STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	05/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39580 Based on interviews, review of Resident Identifier (RI) #58's medical record, the facility's policy titled Notification of Changes and a complaint received by the Alabama State Survey Agency, the facility's licensed nursing staff failed to notify RI #58's physician, responsible party and the facility's Administrative staff of the actual events that took place when RI #58 was found deceased in the facility on [DATE]. The licensed nursing staff was aware that RI #58 had received a Regular diet that consisted of a chicken sandwich instead of a Pureed diet, which was ordered for the resident. When the Certified Nursing Assistant (CNA), Employee Identifier (EI) #5, went to pick up RI #58's meal tray at 5:45 PM, the CNA found RI #58 sitting straight up in the bed, with his/her head tilted to the left side of the pillow, with his/her eyes partially opened and mouth wide open with drool going down the mouth. EI #5 stated she also noticed the resident had blue and white discoloration to the face and lips. RI #58 was unresponsive. Instead of notifying RI #58's physician, the resident's responsible party and the Administrative staff that RI #58 had received the wrong diet order/meal tray for the supper meal, the licensed nursing staff informed RI #58's physician and responsible party that the resident had eaten supper, wanted to go bed, the staff assisted the resident to bed and upon returning to check on RI #58, the staff found the resident deceased . RI #58's physician stated it would have been beneficial to know what actually occurred because being given a chicken sandwich instead of the Pureed diet could have caused RI #58 to choke and could have contributed to the resident's death. This deficient practice placed RI #58, one of four sampled residents reviewed for therapeutic diets, in immediate jeopardy for serious injury, harm, impairment or death. On [DATE] at 3:55 PM, the Administrator, Director of Nursing (DON) and Corporate Nurse were notified of the finding of immediate jeopardy in the area of Resident Rights/Notify of Changes, F 580 and given a copy of the Immediate Jeopardy (IJ) template. Findings include: (continued on next page)

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's undated policy titled Notification of Changes documented Policy The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notify, consistent with his or her authority, resident's representative when there is a change requiring notification. Compliance Guidelines: The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include: . 2. Significant change in the resident's physical, mental or psychosocial conditions such as deterioration in health, mental or psychosocial status. This may include: a. life-threatening conditions; or b. Clinical complications . Additional considerations: . Death of a resident: The resident's physician is to be notified immediately in accordance with State law . On [DATE], the State Agency received a complaint regarding RI #58. The anonymous caller reported on [DATE], RI #58, who has a diagnosis of Dementia and assessed as being independent with eating, was given the wrong diet. The caller stated the resident was ordered to have a Pureed diet but was given a regular diet. The kitchen staff, the nursing staff nor the CNA that served the meal, noticed this mistake. The caller further stated, the resident ate the food, got choked and died . RI #58 was admitted to the facility on [DATE], with a medical history to include diagnoses of: Alzheimer's disease, Cerebrovascular Disease, Lupus and Sjogren's syndrome. In an interview on [DATE] at 5:47 PM, EI #5, CNA, acknowledged that she worked the 3:00 PM to 11:00 PM shift on [DATE]. EI #5 was asked if she was the CNA that passed out RI #58's dinner (supper) meal tray on [DATE]. EI #5 stated she was not, that the meal tray was passed out by EI #6, the other CNA assigned to care for RI #58. When asked what happened on [DATE], EI #5 said when the meal trays came to the hall, the other CNA (EI #6) took RI #58's meal tray to the resident's room. EI #5 said after the trays were all passed out, she checked on the residents that needed help and then EI #6 asked her (EI #5) to pick up the meal trays. When asked what happened after she picked up the meal trays, EI #5 stated she went to the last room, which was RI #58's room. EI #5 said she noticed RI #58 was sitting straight up in the bed, with his/her head tilted to the left side of the pillow, with his/her eyes partially opened and mouth wide open with drool going down the mouth. EI #5 stated she also noticed the resident had blue and white discoloration to the face and lips. EI #5 said she tried to arouse RI #58 by touching the resident on his/her arm and calling his/her name, but RI #58 did not respond. After no response from the resident, EI #5 said she immediately notified the nurse, EI #3. According to EI #5, when EI #3 entered the resident's room, she showed her RI #58's meal tray ticket and told her that it didn't match. EI #5 stated she was told by the nurse (EI #3) to put the ticket on the tray and take the meal tray out of the room to the food cart. When asked if RI #58 had eaten the food on the meal tray, EI #5 said she didn't observe the resident eat the food, but when she picked the meal tray up, there was approximately 75% to 80% of the food had been eaten. EI #5 was asked what kind of diet RI #58 received for the supper meal on [DATE]. EI #5 replied, the resident got a regular meal tray that consisted of a chicken sandwich, potato salad, a dessert, water and sweet tea. When asked how she knew the meal tray was wrong, EI #5 said when she picked the tray up and looked at the ticket, the ticket had the resident's name on it with Puree Diet and the room number, but the food items left on the meal tray were not Puree items. EI #5 said again, RI #58 had received the wrong meal tray. When asked to describe the food items left on RI #58's supper meal tray, EI #5 said there was a quarter size left of a chicken sandwich; 25% of a serving of potato salad; approximately 60 cubic centimeters (cc) of 120cc of sweet tea; and 120cc of water that had not been drank. EI #5 stated the meal ticket said Puree diet but the food on the tray was a Regular diet. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview on [DATE] at 1:11 PM, EI #6, the CNA who delivered RI #58's supper meal tray on [DATE] stated she delivered RI #58's meal tray between 5:00 PM and 5:30 PM. EI #6 acknowledged that she gave RI #58 a regular meal tray that consisted of a chicken sandwich, potato salad, and some other items that she could not remember. EI #6 stated she cut the chicken sandwich up into fourths, gave it to the resident and the resident began eating. After setting RI #58's meal tray up, EI #6 stated she went to the dining room to assist with feeding and stayed there until 7:00 PM. As EI #6 took residents back to their room from the dining room, she stated she saw EI #5 come out of RI #58's room in a hurry. According to EI #6, EI #5 told her that RI #58 might have choked and died . EI #6 stated she asked the EI #5 what she meant, then EI #5 explained to EI #6 that the resident's meal ticket said Regular Puree diet but the resident had received a Regular diet. EI #6 stated EI #5 told her the resident had one-fourth of a chicken sandwich and some potato salad still left on the meal tray. When asked if she told anyone that she had delivered the wrong meal tray to RI #58, EI #6 said she didn't the nurse, EI #3, because she was upset after hearing the resident may have choked. EI #6 stated she was informed by the nurse to provide post-mortem care to RI #58. According to EI #6, during post-mortem care EI #5 became upset and had to leave the resident's room. EI #6 stated she then walked to the resident's room door and found EI #4, a nurse from another hall and asked her (EI #4) if she could assist her (EI #6) in providing RI #58's post-mortem care. EI #6 stated while she and EI #4 provided post-mortem care, she informed EI #4 that she had made an honest mistake. EI #6 stated she wanted to tell the truth from the beginning but was afraid that she would lose her job. EI #6 stated since she didn't know what to do, she along with EI #5, went to talk with the Admissions Nurse, EI #8. According to EI #6, she told the Admissions Nurse that RI #58's death may have been her fault because she had given the resident the wrong meal tray and the resident may have choked and diet. EI #6 said the Admissions told her that if it was a resident's time to go, that God didn't make any mistakes. When asked who she should have told about the incident once she realized that RI #58 had received the wrong supper meal tray, EI #6 said she should have told the nurse but she didn't because she was scared. During an interview on [DATE] at 3:44 PM, EI #4, a Licensed Practical Nurse (LPN) acknowledged that she worked in the facility on [DATE]. EI #4 stated she left her hall when she noticed EI #5, a CNA, was upset. According to EI #4, the CNA (EI #5) told her she was upset because she had found RI #58 in the bed deceased . After finding EI #6 upset, EI #4 stated she told the other CNA, EI #6, that she would assist her in cleaning RI #58 up until EI #5 could return. When asked what happened while she and EI #6 were providing post-mortem care to RI #58, EI #4 said she had not told anyone this before but EI #6 told her that this was her (EI #6) fault and God is going to punish me for this and that RI #58 might have choked. When asked why she thought the resident had choked, EI #4 stated the CNA (EI #6) told her that she had given RI #58 a chicken patty and cut it in half. Also, the resident was supposed to have a Pureed diet but was given a Regular diet. EI #4 was asked if she informed anyone that the CNA told her the resident may have choked, she said no. When asked should she have told anyone, EI #4 said yes ma'am. EI #4 was asked why did she not tell anyone and she stated because she was scared as to what would happen. EI #4 stated the rumor in the facility that was told to her by EI #10, a CNA that the nurse (EI #3) and EI #6, the CNA were saying the resident didn't choked instead he/she died of a heart attack. