 08/01/21 through 09/16/21 revealed R124 received showers on 08/06/21, 08/10/21, 08/13/21, 08/17/21, 08/20/21, 08/24/21, 08/31/21. No showers were documented as given in September 2021. Partial bathing was documented on 08/01/21, 08/02/21, 08/04/21, 08/30/21, 09/01/21, 09/02/21, 09/03/21, 09/04/21, 09/07/21, 09/11/21, 09/12/21, 09/13/21, 09/14/21, and 09/16/21. During an interview with R124 on 09/14/21 at 9:48 AM, he stated he had not had a shower since last Wednesday (09/08/21) due to there not being enough staff to assist with showers. He stated, They keep telling me there isn't any staff to give me a shower, and why is that [not having enough staff] my problem? It shouldn't be my problem. During an interview with R124 on 09/14/21 at 1:37 PM, he indicated it was his shower day and stated, The nurse told me today they only have one CNA (Certified Nursing Assistant), and so I can't get a shower. I'm starting to smell bad between my legs now it's been so long. During an interview with CNA14 on 09/16/21 at 3:29 PM, she indicated she worked a couple of days on the 300 unit per week and stated showers should be given three days per week. CNA14 indicated she did not know what a partial shower was. During an interview with CNA16 (the facility's Restorative CNA) on 09/16/21 03:32 PM, she indicated she hadn't worked on the 300 unit for a long time and was working on the unit due to lack of staff on the unit that shift. She indicated she wasn't sure if residents were receiving their showers as ordered on the 300 unit. During an interview with Licensed Practical Nurse (LPN) 4 (the 300 Unit's Manager) on 09/16/21 at 3:34 PM, she stated she thought a partial shower might be like a bed bath, but she didn't know for sure. LPN4 stated showers were to be documented, by CNAs, straight into the EMR. LPN4 stated residents on the unit should be getting showers twice weekly. During an interview with the Director of Health Services (DHS) on 09/17/21 at 5:35 PM, she stated her expectation was that residents were to be bathed per the facility schedule, and if a shower was refused, CNAs should document the refusal in the EMR. 26190 On 09/15/21 at 2:30 PM a Resident Council Meeting was held with six residents (R12, R24, R35, R74, R118 and R122) in attendance. The resident consensus was they do not get enough showers. R12, R74 and R118 reported they did not receive a shower in the past week. The residents confirmed the issue of the lack of showers being provided has been brought to the attention of facility management several times. Review of the facility's form titled, Grievance/Complaint Log Form: Healthcare Centers, reviewed 10/12/17, stated, complaints of hygiene care concerns were filed by several residents during the months of: December 2020, February 2021, April 2021, May 2021, June 2021, and September 2021. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's report, Point of Care ADL Category Report (MDS 3.0) under the bathing column indicated: R12 received during the time period of: 08/22/21 through 08/28/21 one shower, 08/29/21 through 09/04/21 zero baths/showers, 09/05/21 through 09/11/21 zero baths/showers R24 received during the time period of: 08/22/21 through 08/28//21 one bed bath/zero showers, 08/29/21 through 09/04/21 zero baths/showers, 09/05/21 through 09/11/21 one bed bath/one shower. R35 received during the time period of: 08/22/21 through 08/28/21 two bed baths/zero showers, 08/29/21 through 09/04/21 two bed baths and one partial/zero showers, 09/05/21 through 09/11/21 zero baths/showers. R74 received during the time period of: 08/22/21 through 08/28/21 four partials/zero showers, 08/29/21 through 09/04/21 three partials/zero showers, 09/05/21 through 09/11/21 two partials/zero showers. R118 received during the time period of: 08/22/21 through 08/28/21 three bed baths/zero showers, 08/29/21 through 09/04/21 two bed baths/zero showers, 09/05/21 through 09/11/21 one shower. R122 received during the time period of: 08/22/21 through 08/28/21 two partials/zero showers, 08/29/21 through 09/04/21 four partials/one shower, 09/05/21 through 09/11/21 one bed bath/one partial/one shower. A synopsis of the number of showers provided for six residents over a 3-week period (8/22/21 through 09/11/21) was four showers. During an interview on 09/17/21 at 3:05 PM with the Director of Health Services (DHS), she stated in response to the resident's complaints of not getting showers they have begun to call in staff, for a few hours at a time, just to complete showers (no other duties assigned). DHS said during July 2021 they began doing bath audits. DHS stated education has been provided to the Certified Nursing Assistants (CNAs) regarding the process when a resident refuses a shower. DHS explained the process is when a resident refuses the CNA must report the refusal to the nurse and the nurse then calls the family and let them know of the refusal. 37245 Observations on 09/14/21 at 2:06 PM and 09/17/21 at 10:48 AM revealed R108's nails to be long, untrimmed, and unclean. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/18/21, located under the RAI tab and MDS 3.0 Reports of the electronic medical record (EMR) revealed R108 had a Brief Interview for Mental Status (BIMS) score of eight out of 15, indicating R108 was moderately cognitively impaired. Per this 08/18/21 MDS, R108 was totally dependent on staff for bathing and personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/17/21 at 10:48 AM with R108, he stated that he could not remember the last time his nails had been cleaned but remembers that he requested them to be cleaned within the last week. R108 further stated that he did not remember the last time that he received a bed bath or a shower and felt that he needed to be cleaned up all over. During an interview on 09/17/21 at 10:53 AM with Licensed Practical Nurse (LPN)12, she confirmed that R108's nails were unclean and was unsure of the last time they were cleaned. LPN12 stated Certified Nursing Assistants (CNA) usually perform nail care during the residents' bath. During an interview on 09/17/21 at 11:15 AM with CNA13, she stated she gave R108 a bed bath on Wednesday, 09/15/21. She stated that a bed bath consists of the face, armpits, breasts, groin, and bottom and a partial bath consists of the face. CNA13 stated after giving the residents a bed bath, the process is to complete oral hygiene, nails, and hair. She confirmed she did not cut or clean R108's nails after his bed bath on 09/15/21. CNA13 confirmed R108 does not refuse ADL care and is unable to perform the tasks independently. Review of the Point of Care ADL Category Report from the period of 7/31/21 through 09/16/21 revealed R108 did not receive any showers during this time period. Per the Point of Care ADL Category Report, R108 received three bed baths (face, armpits, breasts, groin, and bottom) during the period of 7/31/21 through 09/16/21. R108 received a partial bath (face only) from 08/11/21 through 09/06/21. Review of the Shower List revealed R108's shower days to be on Mondays and Thursdays on the overnight shift. Review of the Care Plan, with a date of 03/17/21 and located under the RAI tab and Care Plan of the EMR revealed R108 depends on staff for all ADLs. The care plan further revealed an approach for R108 was to be bathed/showered as scheduled and nail care daily and as needed.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on record review, observations, and resident and staff interviews, the facility failed to ensure two of four residents (Resident (R) R75 and R124) who were reviewed for Positioning and Mobility were provided with restorative services per their plan of care. R75 and 124 did not receive assistance to apply their splints per their plans of care. Findings include: The facility's Range of Motion/Splinting Policy was requested by the survey team but was not received prior to the survey exit date of 09/17/21. 1. Review of the undated Resident Face Sheet found in the electronic medical record (EMR) revealed R75 was admitted to the facility on [DATE] with diagnoses including history of stroke and generalized muscle weakness. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/04/21 indicated R75 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of eight out of 15. This MDS indicated R75 had Range of Motion (ROM) impairment to his upper and lower extremities on both sides of his body, and that a splint or brace was in use for the resident. Review of R75's Range of Motion Care Plan, dated 12/21/20 and found in the EMR under the Care Plan tab, indicated R75 was limited in range of motion to his left upper extremity and that a soft palmar support was to be utilized to his left hand. Approaches included: Soft [NAME] support and one rolled up towel placed between left elbow crease to promote static stretching to prevent further joint stiffness and contracture. To be worn daily for up to 4 hours as tolerated. Review of R75's Medication Administration Record (MAR) and Treatment Administration (TAR), dated 09/2021, documented that R75's left soft [NAME] support and rolled up towel to his left elbow crease were applied daily between 09/01/21 and 09/17/21. R75 was observed in bed in his room on 09/14/21 at 10:46 AM. The resident had contractures (fixed stiffening of a joint) to his upper extremities and hands on both sides of his body. R75 was not wearing a soft splint nor was a rolled-up towel placed in the crease of his left elbow. R75 was observed lying in bed in his room on 09/14/21 at 4:19 PM. The soft splint and the rolled-up towel were not applied to the resident's left hand/elbow crease. R75 was observed in his bed in his room on 09/15/21 at 9:50 AM. He was not wearing a soft splint on his left hand nor was a rolled towel placed in the crease of his left elbow. R75 was observed lying in his bed on 09/16/21 at 2:54 PM. The soft split and the rolled-up towel were not applied per the resident's plan of care. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Certified Nursing Assistant (CNA) 16 (the facility's restorative nursing assistant) on 09/16/21 at 4:42 PM, she indicated she thought R75's splint had been discontinued because it was rubbing on his hand and causing skin breakdown. During an interview with Registered Nurse (RN) 19 (the facility's restorative nurse) on 09/16/21 at 6:47 PM, she stated R75's original splints were discontinued because they had been causing the resident pain and skin breakdown. RN19 indicated a soft [NAME] support was ordered when the original splint was discontinued, and that it was not on him when she went to his room earlier that afternoon to check on him. RN19 verified that the [NAME] support had not been applied until 09/16/21 after RN19 found the support in a drawer in the room and stated, It [the soft [NAME] support] should be on him. 2. Review of the undated Resident Face Sheet found in the EMR revealed R124 was admitted to the facility on [DATE], with diagnoses including history of stroke and hemiparesis/hemiplegia (paralysis and weakness) following a stroke. Review of the MDS, with an ARD of 08/25/21, indicated R124 was cognitively intact with a BIMS score of 14 out of 15. The assessment indicated R124 had limited ROM to his upper and lower extremities on one side of his body. Review of R124's ROM Care Plan,dated 10/21/20 and found in the EMR under the Care Plan tab, indicated R124 required splint/brace assistance to his left upper extremity to prevent further abnormal posturing. Approaches included: Follow the guidelines of OT (Occupational Therapy) to provide gentle stretching to the pt's (patient's) left hand and then apply the L (left) hand splint and have him wear for 2 - 3 hours daily as tolerated to prevent further abnormal posturing. Review of the MAR/TAR, dated 09/2021, indicated no documentation to show R124's splint had been applied per his plan of care. R124 was observed seated in his wheelchair in his room on 09/14/21 at 11:10 AM. The resident's left hand was contracted. R124 was not observed to be wearing a splint. R124 was observed seated on his bed in his room on 09/15/21 at 10:30 AM. R124 was not wearing a splint on his left hand. R124 was observed seated in his wheelchair in his room on 09/15/21 at 2:52 PM. R124 was not observed to be wearing a splint on his left hand. During an interview with R124 on 09/16/21 at 3:41 PM, he stated, I had a splint when I first got here, but I haven't seen it in a while. I need one [a splint] in this hand [referring to his contracted left hand]. I would wear one [a splint] if I had one. During an interview with CNA16 on 09/16/21 at 4:48 PM, she indicated R124 had a splint prior to moving to the 300 unit from his prior unit and that she was not sure what happened to it. She stated, He really should have it [the splint]. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with RN19 on 09/16/21 at 6:43 PM, she stated R124 previously had a splint, which was originally ordered in 01/2021, and she had not been able to locate documentation of when the splint was misplaced. RN19 indicated therapy had another splint that could be provided to the resident, however the therapy department wanted to reevaluate R124 before providing the splint since it was unclear when the resident's original splint had been misplaced. She stated, He [R124] should have had it [the splint]. It was lost. During an interview with the Director of Health Services (DHS) on 09/17/21 at 5:38 PM, she stated her expectation was that splints/soft splints be applied per each resident's plan of care.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37245 Based on interview, record review, and facility policy review, the facility failed to ensure residents were free of unnecessary medication by failing to obtain consents for four (Resident (R) 105, R108, R122, and R114) of four residents reviewed for psychotropic medication in a total sample of 22 residents. Findings include: 1. Review of Resident Face Sheet located under the Resident tab and Face Sheet of the electronic medical record (EMR), revealed R105 had the following diagnoses: delusional (false beliefs) disorders and dementia with behavioral disturbances. Review of the Orders located under the Resident tab and Orders of the EMR, revealed R105 was prescribed the following medications: Cymbalta (antidepressant), Seroquel (antipsychotic), and Trazodone (antidepressant). Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/16/21, located under the RAI tab and MDS 3.0 Reports of the EMR revealed R105 had a Brief Interview for Mental Status (BIMS) score of 99/15, indicating the resident was unable to be assessed. 2. Review of Resident Face Sheet located under the Resident tab and Face Sheet of the EMR, revealed R108 had the following diagnoses: dementia with behavioral disturbances, anxiety disorder, metabolic encephalopathy, and other psychotic disorder not due to a substance or known physiological condition. Review of the Orders located under the Resident tab and Orders of the EMR, revealed R108 was prescribed the following medications: Clonazepam (antianxiety medication) and Seroquel. Review of the quarterly MDS with an ARD of 08/18/21, located under the RAI tab and MDS 3.0 Reports of the EMR revealed R108 had a BIMS score of eight out of 15, indicating the resident was moderately impaired. 3. Review of the Resident Face Sheet located under the Resident tab and Face Sheet of the EMR, revealed R122 had the following diagnoses: bipolar disorder and obsessive-compulsive disorder. Review of the Orders located under the Resident tab and Orders of the EMR, revealed R122 was prescribed the following medications: Zyprexa (antipsychotic medication), Lunesta (hypnotic for insomnia), Fluvoxamine (antidepressant), and Lamotrigine (mood stabilizer). Review of the quarterly MDS with an ARD of 08/24/21, located under the RAI tab and MDS 3.0 Reports of the EMR revealed R122 had a BIMS score of 15 out of 15, indicating the resident was cognitively intact. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	18947 Review of the undated Resident Face Sheet, found in the EMR revealed R114 was admitted to the facility on [DATE] with diagnoses including vascular dementia with behavioral disturbance. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/18/21 revealed R114 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of four out of 15. This MDS indicated R114 was receiving an antidepressant medication seven days per week. Review of R114's Psychotropic Drug Use Care Plan, dated 05/14/20 and located in the EMR under the Care Plan tab, indicated R114 was at risk for injury and side effects from psychotropic medication use for his diagnosis of vascular dementia with behaviors. Approaches included: (Give) medication as ordered. Review of R114's Physician Order Report, dated 07/01/21 through 09/17/21 and located in the EMR under the Orders tab, revealed an order for Duloxetine Delayed Release (DR) 60 milligrams (MG), an antidepressant medication, to be administered once daily in the morning. Review of R114's Medication Administration Record (MAR),dated 09/2021, revealed R114 was receiving the Duloxetine per physician order. Review of the R114's medical record revealed nothing to indicate the resident's responsible party had been notified of the potential risks and benefits of receiving the Duloxetine, nor had the responsible party been given an opportunity to consent or refuse the drug's use. During an interview with the Director of Health Services (DHS) on 09/17/21 at 7:21 PM, she stated R114 had been represented by Adult Protection Services (APS) upon his original admission to the facility, and it was not within APS's scope to provide informed consent for resident services such as the administration of psychotropic medication. She stated the resident's daughter had become R114's responsible party some time after his admission to the facility, and opportunity should have been given to the resident's daughter to review and consent to or decline the Duloxetine, however that had not happened. She stated she had reviewed the resident's record and she had been unable to locate anything to show the risks and benefits of the Duloxetine were reviewed with the resident's Responsible Party, or that a consent for the administration of the medication had been provided. Review of the EMRs for R105, R108, R114, and R122 revealed the lack of consent from resident/resident representative for the use of psychotropic medication. During an interview on 09/17/21 at 7:25 PM with the Director of Health Services (DHS), she stated the facility did not obtain consents from the resident or the residents' representative for psychotropic medication.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on facility policy review, record review, observations, and staff interviews, the facility failed to ensure a medication error rate of less than five percent. A total of three errors were made during medication administration for two residents of ten residents (Resident (R) R and R97) who were observed for medication administration. The facility's medication error rate was 8.1%. Findings include: Review of the facility's policy titled Medication Administration: Oral Medications Policy, dated 01/28/20, revealed It is the policy of (Facility Pharmacy) that oral medications are administered in an organized and safe manner; and Crush medications if indicated by Physician's order for this resident only after checking the Crush List; and Explain to patient/resident the type of medication to be administered. 1. Review of the undated Resident Face Sheet found in the Electronic Medical Record (EMR) revealed R4 was admitted to the facility on [DATE] with diagnoses including unspecified intellectual disabilities, hypertension, history of breast cancer, seizure disorder, and depression. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/17/21 revealed R4 was severely cognitively impaired. A Brief Interview for Mental Status (BIMS) was not able to be administered due to the resident's poor cognition, and the assessment indicated the resident had both short and long-term memory deficits. Review of R4's Physician Order Report,dated 09/01/21 through 09/17/21 and located in the EMR under the Orders tab, revealed orders for Carbamazepine 200 milligrams (MG) (an anti-seizure medication) to be administered once daily by mouth, Colace 100 MG (a stool softener) to be administered once daily by mouth, Lactulose 30 milliliters (ML) (a laxative) to be administered given once daily by mouth, Tamoxifen 20 MG (a cancer inhibiting medication) to be given twice daily by mouth, and Triamterene-HCTZ 37.5/25 MG (an anti-hypertensive medication) to be administered once daily by mouth. The physician's order indicated all of the medication was to be administered whole in pudding. Licensed Practical Nurse (LPN) 10 was observed administering R4's medications on 09/15/21 at 9:18 AM. All of R4's above indicated medication was observed to be crushed and mixed with pudding for administration. During an interview with LPN10 on 09/15/21 at approximately 09:20 AM, LPN10 was asked if there was a physician's order for R4 to receive her medication crushed. LPN10 stated, I'll give them [the resident's medication], then I'll call [the resident's physician] to clarify [the order]. LPN 10 administered R4's medication crushed and in pudding. 