STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115585	A. Building B. Wing	09/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Transitional Care & Rehabilitation	460 Auburn Avenue N.E. Atlanta, GA 30312

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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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20958 Based on interviews, policy review, and review of Centers for Medicare and Medicaid Services (CMS) guidelines, the facility failed to promote resident rights and allow residents to have visitors at the time of their choosing. Specifically, the facility failed to ensure family members of non-hospice residents were allowed to visit at a time of the residents'/families' choosing without needing to schedule their visits with the facility in advance for seven residents (R) (R#15, R#19, R#27, R#51, R#52, R#89, and R#148) sampled residents reviewed for resident rights. Findings included: Review of CMS Center for Clinical Standards and Quality/Survey and Certification Group (QSO) memorandum #QSO-20-39-NH, revised 3/10/2022, revealed, Facilities must allow indoor visitation at all times and for all residents as permitted under the regulations. While previously acceptable during the PHE [public health emergency], facilities can no longer limit the frequency and length of visits for residents, the number of visitors, or require advance scheduling of visits. Review of the untitled and undated visitation policy, which was included in the facility's admission agreement, revealed, Visitors are permitted within the Facility at the time and choosing of Resident; provided however, that Visitors are required to comply with Facility policies and procedures. Facility reserves the right to remove or deny visitors that impose on the rights of another Resident or for clinical and safety reasons. During a group interview on 8/3/2022 at 10:55 a.m. with R#15, R#19, R#27, R#51, R#52, R#89, and R#148 revealed their family members and friends had had to schedule appointments in advance of their visits to the facility. Per the residents, the practice had been in effect since the beginning of the COVID-19 pandemic. The residents added that visitation was limited to one to two hours during the scheduled visits. The residents stated scheduling visitation in advance of any intended visit was a facility requirement. The residents clarified that if their family/friends were unable to honor their scheduled appointment, they had to wait until they were able to secure another appointment time. 1.Review of the clinical record for R#15 revealed diagnoses including epileptic seizures and depression. Review of a quarterly Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. (continued on next page)

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

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Review of the clinical record for R#19 revealed diagnoses including cerebral infarction, spinal stenosis, and stage 2 chronic kidney disease. Review of a quarterly MDS, dated [DATE], revealed R#19 had a BIMS score of 15, indicating the resident was cognitively intact. 3. Review of the clinical record for R#27 revealed diagnoses including adjustment disorder with mixed anxiety, depressed mood, and dementia without behavioral disturbance. Review of an annual MDS, dated [DATE], revealed R#27 had a BIMS score of 15, indicating the resident was cognitively intact. 4. Review of the clinical record for R#51 revealed diagnoses which included chronic pulmonary embolism and primary insomnia. Review of a quarterly MDS, dated [DATE], indicated R#51 had a BIMS score of 15, indicating the resident was cognitively intact. 5. Review of the clinical record for R#52 revealed diagnoses including chronic congestive heart failure and essential hypertension. Review of a quarterly MDS dated [DATE] revealed R#52 had a BIMS score of 15, which indicated the resident was cognitively intact. 6. Review of the clinical record for R#89 revealed diagnoses including adjustment disorder with mixed anxiety, depressive mood, and essential hypertension. Review of a quarterly MDS, dated [DATE], revealed R#89 had a BIMS score of 11, which indicated the resident had moderately impaired cognition. 7. Review of the clinical record for R#148 revealed diagnoses which including cognitive communication deficit, epilepsy, and type 2 diabetes mellitus. Review of an annual MDS, dated [DATE], revealed R#148 had a BIMS score of 9, which indicated the resident had moderately impaired cognition. During an interview on 8/2/2022 at 1:13 p.m., the Social Worker (SW) revealed the facility encouraged scheduled visits, but scheduled visits were not required. During an interview on 8/3/2022 at 11:16 a.m., the SW stated the facility encouraged families to make appointments to visit. She stated the visits were allowed in the main dining room, outside, and in the conference room. The facility tried to encourage social distancing. They did not allow residents to have visitors in their rooms unless the resident was on hospice. During an interview on 8/5/2022 at 8:22 a.m., Certified Nursing Assistant (CNA) NN revealed that visitors had to schedule a visit, and the visits had to occur downstairs in the dining room. CNA NN indicated family members were required to make an appointment to visit the residents. (continued on next page)

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/5/2022 at 9:22 a.m., CNA CC revealed visitors had to call the SW to schedule an appointment to visit the residents. CNA CC indicated visitation occurred downstairs in the dining room. During further interview, CNA CC confirmed family members were required to make appointments to visit the residents. During an interview on 8/5/2022 at 10:06 a.m., Licensed Practical Nurse (LPN) Manager AA indicated that due to COVID-19, visitation was conducted downstairs and that visitors had to call and set up an appointment. LPN Manager AA indicated if a visitor did not have an appointment, they could still visit, but visitors were not allowed to come to the floor. During an interview on 8/5/2022 at 10:40 a.m., CNA EE indicated visitors did not come on the floor/unit to visit the residents; they had to stay in the dining room, and appointments were required to visit because of COVID-19. During an interview on 8/5/2022 at 4:08 p.m., the Director of Nursing (DON) stated the facility adopted the idea of scheduling visits in advance during the peak of the COVID-19 pandemic. She acknowledged the CMS directive at that time had since changed and that the new guidance directed the facility be reopened for visitation and not to require residents' family members to schedule visitation in advance. The DON stated the facility did not cease having family members schedule their visits in advance of visitation because they believed COVID-19 was still an issue. 40141 44243

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44243 Based on record review, interviews, and policy review, the facility failed to ensure three of four sampled residents (R) (R#90, R#142, and R#152), newly diagnosed with a serious mental disorder were referred for a Level II Pre-Admission Screening and Resident Review (PASRR), and coordinate services, if warranted. Findings included: Review of the policy titled Preadmission Screening & [and] Annual Resident Review (PASARR) Policy reviewed 11/20/2020, revealed the objective is to ensure that individuals with mental illness and intellectual disabilities receive the care and services that they need in the most appropriate setting. The PASARR will be evaluated annually and upon any significant change for those individuals identified. The facility will refer all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or related condition for a level II review upon a significant change in status assessment to the State PASARR representative. 1. Review of a PASRR Level I Application Resident Identification Screening Instrument dated 6/15/2016 for R#152 revealed the resident had no mental illness diagnoses. Review of a quarterly Minimum Data Set (MDS), dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of zero, indicating severe cognitive impairment. The resident displayed no depression or behavioral symptoms. According to the MDS, R#152 had active diagnoses of anxiety disorder, depression, and bipolar disorder. Review of the clinical record revealed R#152 was originally admitted on [DATE]. The record indicated the resident had a bipolar disorder diagnosis with an onset date of 9/4/2019. There was no evidence in the resident's medical record to indicate the resident was referred for a Level II PASRR upon being newly diagnosed with bipolar disorder. 2. Review of a PASRR Level I Application Resident Identification Screening Instrument, dated 4/25/2014 for R#142, revealed the resident had no mental illness diagnoses. Review of a quarterly MDS, dated [DATE], revealed the resident had a BIMS score of four, indicating the resident had severe cognitive impairment. The MDS also revealed R#t142 had active diagnoses of anxiety disorder, depression, and schizophrenia. Review of the clinical record revealed R#142's was originally admitted on [DATE] and readmitted the resident most recently on 4/1/2022. The record revealed the resident was diagnosed with major depressive disorder on 6/1/2017 and schizoaffective disorder on 5/1/2019. There was no evidence in the medical record to indicate the resident was referred for a Level II PASRR after being diagnosed with these mental illnesses. 35808 (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of a PASRR Level I Application Resident Identification Screening Instrument, dated 9/13/2019 for R#90, revealed the resident had no mental illness diagnoses. Review of a significant change MDS, dated [DATE], revealed the resident had an active diagnosis of bipolar disorder. Review of the clinical record revealed R#90 was admitted on [DATE]. The record indicated R#90 was diagnosed with severe bipolar depression with psychotic features on 9/17/2021. There was no evidence in the resident's medical record to indicate the resident was referred for a Level II PASRR upon being diagnosed with bipolar depression. Interview on 8/3/2022 at 11:30 a.m., the Social Worker (SW) confirmed R#90 should have had a referral for a Level II PASRR for the bipolar disorder diagnosis. She also confirmed R#90 had not had a Level II PASRR referral but was referred to psychiatric services and was being seen by a psychiatric nurse practitioner on a routine basis. The SW stated she had not been making referrals for Level II PASRR screenings for residents who acquired a mental illness diagnoses after being admitted to the facility. During a joint interview on 8/3/2022 at 10:11 a.m. with the Director of Social Work (DSW) and the SW, confirmed they were the PASRR Coordinators at the facility. They stated the facility received a Level I PASRR from the hospital for all residents upon admission to the facility. Per the DSW and SW, the facility also made a referral for all residents upon admission to a third-party psychiatric/behavioral service provider. The provider completed a baseline psychiatric evaluation to determine psychiatric medication management, a treatment plan, the need for psychotherapy, et cetera. They stated the facility did not complete Level II PASRR referrals whether a resident's mental illness diagnosis was primary or secondary. Interview on 8/4/2022 at 4:08 p.m., the Director of Nursing (DON) stated she was not a PASRR expert and had no input on the PASRR screenings. Per the DON, the social work department was designated for that function. The DON stated her expectation was that if the facility needed to screen residents for a PASARR Level II to ensure proper placement and services, the facility should ensure the screening was completed.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35808 Based on interviews, record review, and policy review, the facility failed to ensure a Level II Preadmission Screening and Resident Review (PASRR) was completed for one of four sampled residents (R) (R#71) admitted to the facility with a diagnosis of schizophrenia, to determine whether specialized services were needed. Findings included: Review of the policy titled Preadmission Screening and Annual Resident Review (PASARR), reviewed 11/20/2020, revealed the policy of this facility to screen all potential admissions on an individualized basis. As a part of the preadmission process, this facility participates in the Preadmission Screening and Annual Resident Review (PASARR) screening process (Level I) for all new and readmissions per requirement to determine if the individual meets the criterion for mental disorder (SMI/SMD [serious mental illness/serious mental disorder]), intellectual disability (ID) or related condition. Based upon the Level I screen, the facility will not admit an individual with a mental disorder or intellectual disability until a Level II screening process has been completed and the recommendations allow for a nursing facility admission and the facility's ability to provide the specialized services determined in the Level II screen. Review of the clinical record for R#71 revealed resident had a diagnosis of schizophrenia upon admission to the facility on [DATE]. Review of an admission Minimum Data Set (MDS), dated [DATE], revealed R#71 had an active diagnosis of schizophrenia. Review of the PASARR Level One Application Resident Identification Screening Instrument, dated 8/23/2021 for R#71, revealed the resident had no primary diagnosis of serious mental illness or mental disorder. Further review of the screening instrument revealed If the nursing facility admits the applicant and discovers information that was not disclosed to the PASRR screeners, the nursing facility is required to contact the [screening authority] immediately. Interview on 8/3/2022 at 8:30 a.m. with the Social Worker (SW), revealed she was responsible for checking the PASRR screening status for each resident. The SW confirmed R#71 should have had a PASRR Level II completed due to the schizophrenia diagnosis. The SW stated she kept a PASRR binder and checked residents who were admitted or readmitted to ensure they had a Level II screening if required; however, the SW acknowledged that she had not identified that R#71 needed a Level II screening. Interview on 8/4/2022 at 4:08 p.m. with the Director of Nursing (DON), stated she was not a PASRR expert and had no input on the PASRR screenings. Per the DON, the social work department was designated for that function. The DON stated her expectation was that if the facility needed to screen residents for a PASARR Level II to ensure proper placement and services, the facility should ensure the screening was completed.