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 2:37 PM, EI #8, the Admissions Nurse acknowledged that she worked in the facility on [DATE]. When asked if EI #5 and EI #6, both CNAs came to her office around 7:00 PM on [DATE], EI #8 said yes. EI #8 was asked what EI #6 told her. EI #8 replied that EI #6 said RI #58's death may have been her fault because she gave the resident the wrong meal tray. According to EI #8, EI #6 told her that when she delivered RI #58's supper meal tray, the resident was sitting up in the bed and didn't see anything wrong with the resident while she (EI #6) was in the room. EI #8 stated she asked EI #6 did she look at the resident's meal ticket and she said she couldn't remember what EI #6 said. EI #8 stated she told EI #6 that it was not her fault, that if it was your time to go, when it was your time to go. EI #8 was asked if she advised EI #6 that she should report her concerns to the nurse. EI #8 replied that she didn't know. When asked if she reported the concern to her supervisor and/or Administrator, EI #8 said no. When asked should she have reported this to her supervisor and/or Administrator, EI #8 replied, she guessed. EI #8 was asked why didn't she report this concern to her supervisor and/or Administrator and she stated, she didn't know. In an interview on [DATE] at 3:34 PM, EI #3, a Registered Nurse (RN) stated when she walked into RI #58's room around 5:45 PM, after being told the resident was unresponsive, she found RI #58 in bed in an upright position. EI #3 stated she checked RI #58's pupils and pulse but got no tactile response. The resident's eyes and mouth were partially open and drool was coming out the left side of RI #58's mouth. EI #3 stated she called the resident's name and there was no response. EI #3 explained that since RI #58 was a DNR (Do Not Resuscitate), there was not a need to start CPR (Cardiopulmonary Resuscitation). EI #3 acknowledged that she contacted the physician, EI #7, and informed her that RI #58 had expired. When asked what she had communicated to the physician, EI #7, regarding RI #58 being found unresponsive, EI #3 stated she told EI #7 that RI #58 had expired and the resident was a DNR. EI #3 commented, that was all she remembered telling the physician, EI #7. After notifying the physician, EI #3 stated she asked the CNAs (EI #5 and EI #6) to perform post-mortem care on RI #58. In a telephone interview with RI #58's responsible party on [DATE] at 9:40 AM, she stated she couldn't remember the name of the person who called her, but she received a call on [DATE] around 6:00 PM. According to RI #58's responsible party, the caller stated RI #58 had passed away about 10 minutes ago. RI #58's responsible party stated she was told the resident had eaten supper and then wanted to go to bed. When the staff went back to check on the resident, RI #58 had passed away. In an interview with EI #7, the facility's Medical Director and RI #58's attending physician on [DATE] at 1:03 PM, she acknowledged that she received a call on [DATE] that RI #58, whose code status was DNR, was found unresponsive. EI #7 stated she was told RI #58 had eaten dinner, the staff had taken the resident back to his/her room to get ready for bed and when the staff when to check on the resident again, RI #58 had expired in the bed. EI #7 stated the nurse told her that RI #58 had no pulse, no heart rate and there had been no complications prior to finding the resident and there was no mention of any difficulty with the dinner meal. EI #7 stated since the resident was in his/her 90s, had a code status of DNR and a history of CVA, she felt RI #58's cause of death was probably a coronary event. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 9:02 PM, EI #2, the DON was asked what she knew about RI #58's death in the facility. EI #2 stated she was aware the resident expired in the facility on [DATE] and during the survey of the facility by the State Survey Agency, there was an accusation made that RI #58 received the wrong diet. EI #2 stated since the accusation was made, the facility started an investigation. When asked what she would have expected staff to do related to the events surrounding RI #58 on [DATE], EI #2 stated that she would have expected the staff to notify her immediately and for the CNA to report her concerns to the Charge Nurse, who in turn should have notified the DON immediately. On [DATE] at 9:19 PM, an interview was conducted with EI #1, Administrator. EI #1 said he was not aware of the incident with RI #58 that occurred on [DATE], until the unit manager informed him what EI #5 was alleging on [DATE]. When asked what he expected staff to do in this situation, he said he would expect that it would have been reported to appropriate staff for follow-up for determination if it it needed to be reported to the State Agency or not and to start an investigation immediately. EI #1 said whether it be the person in charge or a subordinate, that either person would acknowledge something inappropriate happened. In a follow-up interview with EI #7, the facility's Medical Director and RI #58's attending physician, on [DATE] at 7:12 PM, she was informed that RI #58 had been served a regular diet instead of a Pureed diet on [DATE]. EI #7 was also notified that when the CNA went to pick RI #58's meal tray up at 5:45 PM, she found the resident unresponsive and reported to the nurse that the resident had received the wrong diet. EI #7 commented that it would have been beneficial for her to know what had occurred. EI #7 stated she was only told the resident had eaten dinner and was in the bed and later when the staff went to check on RI #58, the resident was found deceased . When asked if RI #58 was ordered a Pureed diet, EI #7 said yes. When asked why RI #58 was ordered a Pureed diet, EI #7 stated because the resident had several strokes over the years, with cerebral hemorrhage and the resident had gotten more confused and demented. EI #7 was asked, in her medical opinion, what was the likelihood of the resident getting a regular diet that consisted of a chicken sandwich and potato salad, could this have contributed to the resident's death. EI #7 replied, yes the chicken sandwich could have possibly caused the resident to choke. ********** On [DATE] at 5:30 PM, an acceptable Removal Plan was received which documented: F 580 I. Facility Licensed Nursing staff, failed to follow facility Policy and Procedures for notification 1. Facility Medical Director was notified May, 4 2019 of the events surrounding RI #58 being found deceased 2. Audit of Resident's charts, that have expired in the facility since [DATE] was conducted by the Nurse Consultant and Director of nursing with no notification issues noted 3. Administrator and Director of Nursing were educated [DATE] (by Nurse Consultant) on Notification of Changes Policy (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Director of Nursing, (witnessed by the Administrator) did a one on one in-service on [DATE] on Notification of Change with RN. This nurse was also suspended [DATE] for failure to communicate to physician that resident RI #58 received the wrong meal tray As of [DATE], 17 of 37 licensed staff have been in-serviced on the Notification of Change Policy All licensed facility employees not in-serviced on [DATE], will not work until education has been completed 4. All licensed nursing staff (not in-serviced on Notification Policy) by [DATE] will be notified and not allowed to clock in nor return to work until education has been completed, by the Director of Nursing, Unit Manager and/or Supervisor. Director of nursing will review all records for completion. All new licensed staff, hired on or after [DATE] will be in-serviced during new employee orientation on the Notification of Change Policy). The Director of Nursing will review all records for completion. All facility deaths will be discussed in the morning meeting and chart reviewed to insure accurate documentation beginning [DATE] The likelihood for serious harm to recipient to no longer exist is [DATE] Member of Governing Body met with Administrator, Director of Nursing, Unit Manager, Dietary Manager and Facility Medical Director on [DATE] and are in agreement with these steps of the removal plan. Follow up QA meeting will be conducted [DATE]. ********** After reviewing the facility's information provided in their Removal Plan and verifying the immediate actions had been implemented, the scope/severity level of F 580 was lowered to a D level on [DATE], to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as a result of the investigation of complaint/report number AL00036241.