2. Review of the undated Resident Face Sheet, located in the EMR, revealed R97 was admitted to the facility on [DATE] with diagnoses including other specified eating disorder and constipation. Review of the MDS with an ARD of 08/10/21 indicated R97 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R97's Physician Order Report, dated 09/01/21 through 09/17/21 and located in the EMR under the Orders tab, indicated orders for Prostat SF (Sugar Free) 45 milliliters (MLs) (a protein supplement) to be administered twice daily by mouth and polyethylene glycol powder 17 grams (a laxative) to be administered twice daily by mouth in 240 ML of fluid. Registered Nurse (RN) 18 was observed administering R97's medications on 09/17/21 at 8:59 AM. All ordered medication was observed to be administered with the exception of R97's Prostat and the polyethylene glycol. RN18 did not prepare R97's Prostat or polyethylene glycol prior to administration of his medications, nor did she offer R97 these medications when all of his other medications were administered. During an interview with RN18 on 09/17/21 at 9:12 AM, she stated, [R97] usually refuses the ProStat and the Miralax [polyethylene glycol], so I just didn't bring it to him. During an interview with the Director of Health Services (DHS) on 09/17/21 at 5:56 PM, she stated her expectation was that nursing staff should not omit medication without asking the resident if he/she would take the ordered medication first, and then getting a refusal.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26190 Based on observations, interviews, record review, review of the facility's infection control policies, and review of Centers for Disease Control and Prevention (CDC) guidance, the facility failed to ensure infection control practices were in place for the following areas: 1. one Coronavirus Disease 2019 (COVID-19) positive Resident (R) 96 was not placed on quarantine with transmission-based precautions even though he was exhibiting symptoms related to COVID-19; 2. LPN25 was observed coughing and removing her mask at the rehabilitation unit nurses' station; 3. R393 was placed on isolation precautions due to his diagnosis of Methicillin-resistant Staphylococcus aureus (MRSA), but without the appropriate precautions signage on his door or personal protective equipment (PPE) available for use; 4. R98 was placed on isolation precautions due to his diagnosis of Clostridium difficile (C. diff), but without the appropriate precautions signage on his door; and 5. no hand hygiene during assisting with meals. Failure to properly quarantine the COVID-19 positive resident had the potential to increase the likelihood of spread of infections among all residents and staff in the facility due to staff coming into contact and working throughout the facility. On 09/15/21 at 5:55 PM, the Administrator was notified immediate jeopardy at F880: Infection Control-L existed related to the failure to adequately quarantine one COVID positive resident with use of all required PPE. The immediate jeopardy at F880 was determined to first exist on 09/15/21, the date when the non-compliance was observed. The facility presented an acceptable removal plan for the immediate jeopardy at F880-L on 09/17/21 at 8:20 PM. Through observations, interviews, and record review, the survey team validated the immediate jeopardy was removed on 09/17/21 at 9:22 PM following the facility's implementation of the plan of removal of the Immediate Jeopardy. The deficient practice remained at a lower scope and severity of an F (widespread with potential for more than minimal harm) following the removal of the immediate jeopardy. Findings include: Review of CDC's, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated Sept.10, 2021, revealed the following guidance HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face) . Establish a process to identify anyone entering the facility, regardless of their vaccination status, who has any of the following so that they can be properly managed: 1) a positive viral test for SARS-CoV-2, 2) symptoms of COVID-19, or 3) who meets criteria for quarantine or exclusion from work. Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility. Healthcare personnel (HCP), even if fully vaccinated, should report any of the 3 above criteria to occupational health or another point of contact designated by the facility . (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the facility policy titled, COVID-19 Pandemic Isolation and Cohorting Process for Healthcare Centers, revised 09/09/21, revealed Policy Statement: .will provide designated Levels of units within the center for isolating and cohorting residents when making decisions to accept hospital and community admission, transfers and with management of COVID-19 positive and presumptive in-house residents during the COVID-19 pandemic .Definitions: .severely Ill: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room aur at sea level .Procedure: Healthcare centers designated to admit COVID-19 positive residents will follow procedures for Level 1 .Procedures: .New admissions from a hospital stay for COVID-19 Infection .If hospitalized resident is still recovering (I.E., requiring oxygen .requiring breathing treatments, etc) hospital days do not count down the Level I required days and must be admitted to a Level 1 bed until meets criteria for 10 days minimum symptom based strategy .Quarantine period listed in chart above will be 14 days on Level II (From Chart: Admission and Readmission, Unvaccinated or Partially Vaccinated Residents, Quarantine) .VI. Severely Ill or Severely Immunocompromised Individuals .1. Symptomatic resident with suspected or confirmed COVID-19. Symptom-based strategy. Remain on Level I: At least 20 days have passed since symptoms first appeared, and at least 24 hours have passed since last fever without the use of fever reducing medications, and improvement in symptoms . Document review of the facility's policy titled, Coronavirus COVID-19 Infection Prevention and Control Practices Policy revised 03/06/20 stated, Policy statement: It is the policy of the .organization to initiate the appropriate measures to protect our patients/residents, partners and families from risks associated with the Coronavirus (COVID-19) through mitigation and educational tools, utilizing resources as provided by the Department of Public Health and the Centers for Disease Control .Procedure: II. Screening of Partners, Visitors and Vendors 1. All locations are required to setup screening stations at the main entrance to screen partners .for the following: fever, cough, shortness of breath, fatigue .4. Should any partner present with all the above risk factors, the partner conducting the screening will: .notify the partner's direct supervisor for further instructions .The partner will be considered a Patient Under Investigation (PUI) for COVID-19 if the following criteria is met: .a. Fever of lower respiratory symptoms (e.g., cough or shortness of breath) and any person, including healthcare workers, who has had close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset . 1. Review of R96's undated Face Sheet, found in the electronic medical record (EMR) under the Face Sheet tab, revealed R96 was initially admitted to the facility on [DATE] with the diagnosis of cerebral vascular accident, hemiplegia and hemiparesis following cerebral infarction (stroke) affecting the right non dominant side, epilepsy, muscle weakness. Review of the R96's EMR under the Progress Notes tab revealed a brief history of R96's illness through progress notes: dated 09/01/21 stated, Testing Nurse reported R96 has tested positive for COVID-19 .; dated 09/04/21 stated, .R96 admitted to hospital with COVID + with hypoxia.; dated 09/07/21 stated, Resident returned to the facility. Primary diagnosis of acute respiratory failure with hypoxia, COVID-19 .he is currently on 4 liters of oxygen; dated 09/14/21 stated, R96 continues on Level 1 isolation for COVID-19 .O2 (oxygen) at 4L (liters) via NC (nasal cannula), no s/s (signs and symptoms) of resp. (respiratory) distress observed, resp. (respirations) noted even and non-labored, afebrile . Review of R96's orders found in the EMR under the Orders tab, revealed orders on 09/07/21 stated, Admit to SNF (skilled nursing facility) .Full Code .Oxygen at 4 LPM (liters per minute) via nasal cannula continuous . albuterol sulfate (medication to open airways) every 4 hours PRN (as needed) . (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of R96's EMR under the Census tab showed R96's movement within the facility: on 09/01/21 R96 was moved to a room on the COVID positive unit, on 09/04/21 he was transferred to the hospital, on 09/07/21 he returned from the hospital and was placed in a room on the COVID positive unit, on 09/14/21 he was transferred to a regular room on the rehabilitation floor and on 09/16/21 R96 was discharged to a sister facility due to his positive COVID-19 status with a continuation of symptoms. Observation on 09/15/21 at 9:00 AM, revealed R96 was residing alone in a two-person room on the general rehabilitation unit (moved from the COVID-19 positive unit on 09/14/21) with no precautions being taken by staff when direct patient care was being performed. The observation revealed no transmission based precautions signage located on the door of R96's room stating what precautions were in place and what PPE needed to be utilized for R96, a resident who continued to exhibit symptoms of COVID-19. Also, there was no PPE (gowns, N95 masks, gloves, eye protection) placed by or near R96's room for staff or visitor use. The following are observations on 09/15/21 of staff entering R96's room without wearing appropriate PPE (gowns, gloves, eye protection): At 11:00 AM Certified Nursing Assistant (CNA)26 went to check on resident; At 11:08 AM CNA26 went back into his room to provide patient care; At 11:12 AM Rehab Tech (RT)1 went into R96's room to assist CNA26; At 11:46 AM Housekeeping (HK) 15 entered R96's room and cleaned it. Interviews with nursing staff on 09/15/21 from 10:45 AM to 11:50 AM revealed staff on the unit was unaware of R96's current COVID-19 isolation status. During an interview in the conference room on 09/15/21 at 11:05 AM, the survey team was informed that nursing and housekeeping staff on the Rehabilitation Unit were assigned a current patient load of 26 total residents (five of whom had not been vaccinated for COVID-19 due to recent admission). 