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety 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** 46194 Based on observations, interviews, record review, and policy review, the facility failed to implement the care plan for one resident (R) (R#25) of 24 sampled residents. Specifically, the facility failed to implement the care plan to provide supervision during mealtime for R#25, who was at risk for aspiration (entrance of food, drink, saliva, or vomit into the lungs). R#25 was left unsupervised with his/her meal and was found by the surveyor in respiratory distress. On 9/20/2022, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility's Administrator was informed of the Immediate Jeopardy (IJ) on 9/20/2022 at 6:49 p.m. The noncompliance related to the IJ was identified to have existed on 8/1/2022. A removal plan (Credible Allegation of Compliance) was received on 9/23/22. The survey team conducted observations, reviewed training records, and interviews with staff and residents to verify elements of the facility's removal plan were implemented. The immediacy of the Immediate Jeopardy was removed on 9/24/22. The facility remained out of compliance while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). This oversight process includes the analysis of facility staff's conformance with the facility's policies and procedures. In-service materials and records were reviewed. Observations and interviews were conducted with staff to ensure they demonstrated knowledge of the facility's policies and procedures. Findings included: Review of the policy titled, Care Plan Policy, reviewed November 18, 2021, revealed each resident will have a plan of care to identify problems, needs, and strengths that will identify how the facility staff will provide services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Standard of Practice number 7. Areas of concern or potential concern and residents [sic] strengths will be addressed with measurable goals and specific person-centered approaches to promote attainment or maintenance of the goal(s). Review of the clinical record revealed R#25 was admitted to the facility on [DATE] with diagnoses including vascular dementia without behavioral disturbance and chronic obstructive pulmonary disease (COPD). Review of the quarterly Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. Per the MDS, the resident was totally dependent for eating and did not have signs/symptoms of a possible swallowing disorder. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the care plan reviewed 5/23/2022, revealed resident has a diagnosis of dysphagia and is on a mechanical altered diet. R#25 was on aspiration precautions and had a diagnosis of dysphagia (difficulty swallowing). The care plan indicated on 2/13/2020, the resident was observed choking. On 7/21/2021, a Certified Nursing Assistant (CNA) noted the resident in bed choking while sitting at a 90-degree angle. On 11/26/2021, another choking episode was noted. The care planned interventions/tasks included: - 2/13/2020: Aspiration precautions: assistance with all meals with resident sitting upright. - 7/23/2021: up in wheelchair sitting upright during all meals as needed. - 7/23/2021: must be supervised during all meals ensuring small bits, slow pacing. - 11/16/2021: ST [speech therapy] referral completed. Review of a CNA assignment sheet, dated 8/1/2022, revealed R#25's room/bed number was included on a list of residents who needed to be fed by staff. Review of R#25's Visual/Bedside Kardex Report (a guide used by CNAs to determine the care a resident required) revealed the resident required the following: - Aspiration precautions which included assistance with all meals and that the resident needed to sit upright for all meals (dated 2/13/2020). - Have the resident sit upright in a wheelchair during all meals (dated 7/23/2021). - Supervise the resident during all meals/snacks ensuring the resident takes small bites and eats at a slow pace (undated). - Aspiration precautions (undated). - Assist the resident with all meals as needed (undated). - Clinical staff to monitor communal dining or supervised in room as resident can tolerate (undated). - A regular diet, pureed texture, nectar thick liquids consistency (undated). - Monitor the residents' ability to tolerate diet and notify the Medical Doctor (MD) of any problems (undated). On 8/1/2022 at 1:10 p.m. surveyor observed staff delivering meal trays to residents who ate in their rooms. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/1/2022 at 2:54 p.m. surveyor observed R#25 in his room with a meal tray in front of him, with about 50% of the meal consumed. There were no staff members in the room feeding or supervising the resident. R#25 was slumped over to the left side and had thick mucus running out of the side of his mouth. He appeared to be in respiratory distress, using accessory muscles to breathe, and had an audible gurgle in his chest/throat. The surveyor immediately alerted Licensed Practical Nurse (LPN) LL, who entered the room and started to suction the resident. R#25 was deeply coughing and trying to breathe. LPN LL checked the resident's oxygen saturation, which was noted to be 61% (normal range is greater than 90%). LPN LL obtained an oxygen canister and started R#25 on oxygen. R#25 was moaning and trying to catch his breath. After the oxygen was applied, the oxygen saturation increased to only 82%. LPN LL waved for another LPN, Nurse Manager RR, to assist. Nurse Manager RR asked LPN LL if he wanted to send R#25 to the emergency room (ER), since the resident's oxygen saturation would not increase to greater than 82%. Nurse Manager RR left the room and made a phone call to the physician. Nurse Manager RR came back to the room and stated the physician ordered the resident be sent to the ER. Interview on 8/1/2022 at 3:33 p.m. with CNA NN, stated he was watching R#25 eat until the roommate finished his meal, and he left the room and went to pick up trays on the hall. CNA NN stated R#25 would not let him take his meal tray. CNA NN stated R#25 must have eaten part of the meal after he left the room. CNA NN stated he usually left R#25's tray in front of him, and R#25 was usually fine. Interview on 8/1/2022 at 3:41 p.m., LPN LL stated R#25 was usually fed by staff but was not being fed today, according to CNA NN. LPN LL stated the resident required full assistance with feeding and that R#25 should not have been left with the tray in front of him. Interview on 8/2/2022 at 12:04 p.m. with Nurse Practitioner (NP) TT stated R#25 generally fed himself but needed someone nearby during meals. She stated staff should not leave R#25's tray in front of him and leave the room during mealtime. She stated someone needed to be checking on the resident during the meal. Interview on 8/2/2022 at 12:47 p.m., Speech Therapist (ST) SS stated staff needed to remind R#25 to slow down when eating and staff needed to be in the vicinity where R#25 was eating in case the resident was in distress. Interview on 8/2/2022 at 3:44 p.m., the Director of Nursing (DON) stated R#25 could not be left alone while eating for an extended period. She stated if staff left the resident and picked up trays on the hall, that was an extended period, and R#25 should not have been left without supervision. Interview on 8/3/2022 at 12:33 p.m. with CNA WW, stated if the care plan indicated R#25 must be supervised during all meals, ensuring small bites and slow pacing, the resident should be continuously monitored. She stated that would require someone to always be present with resident during meals. She confirmed R#25 was at risk for choking and should not be left alone. Interview on 8/3/2022 at 3:14 p.m. with the Medical Director, stated if the care plan indicated the resident should be supervised during meals, there should be someone in the room with the resident while the resident was eating. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 9/24/2022 at 10:07 a.m., CNA DDD stated she was required to look at the Kardex or care plan to obtain information on residents' care. She stated supervision meant to stay with the resident and not leave the room until the resident was finished eating. Interview on 9/24/2022 at 10:45 a.m., LPN VV stated CNAs went to the Kardex to know how to care for a resident. He stated staff should never leave a tray in front of a resident who was at risk for aspiration. During a follow-up interview on 9/23/2022 at 12:43 p.m., the DON revealed staff should read the Kardex, which would match the care plan, to determine how to take care of residents. She stated following the plan of care ensured safety for the residents. Interview on 9/23/2022 at 9:39 a.m. with the Regional Director of Clinical Operations stated CNA staff were to look at the Kardex to determine what care to provide to residents on aspiration precautions to keep them safe during meals, snacks, and hydration. Removal Plan: 1. 9/21/22 - Resident #25 continues to reside in the facility, Legacy Nursing and Rehabilitation Center. 8/1/22 - Resident #25 was showing signs of respiratory distress when the surveyor entered the room. A plate of pureed food was left in front of the resident at lunch. The licensed practical nurse suctioned Resident #25 and oxygen was applied. Resident #25 was sent to the emergency room and admitted with a diagnosis of aspiration. Resident #25 returned to the facility 8/4/22. 2. 9/21/22 - a root cause analysis was completed and presented to the Ad Hoc QAPI [Quality Assurance Performance Improvement] Committee (Administrator, Chief Clinical Operations (CCO), Medical Director and Regional Director of Clinical Operations. From the root cause analysis, systems were identified that required an immediate action plan to correct deficient practices including the need to follow residents' care plan and provide supervision during mealtimes for residents at risk for aspiration. 3. 9/21/22 - an Ad Hoc QAPI meeting was held with the QAPI Committee (Administrator, Chief Clinical Operations, Medical Director, and Regional Director of Clinical Operations) to discuss incident involving Resident #25. 4. 9/21/22 - the policies for Care Plan, Incident Report - Documentation, Investigation and Reporting and Respiratory - Aspiration Precautions were reviewed by the Chief Clinical Operations, Medical Director, Regional Director of Clinical Operations, with no revisions made. 5. 9/20/22 - the MDS Director, completed a Care Plan/Kardex Audit of care plans and Kardex for all 10 of the 10 residents identified at risk for aspiration. No deficient practices noted in individualized care plans or interventions. 6. 9/21/22 - Regional Director Clinical Operations in-serviced the IDT, which consists of Chief Clinical Operations (CCO), MDS Director, and Staff Development Coordinator (SDC) on instructions for care plans (resident centered related to importance of following individualized care plans/ interventions for residents identified at risk for aspiration). (continued on next page)