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39580 Based on interviews, review of the facility's policy titled [NAME] Health and Rehab; Food and Nutrition Services, a complaint received by the Alabama State Survey Agency, Resident Identifier (RI) #58 and RI #136's medical records, the facility's diet spreadsheet, and investigation file, the facility failed to ensure RI #58 received a Pureed diet during the supper (dinner) meal on [DATE]. On [DATE], RI #58, a cognitively impaired resident assessed by the facility as requiring set up help only with eating, was ordered a Pureed diet. RI #58 has a medical history to include a diagnosis of Sjogren's syndrome, which causes difficulty swallowing. During the supper meal on [DATE], the Certified Nursing Assistant (CNA) that delivered RI #58's dinner meal tray did not thoroughly read the tray ticket, to ensure the correct diet was given to the resident. When a different CNA went to pick up the dinner meal tray on [DATE], she found the resident sitting up in the bed, with his/her head tilted to the left, eyes partially opened, mouth open with drool going down the resident's mouth, with blue and white face and lips. When the CNA was unable to arouse the resident, she notified the Registered Nurse (RN). The CNA also stated she informed the RN that the resident had received the wrong meal tray/diet. The CNA stated she observed ,d+[DATE] size of chicken sandwich, 25% left of a serving of potato salad, 60 cc of the 120cc of sweet tea; and 120cc of water. According to RI #58's death certificate, the resident was pronounced deceased on [DATE] at 5:45 PM. This deficient practice placed RI #58, one of four sampled residents reviewed for therapeutic diets, in immediate jeopardy for serious injury, harm, impairment or death. On [DATE] at 3:55 PM, the Administrator, Director of Nursing (DON) and Corporate Nurse were notified of the finding of immediate jeopardy in the area of Food and Nutrition Services/Food in Form to Meet Individual Needs, F 805 and given a copy of the Immediate Jeopardy (IJ) template. Findings include: The facility's policy titled [NAME] Health and Rehab; Food and Nutrition Services revised [DATE], documented Policy Statement Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident . Policy Interpretation and Implementation . 6. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident . On [DATE], the State Agency received a complaint regarding RI #58. The anonymous caller reported on [DATE], RI #58, who has a diagnosis of Dementia and assessed as being independent with eating, was given the wrong diet. The caller stated the resident was ordered to have a Pureed diet but was given a regular diet. The kitchen staff, the nursing staff nor the Certified Nursing Assistant (CNA) that served the meal, noticed this mistake. The caller further stated, the resident ate the food, got choked and died . RI #58 was admitted to the facility on [DATE], with a medical history to include diagnoses of: Alzheimer's disease, Cerebrovascular Disease, Lupus and Sjogren's syndrome. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RI #58's Speech Therapy Treatment Encounter Note(s) dated [DATE], documented . Downgrade pt (patient) to puree consistency solids. RI #58's physician orders revealed an order dated [DATE] for a Puree Diet. RI #58's Annual Minimum Data Set (MDS) with an assessment reference date of [DATE] indicated the resident was moderately impaired in cognitive skills for daily decision making, with a Brief Interview for Mental Status (BIMS) of 8. RI #58 was assessed as requiring set up help only and supervision (oversight, encouragement or cueing) with eating. According to this MDS, RI #58 had no natural teeth or tooth fragments and received a mechanically altered diet. RI #58's care plan titled (RI #58) has alteration in nutritional status . requires cueing assistance with eating . is edentulous (without teeth) . last reviewed [DATE] had an approach of . Provide diet per MD (Medical Doctor) orders . RI #58's Annual Nutrition assessment dated [DATE] indicated . Diet: Pureed . (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 5:47 PM, Employee Identifier (EI) #5, a Certified Nursing Assistant (CNA), acknowledged that she worked the 3:00 PM to 11:00 PM shift on [DATE]. When asked if she was assigned to care for RI #58, EI #5 said she was one of the CNAs. When asked who the nurse was assigned to care for RI #58, EI #5 said it was EI #3, a Registered Nurse (RN). EI #5 was asked if she was the CNA that passed out RI #58's dinner (supper) meal tray on [DATE]. EI #5 stated she was not, that the meal tray was passed out by EI #6, the other CNA assigned to care for RI #58. When asked what happened on [DATE], EI #5 said when the meal trays came to the hall, the other CNA (EI #6) took RI #58's meal tray to the resident's room. EI #5 said after the trays were all passed out, she checked on the residents that needed help and then EI #6 asked her (EI #5) to pick up the meal trays. When asked what happened after she picked up the meal trays, EI #5 stated she went to the last room, which was RI #58's room. EI #5 said she noticed RI #58 was sitting straight up in the bed, with his/her head tilted to the left side of the pillow, with his/her eyes partially opened and mouth wide open with drool going down the mouth. EI #5 stated she also noticed the resident had blue and white discoloration to the face and lips. EI #5 said she tried to arouse RI #58 by touching the resident on his/her arm and calling his/her name, but RI #58 did not respond. After no response from the resident, EI #5 said she immediately notified the nurse, EI #3. According to EI #5, when EI #3 entered the resident's room, she showed her RI #58's meal tray ticket and told her that it didn't match. EI #5 stated she was told by the nurse (EI #3) to put the ticket on the tray and take the meal tray out of the room to the food cart. EI #5 said after she placed RI #58's meal tray on the food cart, she went back into the resident's room but when she started crying and having a panic attack, the nurse (EI #3) asked her to leave the room. When asked who found RI #58 unresponsive, EI #5 said she did and she immediately notified EI #3, the RN. When asked if RI #58 had eaten the food on the meal tray, EI #5 said she didn't observe the resident eat the food, but when she picked the meal tray up, there was approximately 75% to 80% of the food had been eaten. EI #5 was asked what kind of diet RI #58 received for the supper meal on [DATE]. EI #5 replied, the resident got a regular meal tray that consisted on a chicken sandwich, potato salad, a dessert, water and sweet tea. EI #5 acknowledged again that RI #58's supper meal tray was delivered to the resident by EI #6, a