2. An observation on 09/15/21 at 11:00 AM, at the nurses' station of the rehab unit, it was observed Licensed Practical Nurse (LPN) 25 coughed several times and did remove her mask, at times, while at the nurses' station. During an interview on 09/15/21 at 11:15 AM with LPN25, she stated when coming in to work a shift there is a questionnaire, at the front desk, we have to fill out and they take our temperature. I did that this morning. Last week they sent me home because I had more sinus stuff and a cough. They tested me three times last week, including a PCR (polymerase chain reaction) and I tested negative. I cough continuously so I don't remember what I put today on my screening. Review of LPN 25's COVID-19 screening dated 09/15/21 indicated LPN 25 failed to indicate her current symptom of coughing on the screening form. A request was made for the previous two months of the facility's staff wide COVID-19 Screening Documentation, but the facility was unable to provide the requested documentation to the survey team. During an interview on 09/15/21 at 12:20 PM with the Director of Nursing (DON), she stated when an employee notes they have a cough, during the screening process, the Administrator or Infection Control Preventionist (ICP) should be notified by the receptionist followed by a nurse assessment of the employee in order to decide how to proceed. 43050 (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Observation on 09/14/21 at 11:20 AM revealed no signage on residents door for isolation precautions. There was also no PPE cart located outside of his room. Review of the Orders, located under the Orders tab in the EMR revealed an order for isolation precautions. During an interview and observation on 09/14/21 at 4:15 PM, the Director of Health Services (DHS) verified that there was no signage on the door for contact precautions and no PPE located outside of R98's room. During an interview on 09/17/21 at 12:41 PM, Licensed Practical Nurse (LPN) 4 revealed that R98's received the last dose of antibiotic and that the isolation precaution order was to be discontinued on 09/18/21. During an interview on 09/17/21 at 12:57 PM, the IP stated that the PPE cart had been outside of the resident's room and for some reason was moved. The IP verified that there was not an isolation sign on R98's door. 37245 5. During an observation on 09/14/21 at 12:56 PM, revealed RN8, Registered Nurse - Case Mix Director providing feeding assistance to Resident (R)339. RN8 was using a spoon to assist R339 with eating mechanical barbeque chicken and greens. RN8 then stopped assisting R339 and walked over to R34's table, picked up R34's spoon and attempted to serve the resident black-eyed peas but R34 did not eat. RN8 did not sanitize or wash her hands between the assistance of R339 and R34. During an observation on 09/14/21 at 1:03 PM, revealed ST24, Speech Therapist, providing feeding assistance to Resident (R)339. ST24 was using a spoon to assist R339 with eating mechanical barbeque chicken and black-eyed peas. ST24 then stopped assisting R339 and walked over to the table to check on R34. At this time, ST24 rubbed R34 on her shoulder, uncovered then recovered R34's food tray, picked up R34's glass of chocolate milk and moved the glass closer to R34. ST24 then walked back over to R339's table, picked up his spoon, and began assisting R339 with eating mechanical barbeque chicken. ST24 did not sanitize or wash her hands between the assistance of R339 and R34. During an interview on 09/14/21 at 1:06 PM, RN8 confirmed she did not wash or sanitize her hands between assisting R339 and R34. During an interview on 09/14/21 at 1:08 PM, ST24 confirmed she did not wash or sanitize her hands between assisting R339 and R34. Review of the facility's policy titled, Infection Prevention - Hand Hygiene, revised on 03/08/2019, indicated, hands should be washed before and after assisting a resident to eat.