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. 9/22/22 and 9/23/22 - the Chief Clinical Operations (CCO)and Staff Development Coordinator (SDC) in-serviced 58 of 68 clinical staff on instruction for care plans (resident centered related to importance of following individualized care plans/interventions for residents identified at risk for aspiration: RN: 4 of 5 LPN: 21 of 25 CMA: 4 of 4 C.N.A: 29 of 34 Total: 85% 8. 9/22/22 and 9/23/22 - the CCO and SDC in-serviced 58 of 68 clinical staff how to access Care Plan/Kardex to identify interventions for residents at risk for aspiration. RN: 4 of 5 LPN: 21 of 25 CMA: 4 of 4 C.N.A: 29 of 34 Total: 85% Those not in-serviced will not be placed in the schedule and/or will not be allowed to return to work until in-services are completed. 9. Newly admitted residents or residents newly identified with swallowing disorders or choking episodes will be referred to therapy services for screening. Therapy will communicate any changes in plan of care with Chief Clinical Officer, CCO or Assistant Chief Clinical Officer, ACCO and Unit Managers who will in-service clinical staff of residents at risk of aspiration including care plan and interventions. All corrective actions were completed on 9/23/22. The facility alleges that the IJ is removed on 9/24/22. Onsite Verification: (continued on next page)

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	115585	A. Building B. Wing	09/24/2022