CNA. When asked how she knew the meal tray was wrong, EI #5 said when she picked the tray up and looked at the ticket, the ticket had the resident's name on it with Puree Diet and the room number, but the food items left on the meal tray were not Puree items. EI #5 said again, RI #58 had received the wrong meal tray. When asked to describe the food items left on RI #58's supper meal tray, EI #5 said there was a quarter size left of a chicken sandwich; 25% of a serving of potato salad; approximately 60 cubic centimeters (cc) of 120cc of sweet tea; and 120cc of water that had not been drank. EI #5 stated the meal ticket said Puree diet but the food on the tray was a Regular diet. According to the facility's diet spreadsheet, the regular supper meal for [DATE] was a chicken breast, mashed potatoes & gravy, cucumber & onion salad, a brownie, roll/margarine and milk/beverage. The Pureed supper meal for [DATE] was Pureed chicken breast, mashed potatoes & gravy, Pureed cucumber & onion salad, a Pureed brownie, Pureed white bread and milk/beverage. (continued on next page)

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Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview on [DATE] at 1:11 PM, EI #6, the CNA who delivered RI #58's supper meal tray on [DATE] stated she delivered RI #58's meal tray between 5:00 PM and 5:30 PM. EI #6 acknowledged that she gave RI #58 a regular meal tray that consisted of a chicken sandwich, potato salad, and some other items that she could not remember. EI #6 stated she cut the chicken sandwich up into fourths, gave it to the resident and the resident began eating. After setting RI #58's meal tray up, EI #6 stated she went to the dining room to assist with feeding and stayed there until 7:00 PM. As EI #6 took residents back to their room from the dining room, she stated she saw EI #5 come out of RI #58's room in a hurry. According to EI #6, EI #5 told her that RI #58 might have choked and died . EI #6 stated she asked the EI #5 what she meant, then EI #5 explained to EI #6 that the resident's meal ticket said Regular Puree diet but the resident had received a Regular diet. EI #6 stated EI #5 told her the resident had one-fourth of a chicken sandwich and some potato salad still left on the meal tray. When asked if she told anyone that she had delivered the wrong meal tray to RI #58, EI #6 said she didn't the nurse, EI #3, because she was upset after hearing the resident may have choked. EI #6 stated she was informed by the nurse to provide post-mortem care to RI #58. According to EI #6, during post-mortem care EI #5 became upset and had to leave the resident's room. EI #6 stated she then walked to the resident's room door and found EI #4, a nurse from another hall and asked her (EI #4) if she could assist her (EI #6) in providing RI #58's post-mortem care. EI #6 stated while she and EI #4 provided post-mortem care, she informed EI #4 that she had made an honest mistake. EI #6 stated she wanted to tell the truth from the beginning but was afraid that she would lose her job. EI #6 stated since she didn't know what to do, she along with EI #5, went to talk with the Admissions Nurse, EI #8. According to EI #6, she told the Admissions Nurse that RI #58's death may have been her fault because she had given the resident the wrong meal tray and the resident may have choked and diet. EI #6 said the Admissions told her that if it was a resident's time to go, that God didn't make any mistakes. When asked who she should have told about the incident once she realized that RI #58 had received the wrong supper meal tray, EI #6 said she should have told the nurse but she didn't because she was scared. EI #6 explained that she had made an honest mistake and had lied to a lot of people about the events that happened on [DATE]. EI #6 stated she wrote a statement when asked to do so, but that what she wrote in her statement and gave to the facility was not true. EI #6 stated she wrote down in her statement that the resident had received a Pureed diet but that was not true. Contained within the facility's investigation file was a written statement signed by EI #6 and dated [DATE] 9:24 PM, which documented I (EI #6) help pass out trays on E hall. I look at all tray cards and match them with the trays as I always do. I also took (RI #58) (his/her) tray there was no issues with (his/her) tray. In a follow-up interview with EI #6, a CNA, on [DATE] beginning at 6:48 PM, she was asked why she gave RI #58 a Regular meal tray when the resident was ordered to have a Pureed meal tray. EI #6 replied, that she didn't read the entire meal ticket. EI #6 explained that it wasn't until EI #5 had told her that RI #58 had received the wrong meal tray that she recognized that she had given the resident the wrong meal tray. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3:44 PM, EI #4, a Licensed Practical Nurse (LPN) acknowledged that she worked in the facility on [DATE]. EI #4 stated she left her hall when she noticed EI #5, a CNA, was upset. According to EI #4, the CNA (EI #5) told her she was upset because she had found RI #58 in the bed deceased . After finding EI #6 upset, EI #4 stated she told the other CNA, EI #6, that she would assist her in cleaning RI #58 up until EI #5 could return. When asked what happened while she and EI #6 were providing post-mortem care to RI #58, EI #4 said she had not told anyone this before but EI #6 told her that this was her (EI #6) fault and God is going to punish me for this and that RI #58 might have choked. When asked why she thought the resident had choked, EI #4 stated the CNA (EI #6) told her that she had given RI #58 a chicken patty and cut it in half. Also, the resident was supposed to have a Pureed diet but was given a Regular diet. EI #4 was asked if she informed anyone that the CNA told her the resident may have choked, she said no. When asked should she have told anyone, EI #4 said yes ma'am. EI #4 was asked why did she not tell anyone and she stated because she was scared as to what would happen. EI #4 stated the rumor in the facility that was told to her by EI #10, a CNA that the nurse (EI #3) and EI #6, the CNA were saying the resident didn't choked instead he/she died of a heart attack. EI #4 explained that after the CNA, EI #5, returned to RI #58's room, to finish assisting EI #6 with post-mortem care, she went back to her assigned hall. In an interview on [DATE] at 2:37 PM, EI #8, the Admissions Nurse acknowledged that she worked in the facility on [DATE]. When asked if EI #5 and EI #6, both CNAs came to her office around 7:00 PM on [DATE], EI #8 said yes. EI #8 was asked what EI #6 told her. EI #8 replied that EI #6 said RI #58's death may have been her fault because she gave the resident the wrong