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Perform COVID19 testing on residents and staff. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43050 Based on observation, interview, record review, and review of Centers for Medicare and Medicaid Services (CMS) QSO memo 20-38-NH REVISED, the facility failed to ensure twice weekly testing for COVID-19 was completed for all staff and residents during an outbreak. The facility failed to ensure the unvaccinated staff were tested twice weekly per their high county Community Transmission Rate. This failure had the likelihood for any resident who had not had COVID-19 within the past 90 days to contract and spread the virus and experience symptoms such as decreased oxygen saturations, fever, cough, respiratory failure, and death. The facility census was 141. Review of the CMS QSO 20-38-NH REVISED memo, dated 09/10/21, revealed that all unvaccinated staff should be tested twice weekly when the Community Transition Rate is in the substantial or high category. The Community Transition Rate in [NAME] County, SC was 13.1% on 09/15/21 putting the county in the high transmission category. In addition, CMS QSO 20-38-NH indicates that all staff and residents, regardless of their vaccination status, should be tested twice weekly during a facility outbreak investigation and for two weeks after the resolution of a facility COVID-19 outbreak. Review of the facility matrix revealed three residents tested positive for COVID-19 on 09/01/21 making the facility in outbreak status. Review of COVID immunization records revealed 16 unvaccinated residents resided in the facility. Interviews with staff currently working in the facility indicated staff was aware of the twice weekly COVID testing requirement however staff was unsure of the facility's testing schedule and was provided no direction from administration related to ensuring testing is done per current requirements. Seven of 30 nursing/ CNA/ therapy/housekeeping/maintenance/ dietary/hospice staff members who were interviewed and working in the facility on 09/15/21, revealed that they had not been tested for COVID-19 twice weekly. On 09/15/21 at 5:55 PM, the Administrator, Director of Health Services (DHS), and the Corporate Nursing Consultant were notified that an immediate jeopardy was identified at F886-L:COVID-19 testing of residents and staff for failure to ensure all staff and residents, regardless of their vaccination status, were tested for COVID-19 as required by current outbreak status as well as the high county COVID-19 Community Transmission Rate of 13.1%. The IJ was identified to have began on 09/01/21. The facility provided an acceptable Removal Plan for the immediate jeopardy on 09/17/21 at 2:47 PM. The survey team validated the Removal Plan through interviews, observations, and record review. The immediate jeopardy was removed on 09/17/21 at 9:22 PM following the facility's implementation of the Removal Plan. The deficient practice remained at F886 at a lower scope and severity of F (widespread with the potential for more than minimal harm) following the removal of the immediate jeopardy. Findings include: Review of CMS QSO 20-38-NH REVISED, dated 09/10/21, revealed for a facility located in a county with a high (red) level of Community Transmission unvaccinated staff are to be tested twice a week. Further review of CMS QSO 20-38-NH REVISED, dated 09/10/21, revealed that all staff and residents, regardless of their vaccination status, are to be tested every three to seven days during an outbreak. The outbreak testing of all staff and residents is to continue for 14 days after the last positive (staff or resident) COVID-19 result. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the facility matrix revealed three residents tested positive for COVID-19 on 09/01/21 making the facility in outbreak status. During an interview on 09/15/21 at 11:01 AM, the DHS and the Infection Preventionist (IP) revealed that they were unable to provide July, August, or September 2021 documentation of staff testing to verify that testing was completed per CMS guidelines. The DHS indicated that the expectation is for staff to be tested twice weekly based on the current County Transmission rate of 13.1%, and for the results of staff COVID-19 tests to be reported to her and the IP for evaluation and monitoring. The DON verified that the facility had no system in place to ensure staff was being tested for COVID-19 per the current county transmission rate. Observation and interview on 09/15/21 at 10:00 AM revealed Licensed Practical Nurse (LPN) 25 sitting at the nurse's station with her surgical mask hanging off her right ear. LPN25 had a constant dry cough and was continuously clearing her throat. When asked when the last time was she was tested for COVID-19, LPN25 stated eight days ago (09/07/21) even though the facility was in a high County Transmission rate of 13.1%. Interview on 09/15/21 at 10:40 AM with LPN20 confirmed that LPN25 did not test this week. Interview on 09/15/21 at 02:45 PM with LPN12 revealed that she had been tested today and that she worked the weekend, and no testing occurs on the weekend. LPN12 verified that she had not been tested twice a week and her last test was on 09/07/21 despite the facility being in a high County Transmission rate of 13. 1% requiring staff be tested twice a week. On 09/16/21 at 05:23 PM, a surveyor completing a record review, found a note in a resident's chart that a staff member tested positive for COVID-19 on 09/16/21. The DHS stated that the staff member had worked the weekend, 09/11/21 and 09/12/21. When asked if she thought the facility should be in outbreak mode and following CMS guidelines, the DHS had no response. The DHS, the Corporate Nurse, and the Administrator returned to the conference room and reviewed the CMS testing guidelines for outbreak testing with the survey team. The facility immediately started testing all staff and residents per outbreak guidelines.