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The IJ was removed on 9/24/2022 after the survey team performed onsite verification that the Removal Plan had been implemented. Interviews were conducted with staff to ensure they demonstrated knowledge of the facility's policies and procedures. Observations revealed staff were providing the care planned level of supervision to residents during mealtime. Care plans and the Kardex were reviewed to ensure accuracy. The Ad Hoc QAPI meeting minutes were reviewed, and attendance sheets were verified. The Minimum Data Set (MDS) Director's care plan/Kardex audit was reviewed. Sign-in sheets were reviewed for the in-service provided on care plans by the Regional Director of Clinical Operations. The Chief Clinical Operation's audit for ensuring supervision of residents at risk of aspiration was also reviewed. In-service sign-in sheets were reviewed to verify staff education was provided per the removal plan including the importance of following the care plan and how to access care plan. Sign-in sheets were verified, and schedules were reviewed to ensure untrained staff were not working prior to being educated. New admissions were reviewed to ensure newly admitted residents with swallowing disorders were referred to therapy.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46194 Based on observations, record review, interviews, and policy review, the facility failed to provide adequate supervision to prevent potential accidents for three residents (R) (R#25, R#167, and R#325) of five sampled residents reviewed for accident hazards. Specifically, the facility failed to: 1. Provide supervision during mealtime for R#25 of three sampled residents at risk for aspiration (entrance of food, drink, saliva, or vomit into the lungs). On 8/1/22, R#25 was left unsupervised with his meal and was found by the surveyor in respiratory distress. The resident was sent to the emergency room (ER) and subsequently admitted with a diagnosis of subsegmental atelectasis (collapse of a small area of the lung) or aspiration. 2. Provide physician ordered thickened liquids for R#167 of three sampled residents at risk for aspiration. 3. Thoroughly investigate a fall from a mechanical lift to determine the cause and facilitate development of effective interventions to prevent potential recurrence for R#325 of two sampled residents reviewed for mechanical lift transfers. On 9/20/2022, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility's Administrator was informed of the Immediate Jeopardy (IJ) on 9/20/2022 at 6:49 p.m. The noncompliance related to the IJ was identified to have existed on 8/1/2022. A removal plan (Credible Allegation of Compliance) was received on 9/23/22. The survey team conducted observations, reviewed training records, and interviews with staff and residents to verify elements of the facility's removal plan were implemented. The immediacy of the Immediate Jeopardy was removed on 9/24/22. The facility remained out of compliance while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). This oversight process includes the analysis of facility staff's conformance with the facility's policies and procedures. In-service materials and records were reviewed. Observations and interviews were conducted with staff to ensure they demonstrated knowledge of the facility's policies and procedures. Findings included: 1. Review of the policy titled, Respiratory - Aspiration Precautions, revised January 2019, revealed the policy statement is to implement and educate patient/caregiver on precautions that prevent aspiration. Considerations 1. Precautions should be taken with all patients who are unable to protect their airway to prevent the involuntary inhalation of foreign substances, such as gastric contents, oropharyngeal secretions, food, or fluids, in the tracheobronchial passages. Procedure 7. Monitor patient when eating/drinking: a. Instruct family or caregiver to do the same. b. Observe adequacy of swallowing. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the clinical record revealed R#25 was admitted to the facility on [DATE] with diagnoses including vascular dementia without behavioral disturbance and chronic obstructive pulmonary disease (COPD). Review of the quarterly Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. Per the MDS, the resident was totally dependent for eating and did not have signs/symptoms of a possible swallowing disorder. Review of the care plan reviewed 5/23/2022, revealed resident was on aspiration precautions and had a diagnosis of dysphagia (difficulty swallowing). The care plan indicated on 2/13/2020, the resident was observed choking. On 7/21/2021, a Certified Nursing Assistant (CNA) noted the resident in bed choking while sitting at a 90-degree angle. On 11/26/2021, another choking episode was noted. The care planned interventions/tasks included: - 2/13/2020: Aspiration precautions: assistance with all meals with resident sitting upright. - 7/23/2021: up in wheelchair sitting upright during all meals as needed. - 7/23/2021: must be supervised during all meals ensuring small bits, slow pacing. - 11/16/2021: ST [speech therapy] referral completed. Review of a Physician Progress Note, dated 11/19/2021, revealed staff were to assist R#25 with feeding and monitor for aspiration or choking. Review of a Physician Progress Note, dated 12/10/2021, revealed staff were to assist R#25 with meals due to the resident's history of difficulty swallowing. Review of an Order Summary Report revealed R#25 had a physician's order dated 05/07/2020 for a regular, pureed/dysphagia diet with liquids thickened to nectar consistency. Review of a CNA assignment sheet, dated 8/1/2022, revealed R#25's room/bed number was included on a list of residents who needed to be fed by staff. On 8/1/2022 at 2:54 p.m. the surveyor observed R#25 in his room with a meal tray in front of him, with about 50% of the meal consumed. No staff were in the room feeding or supervising the resident. R#25 was slumped over to the left side and had thick mucus running out of the side of his mouth. R#25 appeared to be in respiratory distress, using accessory muscles to breathe, and had an audible gurgle in his chest/throat. R#25 was deeply coughing and trying to breathe. The surveyor immediately alerted Licensed Practical Nurse (LPN) LL, who entered the room and started to suction the resident. LPN LL checked resident's oxygen saturation, which was noted to be 61% (normal range is greater than 90%). LPN LL obtained an oxygen canister and started R#25 on oxygen. R#25 was moaning and trying to catch his breath. After the oxygen was applied, the oxygen saturation increased to only 82%. LPN LL waved for another LPN, Nurse Manager RR, to assist. Nurse Manager RR asked LPN LL if he wanted to send R#25 to the emergency room (ER), since the resident's oxygen saturation would not increase to greater than 82%. Nurse Manager RR left the room and made a phone call to the physician. Nurse Manager RR came back to the room and stated the physician ordered the resident be sent to the ER. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a hospital Radiology Result dated 8/1/2022 at 5:00 p.m. revealed the resident's chest x-ray findings included opacities (white spots on the x-ray) that represented atelectasis or aspiration. Review of a hospital Progress Note dated 8/3/2022, revealed the resident presented to the hospital after an acute aspiration event with acute hypoxemic (low oxygen levels in the blood) and hypercapnic (high carbon dioxide levels in the blood) respiratory failure requiring bilevel positive airway pressure (BiPAP) support on presentation. The resident was now weaned to room air, the oxygen saturation level was 92% at rest, and the respiratory failure had resolved. The resident was started on prednisone (a glucocorticoid medication used to decrease inflammation) and Levaquin (an antibiotic) for possible community-acquired pneumonia versus aspiration pneumonia. A review of the hospital Discharge Summary revealed R#25 was transferred back to the facility on [DATE] with orders to continue prednisone and Levaquin. Interview on 8/1/2022 at 3:33 p.m. with CNA NN, stated he was not sure what happened to R#25. He stated R#25 was fine when he set up the meal tray for the resident. CNA NN stated he usually just kept an eye on R#25 while he provided feeding assistance to the resident's roommate. CNA NN stated he was watching R#25 eat until the roommate finished his meal. He stated R#25 would not let him take his meal tray, so he left and went to pick up trays on the hall. CNA NN stated R#25 must have eaten part of the meal after he left the room. CNA NN stated he usually left R#25's tray in front of him, and R#25 was fine. Interview on 8/1/2022 at 3:41 p.m. with LPN LL, stated R#25 was fine earlier that morning and must have had problems while eating. LPN LL stated R#25 was usually fed by staff but was not being fed today, according to CNA NN. LPN LL stated the resident required full assistance with feeding. LPN LL stated R#25 should not have been left with the tray in front of him. LPN LL indicated he provided CNA NN with an assignment sheet that morning, which indicated who required assistance with feeding, and that the assignment sheet specified that R#25 was to be assisted with feeding. Interview on 8/2/2022 at 12:04 p.m., Nurse Practitioner (NP) TT stated R#25 generally fed himself but needed someone nearby during meals. She stated staff should not leave R#25's tray in front of him and leave the room during mealtimes. She stated someone needed to be checking on him during the meal. Interview on 8/2/2022 at 12:47 p.m., Speech Therapist (ST) SS stated R#25 wanted to eat, but every time the resident was evaluated, he had a poor prognosis. She stated R#25 was at high risk for aspiration. She stated the last time she worked with R#25 she recommended a feeding tube be placed. She stated R#25, and his family declined the tube placement. During further interview, she stated someone should be in the room with R#25 while he ate due to the high risk for aspiration. She stated staff needed to remind R#25 to slow down. She stated someone would need to be in the vicinity where R#25 was eating in case the resident was in distress. Interview on 8/2/2022 at 3:44 p.m. with the Director of Nursing (DON), stated R#25 could not be left alone while eating. She stated if staff left the resident and picked up trays on the hall, that was an extended period, and R#25 should not have been left without supervision. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 8/3/2022 at 12:33 p.m. with CNA WW, stated if the care plan indicated R#25 must be supervised during all meals, ensuring small bites and slow pacing, the resident should be continuously monitored. She stated that would require someone to always be present during meals. She stated R#25 was to be sitting upright at a 90-degree angle. She stated R#25 could feed himself but needed to be continuously monitored and reminded to drink and take small bites. She stated R#25 was prone to choking and should not be left alone during meals. Interview on 8/3/2022 at 12:41 p.m. with CNA UU, stated if the care plan indicated R#25 must be supervised during all meals, ensuring small bites and slow pacing, the resident should be continuously monitored. He stated R#25 should not have a meal tray left in front of him. During further interview, he stated R#25 would reach and get food off the tray. He stated R#25 had a history of taking very large bites and choking. Interview on 8/3/2022 at 9:35 a.m. with the DON stated there were no documented staff in-services that covered aspiration precautions during the past year. Interview on 8/3/2022 at 9:47 a.m. with the Administrator, stated he looked back over the past year and found no staff in-service trainings on aspiration precautions. Interview on 8/3/2022 on 3:14 p.m. with the Medical Director, stated if the care plan indicated the resident should be supervised, there should be someone in the room with the resident while the resident was eating. Removal Plan: 1. 9/21/22 - Resident #25 continues to reside in the facility, Legacy Nursing and Rehabilitation Center. 8/1/22 - Resident #25 was showing signs of respiratory distress when the surveyor entered the room. A plate of pureed food was left in front of the resident at lunch. The licensed practical nurse suctioned Resident #25 and oxygen was applied. Resident #25 was sent to the emergency room and admitted with a diagnosis of aspiration. Resident #25 returned to the facility 8/4/22. 