meal tray. According to EI #8, EI #6 told her that when she delivered RI #58's supper meal tray, the resident was sitting up in the bed and didn't see anything wrong with the resident while she (EI #6) was in the room. EI #8 stated she asked EI #6 did she look at the resident's meal ticket and she said she couldn't remember what EI #6 said. EI #8 stated she told EI #6 that it was not her fault, that if it was your time to go, when it was your time to go. EI #8 was asked if she advised EI #6 that she should report her concerns to the nurse. EI #8 replied that she didn't know. When asked if she reported the concern to her supervisor and/or Administrator, EI #8 said no. When asked should she have reported this to her supervisor and/or Administrator, EI #8 replied, she guessed. EI #8 was asked why didn't she report this concern to her supervisor and/or Administrator and she stated, she didn't know. During an interview with EI #9, a LPN on [DATE] at 9:10 AM, she stated she was called to RI #58's room during the evening of [DATE] by EI #5, the CNA and the nurse, EI #3. EI #9 stated when she entered RI #58's room, the resident was in the bed with the head of the bed at a 45 degree angle and she noticed the resident had a white frothy liquid coming from his/her mouth. EI #9 stated she checked the resident's pulse and respiration but there was no pulse or respiration. EI #9 stated during her assessment of the resident, no one was in the room with her but the resident's roommate (RI #136), who was sitting on his/her side of the room. EI #9 stated the nurse, EI #3, may have been at the doorway but she was not present at her side, when EI #9 completed her assessment of the resident. EI #9 stated after she completed her assessment of the resident, she was informed by EI #3 (RN) that RI #58 was a DNR (Do Not Resuscitate). (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 9:40 AM, an interview was conducted with RI #136, the roommate of RI #58 on [DATE]. RI #136 stated he/she ate the supper meal in the dining room on [DATE]. RI #136 stated when he/she came back to the room, he/she glanced over at RI #58, who was in the bed and noticed the resident appeared to be choking. RI #136 stated he/she pulled the privacy curtain because he/she didn't want to see that. When asked if he/she ever saw a regular meal tray in the resident's room, RI #136 said yes. When asked when he/she saw a regular meal tray in the resident's room, RI #136 stated the day RI #58 died . RI #136 was asked if he/she knew what happened, the resident stated he/she heard the staff talking as they were coming in and leaving out of the room say the resident (RI #58) choked on some chicken and that the resident got a regular tray instead of a Pureed meal tray. When asked if he/she remembered anything else about the day RI #58 expired in the facility, RI #136 stated all he/she knew was that RI #58 choked on some chicken and died . RI #136 was admitted to the facility on [DATE] and has a medical history to include diagnoses of: Dementia, Parkinson's disease, and Type II Diabetes Mellitus. RI #136's Quarterly MDS with an assessment reference date of [DATE] indicated RI #136 was moderately impaired in cognitive skills, with a BIMS of 12. During this assessment period, RI #136 displayed no altered level of consciousness, disorganized thinking or inattention. In an interview on [DATE] at 3:34 PM, EI #3, a RN stated when she walked into RI #58's room around 5:45 PM, after being told the resident was unresponsive, she found RI #58 in bed in an upright position. EI #3 stated she checked RI #58's pupils and pulse but got no tactile response. The resident's eyes and mouth were partially open and drool was coming out the left side of RI #58's mouth. EI #3 stated she called the resident's name and there was no response. EI #3 explained that since RI #58 was a DNR, there was not a need to start CPR (Cardiopulmonary Resuscitation). EI #3 was asked why type of diet was RI #58 ordered and she said, a Pureed diet. When asked if she had been told that RI #58 had received the wrong meal tray, EI #3 said no. EI #3 was asked if she was familiar with RI #58 and she stated on [DATE] was the first time she had ever been assigned to care for RI #58. EI #3 acknowledged that she contacted the physician, EI #7, and informed her that RI #58 had expired. After notifying the physician, EI #3 stated she asked the CNAs (EI #5 and EI #6) to perform post-mortem care on RI #58. RI #58's Departmental Notes dated [DATE] 9:20 PM written by EI #3, a RN, documented At 5:45 PM CNA entered room and found Resident deceased . VS (vital signs) checked by two nurses. Absence of VS for period of fifteen minutes. CNAs instructed to provide death care. UM (Unit Manager) notified. MD (Medical Director) notified. DON notified. Resident's sponsor notified . (name) is the funeral home with Resident's policy. They arrived to pick up Resident's body at 8:25 PM and departed the facility at 8:31 PM . During an interview on [DATE] at 9:02 PM, EI #2, the DON was asked what she knew about RI #58's death in the facility. EI #2 stated she was aware the resident expired in the facility on [DATE] and during the survey of the facility by the State Survey Agency, there was an accusation made that RI #58 received the wrong diet. EI #2 stated since the accusation was made, the facility started an investigation. When asked what she would have expected staff to do related to the events surrounding RI #58 on [DATE], EI #2 stated she would have expected the CNA that delivered the tray to have verified it was the correct diet and if it was not, to send it back to the kitchen for the correct tray. EI #2 further stated that she would have expected the staff to notify her immediately and for the CNA to report her concerns to the Charge Nurse, who in turn should have notified the DON immediately. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 11:27 AM, EI #11, the Certified Dietary Manager was asked, had a meal tray ever left the kitchen that was incorrect according to the physician order. EI #11 replied, yes. On [DATE] at 2:25 PM, EI #12, a dietary aide was asked how RI #58 could have received the wrong meal tray on [DATE]. EI #12 replied, if somebody was not paying attention to the meal ticket. On [DATE] at 2:36 PM, EI #13, a dietary aide was asked how RI #58 could have received the wrong meal tray on [DATE]. EI #13 replied, from not looking at the tray card. In an interview with EI #7, the facility's Medical Director and RI #58's attending physician on [DATE] at 1:03 PM, she acknowledged that she received a call on [DATE] that RI #58, whose code status was DNR, was found unresponsive. EI #7 stated she was told RI #58 had eaten dinner, the staff had taken the resident back to his/her room to get ready for bed and when the staff when to check on the resident again, RI #58 had expired in the bed. EI #7 stated the nurse told her that RI #58 had no pulse, no heart rate and there had been no complications prior to finding the resident and there was no mention of any difficulty with the dinner meal. EI #7 stated since the resident was in his/her 90s, had a code status of DNR and a history of CVA, she felt RI #58's cause of death was probably a coronary event. According to an untitled facility document, RI #58's meal intake percentage (the amount of food consumed by the resident) for the dinner meal on [DATE] was NOT AVAIL (available) Resident Expired. In a follow-up interview with EI #7 on [DATE] at 7:12 PM, she was informed that RI #58 had been served a regular diet instead of a Pureed diet on [DATE]. EI #7 was also notified that when the CNA went to pick RI #58's meal tray up at 5:45 PM, she found the resident unresponsive and reported to the nurse that the resident had received the wrong diet. EI #7 commented that it would have been beneficial for her to know what had occurred. EI #7 stated she was only told the resident had eaten dinner and was in the bed and later when the staff went to check on RI #58, the resident was found deceased . When asked if RI #58 was ordered a Pureed diet, EI #7 said yes. When asked why RI #58 was ordered a Pureed diet, EI #7 stated because the resident had several strokes over the years, with cerebral hemorrhage and the resident had gotten more confused and demented. EI #7 was asked, in her medical opinion, what was the likelihood of the resident getting a regular diet that consisted of a chicken sandwich and potato salad, could this have contributed to the resident's death. EI #7 replied, yes the chicken sandwich could have possibly caused the resident to choke. RI #58's death certificate revealed RI #58 date and time of death as [DATE] at 5:45 PM, with the immediate cause of death listed as Cardiopulmonary Arrest. ********** On [DATE] at 5:30 PM, an acceptable Removal Plan was received which documented: F 805 II Food in form to meet individual needs: (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. When the matter of the incorrect diet was brought to the attention of administration, on [DATE], an investigation was immediately initiated and Investigative Summary will be completed within 5 working days. 2. The facility suspended the CNA ([DATE]) that delivered the supper meal tray on [DATE], that failed to insure the correct diet was delivered. This CNA will be terminated [DATE] for failure to report in a timely manner, and falsification of an investigative statement The facility suspended the CNA ([DATE]) that picked up the supper meal tray on [DATE], that failed to report her concerns about the delivery of the wrong tray to Administration. This CNA was terminated [DATE], for failure to report in a timely manner RN Admission Nurse was suspended ([DATE]) and subsequently terminated ([DATE]) for failure to report knowledge of incorrect diet being delivered to resident RI #58 on [DATE], to Administration in a timely manner LPN that assisted with Post Mortem Care was suspended ([DATE]) and subsequently terminated ([DATE]) for failure to report knowledge of incorrect diet being delivered to resident RI #58 on [DATE] to Administration in a timely manner RN Charge Nurse was suspended ([DATE]) for failure to communicate to physician and other administrative staff that resident had received the wrong meal tray Facility Medical Director was notified [DATE] of incorrect supper meal being delivered to RI #58 on [DATE] 3. Administrator and Director of Nursing were educated [DATE] (by Nurse Consultant) on Food and Nutrition Services Policy The Director of Nursing educated Facility Unit Managers and Nursing Supervisor [DATE], on Food and Nutrition Services Policy All licensed staff working 7am - 7pm, [DATE] were educated by the Unit Manager on Food and Nutrition Services Policy All licensed staff working 7pm - 7am, [DATE], were educated by the Unit Manager on: Food and Nutrition Services Policy All CNA's working the ,d+[DATE] shift ([DATE]) were educated by the Unit Managers and Nursing Supervisor on Food and Nutrition Services Policy All CNA's working the ,d+[DATE] shift ([DATE]) were educated by the Unit Managers and Nursing Supervisor on Food and Nutrition Services Policy As of [DATE], 17 of 37 licensed staff have been educated on Food and Nutrition Services Policy As of [DATE], 33 of 61 CNA's have been educated on Food and Nutrition Services Policy (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	All Dietary staff working the evening shift ([DATE]) were educated on Food and Nutrition Services Policy As of [DATE], 8 of 20 Dietary employees have been educated on Food and Nutrition Services Policy All licensed nursing staff, CNA's and Dietary staff (not in-serviced on Food and Nutrition Policy) by [DATE] will be notified and not allowed to clock in nor return to work until education has been completed, by the Director of Nursing, Unit Manager and/or Supervisor. All new licensed staff, CNA's, and Dietary staff hired on or after [DATE] will be in-services during new employee orientation on the Food and Nutrition Policy). The Director of Nursing will review all records for completion. 4. All pureed supper meals served [DATE] were observed for appropriate diet orders by the Director of Nursing and Dietary Manager with no issues noted, All pureed breakfast meals served [DATE] were observed by Unit Managers and Dietary Manager for appropriate diet orders, with no issues noted. All pureed lunch meals served on [DATE] were observed by Unit Managers and Dietary Manager for appropriate diet orders, with no issues noted All licensed nursing staff, CNA's and Dietary staff (not in-serviced on Food and Nutrition Services Policy) by [DATE] will be notified and not allowed to clock in nor return to work until education has been completed, by the Director of Nursing, Unit Manager and/or Supervisor. Director of Nursing will review all records for completion. The likelyhood (likelihood) for serious harm to recipient to no longer exist is [DATE] Member of Governing Body met with Administrator, Director of Nursing, Unit Manager, Dietary Manager and Facility Medical Director on [DATE] and are in agreement with these steps of the removal plan. Follow up QA meeting will be conducted [DATE]. ********** After reviewing the facility's information provided in their Removal Plan and verifying the immediate actions had been implemented, the scope/severity level of F 805 was lowered to a D level on [DATE], to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as a result of the investigation of complaint/report number AL00036241.

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F 0842 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39580 Based on interviews, review of Resident Identifier (RI) #58's medical record, facilities' policies titled Death of a Resident, Documenting, Charting and Documentation, Vital Signs, an unlabled facility document, and a complaint received by the Alabama State Survey Agency, the facility's licensed nursing staff failed to document in RI #58's medical record an accurate description of the events surrounding the resident being found deceased in the facility on [DATE]. The licensed staff further failed to document in RI #58's medical record, a complete assessment of the resident, to include vital signs, the findings from the assessment, the time of pronouncement and the name of the individual who pronounced RI #58 deceased to ensure RI #58's medical record validated the accuracy of the resident's death in the facility. Without a complete documented description of the details leading up to RI #58 being found unresponsive, to include what happened when the resident was found unresponsive and how staff responded, the facility cannot be assured staff was compliant with following the facility's policies, the Standards of Practice for a licensed nurse and Federal and State regulations. This deficient practice placed RI #58, one of one sampled resident reviewed for death in the facility, in immediate jeopardy for serious injury, harm, impairment or death. On [DATE] at 3:55 PM, the Administrator, Director of Nursing (DON) and Corporate Nurse were notified of the finding of immediate jeopardy in the area of Administration/Resident Records, F 842 and given a copy of the Immediate Jeopardy (IJ) template. Findings include: The facility's policy titled Death of a Resident, Documenting revised [DATE], documented Policy Statement Appropriate documentation shall be made in the clinical record concerning the death of a resident. Policy Interpretation and Implementation . 2. All information pertaining to a resident's death (i.e. [for example], date, time of death, the name and title of the individual pronouncing the resident dead, etc.[and so on]) must be recorded on the nurses' notes . The facility's policy titled Charting and Documentation revised [DATE], documented Policy Statement All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. Policy Interpretation and Implementation 1. All observations, medications administered, services performed, etc., must be documented in the resident's clinical records . The facility's policy titled Vital Signs reviewed [DATE], documented Policy: The purpose of this policy is to provide guidelines for the measurement and reporting of vital signs. Definition: Vital signs are indicators of health status, including temperature, pulse, blood pressure, respiratory rate, oxygen saturation, and pain. Policy Explanation and Compliance Guidelines: 1. Routine vital signs include: temperature, pulse, blood pressure and respiratory rate. 2. Oxygen saturation and pain are to be obtained and interpreted by licensed nurses. 3. Vital signs shall be documented at least in the following circumstances: . e. When the resident's general condition changes . (continued on next page)

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F 0842 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An unlabeled facility document with a revised date of [DATE], documented . Purpose: To establish the procedure for the registered nurse or nurse practitioner to follow when pronouncing a resident in a skilled nursing facility . B. Responsibilities of the nurse at the nursing home . 9. Document in the medical record: the time of pronouncement; findings from the assessment of the patient that substantiated the conclusion that death has occurred; notification of the physician, family, and funeral home; removal of the body; disposal of medications. On [DATE], the State Agency received a complaint regarding RI #58. The anonymous caller reported on [DATE], RI #58, who has a diagnosis of Dementia and assessed as being independent with eating, was given the wrong diet. The caller stated the resident was ordered to have a Pureed diet but was given a regular diet. The kitchen staff, the nursing staff nor the Certified Nursing Assistant (CNA) that served the meal, noticed this mistake. The caller further stated, the resident ate the food, got choked and died . RI #58 was admitted to the facility on [DATE], with a medical history to include diagnoses of: Alzheimer's disease, Cerebrovascular Disease, Lupus and Sjogren's syndrome. RI #58's Departmental Notes dated [DATE] 9:20 PM written by Employee Identifier (EI) #3, a Registered Nurse (RN), documented At 5:45 PM CNA entered room and found Resident deceased . VS (vital signs) checked by two nurses. Absence of VS for period of fifteen minutes. CNAs instructed to provide death care. UM (Unit Manger) notified. MD (Medical Director) notified. DON notified. Resident's sponsor notified. She stated that she is in the hospital preparing to have surgery and asked that I notify second contact person. I called (name) and notified her of Resident's expiration. She became upset and hung up the phone. Resident's sponsor contacted again and she stated that she could not remember which funeral home was to be used but that she had a policy at one of them. After several calls, (name) is the funeral home with Resident's policy. They arrived to pick up Resident's body at 8:25 PM and departed the facility at 8:31 PM. (Name of funeral home) phone number is (number). In an interview on [DATE] at 3:34 PM, EI #3, a RN stated when she walked into RI #58's room around 5:45 PM, after being told the resident was unresponsive, she found RI #58 in bed in an upright position. EI #3 stated she checked RI #58's pupils and pulse but got no tactile response. The resident's eyes and mouth were partially open and drool was coming out the left side of RI #58's mouth. EI #3 stated she called the resident's name and there was no response. EI #3 explained that since RI #58 was a DNR (Do Not Resuscitate), there was not a need to start CPR (Cardiopulmonary Resuscitation). In a follow up interview on [DATE] at 7:49 PM, EI #3 was asked did she document in RI #58's medical record, the time the resident's death and the name of the individual that pronounced the resident deceased . EI #3 replied, no. When asked if she followed the facility's policy with documenting the death of RI #58 on [DATE], EI #3 stated, evidently not. EI #3 was asked why she should document the time the resident's death and the name of the individual that pronounced the resident deceased . EI #3 stated, for the official record, it validates the accuracy of the medical record for the death of RI #58. When asked what according to the facility's policy what she should have documented as related to RI #58's vital signs, EI #3 answered, temperature, pulse, respirations, blood pressure, oxygen saturation, pain and health status. When asked if she followed the facility's policy when she documented RI #58's vital signs in the resident's medical record on [DATE], EI #3 said no. (continued on next page)

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	015203	A. Building B. Wing	05/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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F 0842 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with EI #9, a Licensed Practical Nurse (LPN) on [DATE] at 9:10 AM, she stated she was called to RI #58's room during the evening of [DATE] by EI #5, the CNA and the nurse, EI #3. EI #9 stated when she entered RI #58's room, the resident was in the bed with the head of the bed at a 45 degree angle and she noticed the resident had a white frothy liquid coming from his/her mouth. EI #9 stated she checked the resident's pulse and respiration but there was no pulse or respiration. EI #9 stated during her assessment of the resident, no one was in the room with her but the resident's roommate (RI #136), who was sitting on his/her side of the room. EI #9 stated the nurse, EI #3, may have been at the doorway but she was not present at her side, when EI #9 completed her assessment of the resident. EI #9 stated after she completed her assessment of the resident, she was informed by EI #3, the RN, that RI #58 had a code status of DNR. When asked where she documented her assessment of RI #58, EI #9 said she did not document it. EI #9 was asked why she did not document and she stated she presumed EI #3 had documented. When asked what information was communicated from EI #3 to her, EI #9 stated she was only told the resident was a DNR. When asked what the facility's policy was for documenting a resident assessment, EI #9 replied that she should have documented her assessment. EI #9 was asked who was responsible for documenting the vital signs that she obtained. EI #9 said she should have. When asked did she document RI #58's vital signs that she obtained on [DATE], EI #9 answered no. On [DATE] at 9:02 PM, an interview was conducted with EI #2, the DON. EI #2 was asked if the licensed nursing staff followed the facility's policy titled . EI #2 answered, no. When asked what should the licensed nursing staff have documented in RI #58's medical record regarding the resident's death in the facility on [DATE], EI #2 replied, the date, time of death, the name and title of the individual, that pronounced RI #58 deceased should have been documented in the nursing notes. EI #2 was asked what did vital signs consist of and she replied, temperature, pulse, respiration, blood pressure, oxygen status, pain and health status. When asked if RI #58s' vital signs were documented on [DATE], EI #2 said no. It was explained to EI #2 that the licensed nursing staff only obtained RI #58's pulse and respiration then asked, did the staff obtain the resident's vital signs as directed by the facility's policy. EI #2 answered, no. When asked if the licensed nursing staff documented appropriate documentation for the death of RI #58, EI #2 replied no. EI #2 was asked why should RI #58's nursing notes indicate the time in which the resident was pronounced deceased . EI #2 stated, to validate the accuracy of the medical record for the death of the resident. During an interview with EI #1, the Administrator, on [DATE] at 9:19 PM, he was asked did the licensed nursing staff follow the facility's policy for documenting the death of RI #58 that occurred in the facility on [DATE]. EI #1 answered, no. During an interview with EI #14, the Nurse Consultant, on [DATE] at 9:41 PM, she was asked did the licensed nursing staff follow the facility's policy for documenting the death of RI #58 that occurred in the facility on [DATE]. EI #14 answered, no. ********** On [DATE] at 5:30 PM, an acceptable Removal Plan was received which documented: F 842 III Resident records - identifiable records (continued on next page)