2. 9/21/22 - a root cause analysis was completed and presented to the Ad Hoc QAPI [Quality Assurance Performance Improvement] Committee. (Administrator, Chief Clinical Operations (CCO), Medical Director and Regional Director of Clinical Operations). From the root cause analysis, systems were identified that required an immediate action plan to correct deficient practices including the need to follow residents' care plan and provide supervision during mealtimes for residents at risk for aspiration. 3. 9/21/22 - an Ad Hoc QAPI meeting was held with the QAPI Committee, Administrator, Chief Clinical Operations (CCO), Medical Director, and Regional Director of Clinical Operations, to discuss incident involving Resident #25. 4. 9/21/22 - the policies for Care Plan and Respiratory - Aspiration Precautions were reviewed by the Administrator, Chief Clinical Operations, Medical Director, and Regional Director of Clinical Operations, with no revisions made. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. 9/20/22 - the MDS Director, completed a Care Plan/Kardex Audit of care plans and Kardex for all 10 of 10 residents identified at risk for aspiration. No deficient practices were noted in individualized care plans or interventions. 6. 9/21/22 - The Chief Clinical Operations, CCO, began completing a daily written Resident at Risk for Aspiration Monitoring Audit (Monday through Sunday) for the 10 residents with risk for aspiration and/or Nursing Supervisor designee to perform Quality Improvement Monitoring of residents at risk for aspiration. 7. 9/21/22 - Regional Director Clinical Operations in-serviced the IDT [Interdisciplinary Team], which consists of Chief Clinical Operations (CCO) MDS Director, and Staff Development Coordinator (SDC) on instructions for care plans (resident centered related to importance of following individualized care plans/ interventions for residents identified at risk for aspiration). 8. 9/22/22 and 9/23/22 - The CCO and SDC in-serviced 58 of 68 clinical staff regarding aspiration precautions and providing supervision during meals for residents who have a history of swallowing disorders and choking episodes and are at risk for aspiration. RN (Registered Nurse): 4 of 5 LPN (Licensed Practical Nurse): 21 of 25 CMA (Certified Medication Aide): 4 of 4 CNA (Certified Nursing Assistant): 29/34 Total: 85% 9. Those not in-serviced will not be placed in the schedule and/or will not be allowed to return to work until in-services are completed. 10. Newly admitted residents or residents newly identified with swallowing disorders or choking episodes will be referred to therapy services for screening. Therapy will communicate any changes in plan of care with Chief Clinical Officer, CCO or Assistant Chief Clinical Officer, ACCO and Unit Managers, who will in-service clinical staff of residents at risk of aspiration including care plan and interventions. All corrective actions were completed on 9/23/22. The facility alleges that the IJ is removed on 9/24/22. Onsite Verification: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The IJ was removed on 9/24/2022 after the survey team performed onsite verification that the Removal Plan had been implemented. Observations revealed staff were providing supervision during mealtime for all residents at risk for aspiration, according to their care plans. Care plans and Kardex were reviewed to ensure accuracy. The facility's root cause analysis was reviewed. The Ad Hoc QAPI meeting minutes were reviewed, and attendance sheets were verified. The Minimum Data Set (MDS) Director's care plan/Kardex audit was reviewed. Sign-in sheets were reviewed for the in-service provided on care plans by the Regional Director of Clinical Operations. The Chief Clinical Operation's audit for ensuring supervision of residents at risk of aspiration was also reviewed. In-service sign-in sheets were reviewed to verify staff education was provided per the removal plan, including the importance of following the care plan and how to access the care plan. Sign-in sheets were verified, and schedules were reviewed to ensure untrained staff were not working prior to being educated. New admissions were verified to ensure newly admitted residents with swallowing disorders were referred to therapy. 2. Review of the Transfer/Discharge Report revealed R#167 had diagnoses that included acute kidney failure, dependence on supplemental oxygen, and dysphagia oral phase. Review of the quarterly MDS, dated [DATE], revealed R#167 had a BIMS score of two, indicating severely impaired cognition. The MDS indicated the resident was totally dependent with eating and received a mechanically altered diet. Review of a care plan revised 4/29/2021, revealed resident was at risk for nutritional/hydration problems related to being on a therapeutic diet. The care plan indicated that the resident pocketed food (held food in his mouth without swallowing). A planned interventions was to provide the diet as ordered. Review of the Rehab Services Referral (Nursing Communication) form, dated 7/7/2021, revealed the resident was referred for a swallowing study related to the resident pocketing food. Speech Therapy (ST) was to evaluate the resident and treat as indicated. Review of an Order Summary Report revealed R#167 had a physician's order dated 2/7/2022 for a pureed/dysphagia diet, mechanical soft with pureed meats, and liquids thickened to nectar consistency. Review of the Healthcare Services Dietary assessment dated [DATE], revealed R#167 had orders for a mechanical soft diet, with no added salt, low concentrated sweets, and pureed meat. The assessment indicated the resident was edentulous (without teeth), causing difficulty with chewing. On 8/3/2022 at 12:15 p.m., R#167 was observed lying in bed with the head of the bed elevated. An empty glass with a straw was on the over-bed table, which was positioned across the bed in front of the resident. Observation on 8/3/2022 at 12:45 p.m., revealed R#167 had been served a pureed diet and a glass of lemonade with ice that was not thickened to nectar consistency. The resident was observed to take a drink of the lemonade. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 8/3/2022 at 12:55 p.m., Licensed Practical Nurse (LPN) Unit Manager (UM) DD was asked to observe the resident's liquids for consistency. LPN UM DD observed the lemonade and confirmed it was not thickened. LPN UM DD then went to the computer, reviewed the resident's diet order, and reported the resident was to have nectar thickened liquids. Interview on 8/3/2022 at 1:00 p.m., LPN UM DD confirmed R#167 had received the wrong liquids. She stated the resident was supposed to receive thickened liquids. LPN UM DD reported the dietary department put the thickened liquids on the food trays prior to delivering them to the units to give to the residents. LPN UM DD with the surveyor reviewed the meal card that was on R#167's lunch tray. The card indicated the resident was to receive a pureed diet, no added salt, and low concentrated sugar. The beverage section of the card indicated, NA [not applicable]. The meal card did not address the order for thickened liquids. Interview on 8/3/2022 at 1:14 p.m., LPN UM DD stated Speech Therapy was assessing R#167 to determine whether the resident aspirated the non-thickened liquids. Interview on 8/3/2022 at 1:18 p.m., Speech Therapist (ST) SS verified the current diet order and stated R#167 was to receive nectar-consistency thickened liquids and pureed food. ST SS stated a chest x-ray would be obtained to rule out aspiration. Review of the Rehabilitation Screening Form, dated 8/3/2022 by ST SS, revealed a nurse had reported possible aspiration for R#167. The report indicated R#167 was on a nectar liquid/pureed diet and had no signs or symptoms of aspiration. Review of an Order Summary Report revealed a physician's order was obtained on 8/3/2022 for a chest x-ray to rule out aspiration. An additional order dated 8/3/2022 indicated the resident was to be monitored for signs and symptoms of aspiration pneumonia every 12 hours. Review of an Order Summary Report revealed a physician's order was obtained on 8/3/2022 for a chest x-ray to rule out aspiration. An additional order dated 8/3/2022 indicated the resident was to be monitored for signs and symptoms of aspiration pneumonia every 12 hours. Observation and interview on 8/3/2022 at 2:42 p.m. with Director of Social Work (DSW) JJ was passing drinks to residents during the lunch meal. DSW JJ was passing only regular consistency liquids and reported going by the dietary card to determine who could have regular liquids. DSW JJ denied having passed the regular lemonade to R#167. Interview on 8/6/2022 at 2:19 p.m., Dietary Manager (DM) XX confirmed the resident had an order for thickened liquids, but it was not on the resident's dietary card. DM XX reported the process for changes to diets was that a pink slip would be completed and given to the dietary department, and the card would be updated in the computer. DM XX denied having received a pink slip changing to thickened liquids for R#167. DM XX reported the meal card was updated to reflect thickened liquids, and the thickened liquids would be coming from the dietary department on meal trays. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 8/7/2022 at 8:12 a.m. with the DON, stated the resident should have received the nectar-thick liquids and that the facility would be returning to weekly audits of dietary orders. The DON indicated the unit manager and nurse managers were working the carts and the floor due to being short of nurses, and therefore, processes had been lacking. During further interview, she stated their goal was to get back to auditing. The Administrator was not available for interview. 3. Review of a Transfer/Discharge Report revealed R#325 had diagnoses that included chronic respiratory failure, muscle weakness, morbid obesity, left sided hemiplegia, and peripheral vascular disease (PVD). Review of a quarterly Minimum Data Set (MDS), dated [DATE], revealed R#325 had a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact. The MDS indicated R#325 was totally dependent for bed mobility and transfer. According to the MDS, the resident had experienced one fall with no injury since admission, reentry, or prior assessment. Review of the Progress Note, dated 12/28/2021 at 11:08 p.m. revealed R#325 had a fall from the mechanical lift, after which the resident complained of pain to the left leg. Pain medication was administered, and an x-ray was ordered immediately (STAT). Review of the related incident report dated 12/28/2021 at 11:00 p.m. revealed R#325 fell from the mechanical lift. The resident reported suffering a hard fall and was having leg pain. The immediate actions taken included notification of the Director of Nursing and Medical Doctor, administration of pain medication, and obtaining an order for an x-ray. Further review of the incident report revealed the following: - The location of the incident was the resident's room. The report indicated there were no witnesses to the fall but also indicated the resident, fell from Hoyer [mechanical] lift while being transferred. - A note dated 12/29/2021 on the report revealed, Resident was lowered to the floor by the assigned CN [Charge Nurse] and CNA [Certified Nursing Assistant] from the Hoyer lift. The BLE [bilateral lower extremities] x-ray revealed no abnormalities. - A handwritten statement with the incident report revealed the staff member was transferring the resident from a Geri chair to bed. When the lift was moved from the hallway to the bed, the staff member was having to hold onto the sling under the resident's bottom, and the lift began to tilt and fall over. The staff member managed to guide [resident's] feet first onto the floor, having hold of the top of the sling. I put my foot under [her] bottom, I eased [her] back down as it was in an upright position and made sure [she] would not hit [her] head, made sure [she] was able to keep [her] head up before I let go to go & [and] get pillows. Review of an x-ray report, dated 12/29/2021 at 2:15 a.m., indicated the x-ray was completed due to pain in the resident's right and left thighs. The results indicated no fracture or dislocation was seen, and the hip joint was grossly intact. (continued on next page)

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Legacy Transitional Care & Rehabilitation	460 Auburn Avenue N.E. Atlanta, GA 30312

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Transfer/Discharge Report revealed that on 12/30/2021, R#325 was transferred to the hospital for further evaluation post-fall. Interview on 8/4/2022 at 12:16 p.m. with Licensed Practical Nurse (LPN) Manager AA indicated she recalled the resident and the incident but had no training documents related to the incident. Interview on 8/4/2022 at 12:58 p.m. with the Social Worker (SW) reported incidents were discussed in morning meetings, and nursing investigated the falls. Interview on 8/4/2022 at 1:21 p.m. with the DON stated the CNA involved in the incident gave a statement which indicated the mechanical lift tipped over during the transfer. The DON revealed she did not have a documented investigation of the incident and had not determined the root cause of the mechanical lift tipping. The DON reported it had not been determined how many staff were present during the transfer, or if the mechanical lift had been used properly. The DON reported there had not been any additional training for staff using the mechanical lift since the incident. During a follow-up interview on 8/7/2022 at 8:12 a.m. with the DON, stated she felt it was an isolated incident. The DON reported she expected a thorough investigation be completed and that the findings should be documented. The Administrator was not available for interview. 20958

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46194 Based on observations, interviews, and policy review, the facility failed to ensure that food items were sealed and dated. In addition, the facility failed to maintain sanitary conditions in kitchen by not having fan pointed toward clean dishes and failed to promptly clean a blood spill from the kitchen floor. There were 166 residents who received meals from the kitchen. Findings included: 1. A review of the policy titled Use & [and] Storage of Food & Beverage Brought in for Residents, Food Procurement, dated 11/28/2017, revealed the objective/intent of the policy included ensuring that the facility, 2. Follows proper sanitation and food handling practices to prevent the outbreak of foodborne illness. Observation and interview on 8/1/2022 at 9:25 a.m., during the initial tour of the kitchen revealed there was a red liquid on the kitchen floor, a fan with the face covering noted with a greasy, black fuzzy debris hanging from the covering, which was pointed toward clean dishes. During an interview at this time, the Dietary Manager (DM) revealed a staff member took beef tips out of the refrigerator that morning and spilled blood on the floor and should have cleaned it up. The DM stated she was not sure who was supposed to clean the fan and indicated maintenance may be responsible. The DM confirmed the fan was dirty and needed to be cleaned. Interview on 8/6/2022 at 9:19 a.m., Prep-Cook ZZ stated on the morning of 8/1/2022, she had taken beef tips out of the walk-in refrigerator and spilled blood from the beef tips onto the floor. She stated the meat was in a deep pan, and when she bent down to pick it up, the blood spilled. She stated she was going back to mop it up when the survey team entered. She stated the blood should have been cleaned up as soon as possible. Interview on 8/6/2022 at 1:19 p.m., the Maintenance Director stated he did not know whose responsibility it was to clean the fan in the kitchen but would assume the kitchen staff was responsible. He stated the fan should be cleaned when if it was dirty. Interview on 8/7/2022 at 11:11 a.m., the Director of Nursing (DON) stated the kitchen should not be using a dirty fan. She also stated the dietary staff should clean blood from the floor right away. 2. Review of an undated facility policy titled, Dating and Labeling, revealed General Guidelines. FIFO (First In, First Out) - Date each package or container with the 'received date.' Place newest products behind the older products in order to use the older products FIRST. Pay attention to the 'Expiration' and 'Best if Used By' dates. The policy indicated that for refrigerated foods, 1. Foods that are potentially harmful must be marked with the date it was prepared as well as the discard date (Day3). 2. Food must be used or discarded within 7 days of the date it was prepared or opened if it is a potentially harmful food. 3. Containers will be dated when open and discarded by the expiration date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 8/1/2022 at 9:25 a.m., during the initial tour of the kitchen, revealed opened, undated foods, which included a package of deli smoked turkey breast, lettuce, a bag of cookies, dinner rolls, and biscuits. Bag of riblets and French toast were observed opened to air/unsealed. During an interview on 8/1/2022 at 9:25 a.m., the DM revealed foods that were opened must be labeled with the date they were opened. She stated the bags of food should be tied and sealed to keep the food fresh. The DM confirmed the items identified were opened and undated. Interview on 8/7/2022 at 11:11 a.m., the DON stated if food was opened, the dietary staff should have dated the food item with an open date. The DON also indicated opened food items should be sealed properly.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35808 Based on record review, interviews, policy review, and review of the Centers for Disease Control and Prevention (CDC) COVID-19 guidance, the facility administration failed to provide oversight and monitoring of the Infection Control Program by not implementing the Center for Medicare and Medicaid Services (CMS) and CDC recommended practices to prevent the spread of COVID-19 to residents. Specifically, the facility failed to promptly and correctly initiate COVID-19 outbreak testing, failed to properly cohort COVID-19 positive and negative residents, and failed to perform COVID-19 testing of staff based on the level of community transmission. On 8/4/2022, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility's Administrator was informed of the Immediate Jeopardy (IJ) on 8/4/2022 at 5:24 p.m. The noncompliance related to the IJ was identified to have existed on 7/25//2022. A removal plan (Credible Allegation of Compliance) was received on 8/6/22. The survey team conducted observations, reviewed training records, and interviews with staff and residents to verify elements of the facility's removal plan were implemented. The immediacy of the Immediate Jeopardy was removed on 8/6/22. The facility remained out of compliance while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). This oversight process includes the analysis of facility staff's conformance with the facility's policies and procedures. In-service materials and records were reviewed. Observations and interviews were conducted with staff to ensure they demonstrated knowledge of the facility's policies and procedures. Findings included: Review of the CDC guidance titled Contact Tracing for COVID 19, https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/overview.html and dated 2/10/2022, revealed, Investigation and contact tracing are fundamental activities that involve working with a patient (symptomatic and asymptomatic) who has been diagnosed with an infectious disease to identify and provide support to people (contacts) who may have been infected through exposure to the patient. This process prevents further transmission of disease by separating people who have (or may have) an infectious disease from people who do not. It is a core disease control measure that has been employed by public health agency personnel for decades. Case investigation and contact tracing are most effective when part of a multifaceted response to an outbreak. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the policy titled Facility Testing Requirements for Staff and Residents, revised 9/24/2021, revealed Outbreak Trigger Testing - Test all staff and residents in response to an outbreak (defined [as] any single new infection in staff or any nursing home onset infection in a resident). Continue to test all staff and residents that tested negative every three days to seven days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result. Standard of Practice, step 1. The facility may choose to conduct outbreak testing, through either a contact tracing or broad-based testing approach. For a newly identified COVID-19 positive staff or resident in a facility that could not identify close contacts, should test all staff (vaccinated and unvaccinated) facility-wide or at a group level if staff were assigned to a specific location where the new case occurred and test all residents (vaccinated and unvaccinated) facility-wide or at a group level. Routine testing for unvaccinated staff will be conducted based on the community COVID-19 transmission level rates. The Routine Testing Intervals indicated for counties with substantial or high community transmission rates, unvaccinated staff were to be tested twice a week. The facility failed to provide effective oversight and monitoring of their infection control and prevention program. 1. Administration failed to ensure monitoring systems were provided with feedback for data collection related to Infection Control, including COVID-19 outbreak testing, and failed to identify issues with outbreak and routine testing for staff and outbreak testing for residents. A total of 40 residents tested positive for COVID-19 from 7/25/2022 through 8/7/2022. Cross Refer to F867 2. Administration failed to ensure COVID positive residents were not cohorted with COVID negative residents and failed to place newly admitted residents in isolation/persons under investigation. Cross Refer to F880 3. Administration failed to ensure routine and outbreak testing for COVID-19 for staff was conducted in a manner consistent with current standards of practice based on the level of community transmission. The facility's county community transmission rate for COVID-19 was RED (high community transmission) prior to the outbreak. The facility did not perform employee testing twice weekly for those not up to date with vaccines. The facility had 15 unvaccinated employees who tested on ce weekly on Wednesdays. Cross Refer to F886 On 7/25/2022, the first day of the COVID-19 outbreak, the facility completed COVID-19 testing on the third-floor residents, and 14 residents tested positive for COVID-19. No residents were placed in Persons Under Investigation (PUI) status for exposure. No residents on the second and fourth floor units were tested . No staff were tested . No contact tracing was completed. On 7/26/2022, the residents on the second floor were tested , and two additional residents who were new admissions tested positive for COVID-19. No residents were placed in PUI status for exposure. No residents on the fourth floor were tested . No staff were tested . No contact tracing was completed. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 7/27/2022, the unvaccinated staff were tested for COVID-19. No other staff members were tested . According to the CDC guidance, unvaccinated staff should be tested twice a week when the county transmission rate was high and all staff should be tested during a COVID-19 outbreak in the facility, regardless of vaccination status. On 7/29/2022, the 14 residents on the third floor were re-tested , and four of the residents tested positive for COVID-19. No residents were placed in PUI status for exposure. No staff or other residents were tested . On 8/1/2022, the residents on the second floor were re-tested , and an additional eleven residents tested positive for COVID-19. Residents on the third floor were re-tested , and one additional resident tested positive for COVID-19. No residents were placed in PUI for exposure. No residents on the fourth floor were tested , and no staff were tested . On 8/2/2022, the residents on the fourth-floor unit were tested , and one resident tested positive for COVID-19. No staff were tested , and no residents were placed in PUI status. Interview on 8/3/2022 at 12:26 p.m. with the Director of Nursing (DON), revealed the reason she did not test all residents and staff on 7/25/2022 was because the facility practiced panic control. The DON stated there were no residents exhibiting signs and symptoms of COVID-19 on the second and fourth floor units and that the facility only tested unvaccinated staff. The DON indicated there were 15 unvaccinated staff at that time. She stated the facility had still not tested all staff and residents on 7/26/2022 when additional residents tested positive because the facility again practiced panic control. The DON and the ADON confirmed that the facility tested residents based on signs and symptoms and stated there were no residents with signs and symptoms during that time. The DON stated the fourth-floor unit was tested on [DATE] for the first time because there was a resident who had signs and symptoms of COVID-19. She stated the resident who had signs and symptoms tested negative for COVID-19; however, another resident who was not exhibiting signs and symptoms tested positive for COVID-19. Interview on 8/4/2022 at 8:50 a.m., the DON stated she misunderstood the surveyor's questions in the previous interview and that the facility had performed contact tracing during the COVID-19 outbreak. She stated she made a floor grid and reviewed to determine if there were any common factors with the residents who had tested positive. The DON stated she determined if there were any visitors who had visited those residents and which staff had worked with those residents. She concluded that after the first positive resident case, she would assign designated staff to work on those units. She stated she could not pinpoint any common factors related to the first COVID-19 positive residents. The DON indicated there were no visitors for the first positive residents and that none of the staff who had taken care of those residents had tested positive. When asked how she determined this, since the facility only tested unvaccinated staff, the DON was unable to explain how she arrived at the determination. She stated, I would not be able to determine that; we are not testing all of the staff. The DON confirmed the facility had not effectively implemented and completed contact tracing during the COVID-19 outbreak. She stated she had not documented the contact tracing she performed. The DON stated the only COVID-positive employee to date was an activity aide who had worked the fourth-floor unit for the past two weeks. She indicated out of 140 total staff members, 15 were unvaccinated. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview on 8/7/2022 at 10:25 a.m., the Regional Director revealed the facility had a Quality Assurance Performance Improvement (QAPI) meeting on 7/28/2022 and had discussed the residents who tested positive on 7/25/2022 and 7/26/2022. Monitoring for signs and symptoms was discussed, but the QAPI members had not discussed outbreak testing, cohorting, or contact tracing. The facility implemented the following actions to remove the Immediate Jeopardy: 1. Root cause completed with (DON) Director of Nursing. From the root cause analysis, systems were identified that required an immediate action plan to correct deficient practices. The root cause analysis findings that the facility failed to ensure effective testing procedures covid-19, appropriate cohorting (which means who would be appropriate to have in the same room), and completion of contact tracing staff sign in sheets were reported to the Ad Hoc Quality Improvement Performance Improvement Committee. This committee reviewed and approved the (IJ) Immediate Jeopardy removal plan on August 6, 2022. Members of the Ad Hoc QAPI committee consisted of Medical Director and LNHA [Licensed Nursing Home Administrator] via phone, DON, Regional Director, and Department Heads. 2. A Quality improvement tool was developed and initiated which will be monitored weekly by DON or designee to ensure effective testing procedures covid-19, appropriate cohorting, and completion of contact tracing staff sign in sheets. An audit was completed on August 5, 2022, on 20 COVID-19 positive residents. Initial audit results where contact tracing employee signature forms were needed on the rooms of those 20 covid-19 positive residents and have been reported to the QAPI AD HOC committee and corrective measure taken to ensure compliance of COVID19 testing and proper cohorting and isolation precautions have been taken. Daily audits will be conducted on newly admitted residents, or those returning from extended leaves of absences. Future audit will be completed weekly x's [times] eight weeks and then monthly x's three months. DON will report findings in QAPI x's three months or until a period of compliance is achieved. 3. On 8/5/2022 45 staff tested for COVID-19. 44 of staff test results negative. One staff test resulted positive. Staff members who have not completed COVID-19 testing will be unable to work until COVID19 testing has been completed. 4. On 8/5/2022 167 in-house residents were tested for COVID-19. 147 test results negative. 20 test results positive. [Room numbers of COVID-19 positive residents]. 5. On 8/5/2022 all new admissions tested . 1 tested with negative test results for COVID-19. Any new admissions/readmissions will be tested for COVID-19 going forward. 6. On 8/5/2022 (20) Residents tested positive have been cohorted with other residents that tested positive and placed in transmission-based precautions. The following rooms have COVID positive residents in transmission-based precaution isolation. [Room numbers of COVID-positive residents]. 7. On 8/5/2022 (30) residents that tested negative and were in close contact or assigned to the same room as a resident who tested positive will be cohorted with other residents who also tested negative and were in close contact or assigned to the same room as a resident who tested positive and placed on transmission-based precautions as PUIs. (30) of residents meet CDC criteria for possible exposure risk and are categorized as a PUI. The following rooms are identified as persons under investigation for COVID19 due to their possible exposure risk. [Room numbers of residents under PUI status]. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	8. On 8/5/2022 all new admissions who are unvaccinated placed with other new admissions who are unvaccinated and placed on transmission-based precautions as PUIs. One new admission was tested and assigned to appropriate rooms based on test results. Any unvaccinated new admissions going forward will be placed in PUI with other unvaccinated new admissions, following CDC guidelines. 9. On 8/5/2022 all rooms with any resident that tested positive or were in close contact or assigned to the same room as a resident who tested positive will have a staff contact tracing sign in log attached to their door. [Room numbers]. 10. On 8/5/2022 DON, Infection preventionist and Administrator educated on COVID-19 testing policy, Cohorting practices, PUI practices, and contact tracing by Regional Director. 11. On 8/5/2022 124 [staff] will be educated on COVID-19 testing policy, cohorting practices, PUI practices, and contact tracing by DON or her designee who is trained by the DON. Any staff member who has not completed education and COVID-19 testing will be unable to work until it has been completed. 68 out of 124 employees [completed]. 12. Facility COVID-19 testing policy, Facility Respiratory Protection Program, CDC recommendations for transmission-based practices to prevent the spread of COVID19 including cohorting guidelines, persons under investigation related to possible exposure to COVID-19, Contact Tracing procedures were reviewed by the Medical Director, Administrator, Director of Nursing and Regional Director of Clinical Operations during an Ad Hoc QAPI meeting on 8/5/2022. The Infection Control and Prevention policy was reviewed on 8/5/2022 and no changes were made. 13. 55 employees participated in N-95 fit (re)testing with the medical clearance forms on 8/5/2022. The DON has been trained to perform the fit tests. Anyone who cannot physically complete the fit testing will have documentation that they cannot medically complete the testing. 14. All corrections were completed on August 5, 2022. 15. The immediacy of the IJ was removed on August 6, 2022. Survey Agency validated removal of the Immediate Jeopardy as follows: The IJ was removed on 8/6/2022 after the survey team performed onsite verification that the Removal Plan had been implemented. COVID-19 positive residents were verified to have been moved to the second floor and were not placed with COVID-19 negative residents. Implementation of the removal plan was verified through observations, staff interviews, and record reviews. Observations and record reviews verified that the staff and residents were tested as per the removal plan, residents were cohorted according to their positive or negative COVID-19 test results, and residents who were exposed to COVID-positive residents were placed in PUI status. Contact tracing sheets were observed on resident room doors. Interviews with staff verified education and training was provided related to COVID-19 testing, cohorting, and contact tracing.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 31524 Based on observations, interviews, and policy review, the facility failed to have an effective Quality Assurance and Improvement Program and Committee (QAPI) process that identified concerns with COVID-19 procedures and develop a corrective action plan to address deficient practices related to infection control. The census was 175. Findings included: Review of the policy titled Quality Assurance Performance Improvement Plan, dated 2015, revealed it is the intent of the facility to conduct an on-going quality assurance/performance improvement program designed to systematically monitor and evaluate the quality and appropriateness of resident care, pursue opportunities to improve resident care, resolve identified problems and identify opportunities for improvement. Procedure 5. The facility will identify areas for Quality Assurance/Performance Improvement monitoring and tools/resources to be used. These monitoring activities should focus on those processes that significantly affect resident outcomes. This ongoing monitoring is used to establish the facility's baseline and the predictability of various outcomes. Procedure 14. The Quality Assurance Performance Improvement Committee has the responsibility for designing and implementing corrective action plans as needed to resolve identified resident aspects of care/service problems. Observations from 8/1/2022 to 8/7/2022, concerns were identified related to facility failures to maintain an effective infection prevention and control program to prevent the transmission of COVID-19. The identified concerns included: - Failure to ensure COVID-19 positive and negative residents were not cohorted together during a COVID-19 outbreak. - Failure to ensure unvaccinated new admissions/re-admissions and residents who had been exposed to COVID-19 were placed in quarantine. - Failure to ensure staff were fit tested for N95 masks. - Failure to ensure staff/visitors were consistently and properly screened for signs and symptoms of COVID-19 prior to entering the facility. Interview on 8/7/2022 at 10:25 a.m., the Director of Nursing (DON) stated the facility's last QAPI meeting was held on 7/28/2022, during which the QAPI members discussed residents who tested positive for COVID-19 the previous week at the start of their current outbreak on the third floor on 7/25/2022. The DON stated the facility did not cohort COVID-19 positive residents away from their COVID-19 negative roommates. The DON revealed the QAPI Committee had not identified the concerns with infection control because they could not determine how the first two residents contracted COVID-19. During further interview, the DON stated the QAPI Committee did not discuss testing staff and residents per the Centers for Disease Control and Prevention (CDC) guidelines, fit testing staff for N95 masks, or quarantining positive residents from negative residents. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 8/7/2022 at 10:25 a.m., the Regional Director of Operations (RDO) stated the facility now understood they needed to conduct COVID-19 testing for residents twice weekly, based on the county positivity rate, until all residents tested negative. The RDO stated the facility knew they should have been conducting twice-weekly COVID-19 testing, and management needed to do a root cause analysis to determine where the breakdown occurred with the infection control program.