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F 0842 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1 RN failed to document vital signs and pronouncement of death in RI #58 medical record on [DATE] * RN received one on one education by the Director of Nursing (witnessed by Administrator) that included: Documentation of Death and Pronouncement of Death ([DATE]) * RN will be in-serviced (if and when allowed to return to work) on Vital Sign Policy 2 A (An) audit of resident's charts (that have expired in the facility since [DATE]) were conducted by the Nurse Consultant and Director of Nursing, with no issues noted. This audit was conducted on [DATE] 3 The Director of Nursing educated Facility Unit Managers on Pronouncement of Death, Documenting of Death and Vital Signs * All licensed staff working 7am - 7pm ([DATE]) were educated by the Unit Manager on facility policies that include: Pronouncement of Death, Documenting of Death and Vital Signs. The Director of Nursing will review all records for completion * All licensed staff working 7pm - 7am ([DATE]) were educated by the Unit Manager on facility policies that include: Pronouncement of Death, Documenting of Death and Vital Signs. * As of [DATE], 17 of 37 licensed staff have been in-serviced on Pronouncement of Death, Documenting Death and Vital Signs 4 The Nurse Consultant and Director of Nursing reviewed the only other in facility death since [DATE] with no issues related to documentation of death and pronouncement of death All facility deaths will be discussed in the morning meeting and chart reviewed to insure accurate documentation beginning [DATE] All licensed nursing staff (not in-serviced on Vital Signs, Pronouncement of Death and Documenting the Death of a Resident) by [DATE] will be notified and not allowed to clock in nor return to work until education has been completed, by the Director of Nursing, Unit Manager and/or Supervisor. All new licensed staff hired on or after [DATE] will be in-serviced during new employee orientation on Pronouncement of Death, Documenting of Death and Vital Signs). The Director of Nursing will review all records for completion The likelihood for serious harm to recipient to no longer exist is [DATE] Member of Governing Body met with Administrator, Director of Nursing, Unit Manager, Dietary Manager and Facility Medical Director on [DATE], and are in agreement with the steps of the removal plan. Follow up QA meeting will be conducted [DATE]. ********** (continued on next page)

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F 0842 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	After reviewing the facility's information provided in their Removal Plan and verifying the immediate actions had been implemented, the scope/severity level of F 842 was lowered to a D level on [DATE], to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as a result of the investigation of complaint/report number AL00036241.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 39077 Based on observation, interviews, and the facility's policy titled Standard Precautions Infection Control, the facility failed to ensure Employee Identifier (EI) #15, a laundry aide, washed her hands after touching a door knob in the soiled utility room, walked into the clean utility room, and began folding linen without washing her hands, and did not touch her upper area of her uniform top, prior to folding clean F Hall resident's linen. This had the potential to affect one of seven halls, the F Hall where 34 of 157 residents in the facility reside. Findings include: The facility's policy titled Standard Precautions Infection Control, with a copyright date of 2016 revealed, . 1. Hand Hygiene. After touching .contaminated items . Laundry. Handle in a manner that prevents transfer of microorganisms to others and to the environment . On 5/2/2019 at 7:45 AM, EI #15, a laundry aide, opened the door to the soiled utility room, touched the door knob with her hands, walked into the clean utility room, and started folding linen from F Hall without washing her hands. EI #15 was observed to take F Hall residents' linen from the laundry bin, she then touched the upper area of her uniform top prior to folding the following items: ten residents' bed pads, one resident sheet, and two resident blankets. On 5/2/2019 at 2:30 PM, the surveyor conducted an interview with EI #15. EI #15 was asked when she folded the ten residents' bed pads, one sheet, and two blankets from the laundry bin in the clean utility room, did the clean line touch the upper area of her top uniform to the abdomen area. EI #15 stated yes. EI #15 was asked should clean linen removed from a laundry bin, touch an employee's top uniform. EI #15 stated no and it could cause cross contamination. EI #15 was asked did she wash her hands or gel her hands after opening the door in the soiled utility room and walking into the clean utility room, before folding linen from F Hall. EI #15 stated no. EI #15 was asked what would be the concern with not washing her hands after opening a door on the soiled utility room, walking into the clean utility room, and then folding residents' linen. EI #15 stated germs from the door knob. EI #15 further stated that these germs could transfer to the residents. EI #15 was asked what the facility's policy was on handwashing after touching an item that could be contaminated. EI #15 stated to wash or gel your hands, after touching items that could be contaminated. EI #15 was asked if the facility's policy was followed when she opened the door into the soiled utility room, walked into the soiled utility room, and then began folding residents' linen without washing her hands. EI #15 stated no. EI #15 further stated that she was folding the linen from this laundry bin for F hall residents. In an interview on 5/2/2019 at 2:44 PM, EI #16, the temporary Infection Control Preventionist was asked what would be the concern with an employee taking residents' clean linen out of a laundry bin and touching their upper top uniform with the clean linen prior to folding the linen. EI #16 stated it could cause germs to be transferred to a resident. EI #16 was asked what would be the concern with an employee not washing their hands after opening a door on the soiled utility room, walking into the clean utility room, and began folding clothes. EI #16 stated it could cause germs to be transferred to a resident from not washing her hands. EI #16 was asked what the facility's policy was on handwashing, after touching a contaminated item. EI #16 stated to wash or gel their hands after touching a contaminated item.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 39077 Based on observation, interviews, and the facility's policy titled Required Training, Certification and Continuing Education of Nurse Aides, the facility failed to ensure Employee Identifier (EI) #17, a Certified Nursing Assistant (CNA) received Continuing Education Units (CEUs) on Dementia Training from the period of 4/4/2018 to 4/4/2019. This affected one of five CNAs reviewed for Dementia Training. Findings include: The facility's undated policy titled Required Training, Certification and Continuing Education of Nurse Aides, revealed Policy Explanation and Compliance Guidelines . 6. In-service training . Minimum training will include: . b. Dementia management and care of the cognitively impaired . On 5/2/2019 at 8:54 AM, EI #17's CNA CEUs revealed that EI #17 was hired on 4/4/2017 and EI #17 had not receiving any dementia training for the time period 4/4/2018 to 4/4/2019. On 5/2/2019 at 10:02 AM, EI #2, the Director of Nursing, was asked who the Staff Education Coordinator was. EI #2 stated that she was the temporary education coordinator. EI #2 was if EI #17 had received CEU Dementia Training during 4/4/2018 to 4/4/2019. EI #2 stated no, and there is no recording of the CNA receiving Dementia Training during this time period. EI #2 was asked what date the CEU Dementia Training was done during the period of 4/4/2018 to 4/4/2019. EI #2 stated the CEU Dementia Training was done during the May 2018 Staffing In-Service. EI #2 was asked if EI #17's signature was on the Record of In-Service Training and Attendance Form for May 2018. EI #2 stated no. EI #2 was asked why EI #17 did not receive CEU Dementia Training during the period of 4/4/2018 to 4/4/2019. EI #2 stated that she had just became aware of this and was unsure at this moment. EI #2 was asked why EI #17, a CNA, should have received CEU Dementia Training during the period of 4/4/2018 to 4/4/2019. EI #2 stated it helps the CNA deal with dementia patients, to know how to care for dementia residents, and understand their disease process.