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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** 40141 Based on observations, record review, staff interviews, and policy review, the facility failed to maintain an effective infection control program to prevent the spread of COVID-19 on three of three nursing units (second floor, third floor, and fourth floor). Specifically, the following failures were identified: 1.The facility failed to ensure one resident (R) (R#233) of 11 residents admitted in the last 30 days was promptly tested for COVID-19 and quarantined, which resulted in failure to separate COVID-positive and COVID-negative residents to the extent possible. 2. The facility failed to ensure testing of residents and staff for COVID-19 was promptly initiated when a COVID-19 outbreak was identified in the facility. 3. The facility failed to ensure staff were fit tested for N95 masks in accordance with Occupational Safety and Health Administration (OSHA) standards and adhered to requirements for the use of personal protective equipment (PPE) during a COVID-19 outbreak in the facility. 4. The facility failed to ensure screening for signs and symptoms and/or exposure to COVID-19 was consistently completed for staff upon entering the facility. On 8/4/2022, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility's Administrator was informed of the Immediate Jeopardy (IJ) on 8/4/2022 at 5:24 p.m. The noncompliance related to the IJ was identified to have existed on 7/25//2022. A removal plan (Credible Allegation of Compliance) was received on 8/6/22. The survey team conducted observations, reviewed training records, and interviews with staff and residents to verify elements of the facility's removal plan were implemented. The immediacy of the Immediate Jeopardy was removed on 8/6/22. The facility remained out of compliance while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). This oversight process includes the analysis of facility staff's conformance with the facility's policies and procedures. In-service materials and records were reviewed. Observations and interviews were conducted with staff to ensure they demonstrated knowledge of the facility's policies and procedures. Findings included: Review of the facility's policy titled, Pandemic Event Emergency Procedure Coronavirus (COVID-19) Respiratory Disease Infection, revised 3/20/2020, revealed Strategies to prevent the spread of the COVID-19 virus in general are the same strategies to detect and prevent the spread of other respiratory viruses. The facility will make attempts to protect the health and safety of our employees, residents, and visitors by attempting to prevent the spread of this emerging disease. The facility will adhere to recommendations from the Centers for Disease Control and Prevention. (continued on next page)

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Legacy Transitional Care & Rehabilitation	460 Auburn Avenue N.E. Atlanta, GA 30312

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1. Review of the policy titled, Facility Testing Requirements for Staff and Residents, revised 9/24/2021, revealed Residents will be tested upon admission for COVID-19. Review of the facility's policy titled, Cohorting Residents Guidance, dated 8/2/2020, revealed, Cohorting - The practice of isolating multiple individuals with similar symptoms and conditions together. The policy included a grid, which indicated residents with the same COVID-19 status should be cohorted. The examples included housing two residents with unknown COVID-19 status and no symptoms together or housing two residents with unknown COVID-19 status with symptoms together. For a COVID-positive resident, the options were to place the resident in a private room or COVID unit or to cohort them with another COVID-positive resident. Review R#233's clinical record revealed he was admitted to the facility on [DATE] with diagnoses of cerebral infarction (stroke) due to thrombosis (blood clot) of right posterior cerebral artery and vascular dementia. Review of the resident's immunization history revealed no evidence the resident had been vaccinated against COVID-19. Review of the Resident COVID Line Testing revealed R#233's COVID-19 status was unknown until testing on 7/26/2022 when R#233 tested positive for COVID-19. A concurrent review of the Resident COVID Line Testing and the Detailed Census Report revealed, R#233 had changed rooms three times between 7/21/2022 and 7/26/2022. Further review of the Detailed Census Report dated 8/6/2022 revealed R#233 was admitted to a room on the second floor. On 7/23/2022 and 7/26/2022, the resident was moved to other rooms on the second floor. Review of the Resident COVID Line Testing dated 8/1/2022 revealed four residents (R#14, R#4, R#232 and R#60) who had been roommates of R#233 between 7/21/2022 and 7/26/2022 had tested positive for COVID-19. Interview on 8/4/2022 at 2:26 p.m., the Director of Nursing (DON) confirmed if a resident tested positive for COVID-19 and the roommate tested negative, the facility would leave them in the same room. During continued interview, the DON indicated the facility had been at 180 capacity and, if a resident tested positive, then the roommate was likely positive. The DON stated, We did not move anyone, just in case we had false positives, and to decrease transmission. Interview on 8/7/2022 at 9:35 a.m., the DON indicated her expectation was that new admissions would be tested on admission and room placement would be based on COVID-19 status. She stated Persons Under Investigation (PUI) would be in quarantine for 14 days. 2. Review of the policy titled, Facility Testing Requirements for Staff and Residents, revised 9/24/2021, revealed, a table titled, Testing Summary which indicated Newly identified COVID-19 positive staff or resident in a facility that is unable to identify close contacts - Test all staff vaccinated and unvaccinated, facility wide or at a group level if staff are assigned to a specific location where the new case occurred. The policy also indicated, Outbreak Trigger Testing - Test all staff and residents in response to an outbreak (defined [as] any single new infection in staff or any nursing home onset infection in a resident). Continue to test all staff and residents that tested negative every three days to seven days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview on 8/1/2022 at 9:59 a.m., the Administrator stated the facility had some COVID-19 positive residents in the building. Review of a Resident COVID Line Testing document, dated 7/25/2022 for the third floor of the facility, revealed 14 residents (R#150, R#76, R#116, R#134, R#54, R#140, R#22, R#135, R#33, R#130, R#93, R#104, R#156, and R#63) tested positive for COVID-19. Review of a Resident COVID Line Testing document dated 7/26/2022 for the second floor of the facility revealed two residents (R#233 and R#275) tested positive for COVID-19. Review of a Resident COVID Line Testing document dated 7/29/2022 for the third floor revealed one resident (R#20) tested positive for COVID-19. Review of a Resident COVID Line Testing document dated 8/1/2022 revealed 11 additional residents on the second floor (R#103, R#165, R#23, R#2, R#137, R#172, R#43, R#14, R#4, R#232 and R#60) tested positive for COVID-19. Review of a Resident COVID Line Testing document revealed testing for the fourth floor of the facility was not completed until 8/2/2022, eight days after the COVID-19 outbreak started. The document for the fourth floor revealed one resident (R#90) tested positive. Interview on 8/3/2022 at 11:04 a.m., the DON and the Assistant DON (ADON) stated they were sharing the Infection Preventionist (IP) role because the Staff Development Coordinator was new. The DON indicated outbreak testing had started on 7/25/2022, when two residents (R#93 and R#320) on the third floor had signs and symptoms of COVID-19. The DON indicated all residents on the third floor were tested and 14 tested positive. The DON indicated unvaccinated staff were tested every Wednesday; however, the DON revealed not all staff had been tested . The DON indicated the facility determined staff testing needs by presence of signs and symptoms and reported none of the staff had symptoms. The DON indicated the second-floor residents were tested on [DATE], and two residents tested positive. The fourth-floor residents were tested on [DATE], and one resident tested positive. The DON indicated the delay in testing the residents on the fourth floor was due to none of the residents on the fourth floor having displayed signs or symptoms of COVID-19. The DON indicated the third-floor residents were retested on [DATE], and four of the 14 residents remained positive. The DON indicated from 7/25/2022 to 8/3/2022, one staff member had tested positive. The ADON added that unvaccinated staff were tested on ce weekly (Wednesday) prior to the outbreak; this did not include existing residents, just unvaccinated employees, and any new admissions. The ADON indicated new admissions were tested on admission and all residents had orders to be tested as needed. Interview on 8/3/2022 at 11:16 a.m., the ADON confirmed the facility only tested unvaccinated staff routinely. Other employees were only tested if they had signs and symptoms. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	3. Review of the Centers for Disease Control and Prevention (CDC) guidance titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, revised 2/2/2022, revealed, Source control options for HCP [healthcare personnel] include: A NIOSH [National Institute for Occupational Safety and Health]-approved N95 or equivalent or higher-level respirator OR a respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators. (Note: These should not be used instead of a NIOSH-approved respirator when respiratory protection is indicated) OR a well-fitting facemask. Further review of the CDC guidance revealed, Source Control and physical distancing (when physical distancing is feasible and will not interfere with provision of care) are recommended for everyone in a healthcare setting. Additionally, the guidance indicated, Implement universal use of PPE for healthcare personnel. Review of Occupational Safety and Health Administration (OSHA) Health Standard 1910.134, titled, Respiratory Protection, revealed the following: - 1910.134(c)(1) - In any workplace where respirators are necessary to protect the health of the employee or whenever respirators are required by the employer, the employer shall establish and implement a written respiratory protection program with worksite-specific procedures. The program shall be updated as necessary to reflect those changes in workplace conditions that affect respirator use. The employer shall include in the program the following provisions of this section, as applicable: Procedures for selecting respirators in the workplace; Medical evaluations of employees required to use respirators; Fit testing procedures for tight-fitting respirators; Training of employees in the proper use of respirators, including putting on and removing them, any limitations on their use, and their maintenance. - 1910.134(f) - Fit testing. This paragraph requires that, before an employee may be required to use any respirator with negative or positive pressure tight-fitting facepiece, the employee must be fit tested with the same make, model, style, and size of respirator that will be used. - 1910.134(f)(2) - The employer shall ensure that an employee using a tight-fitting facepiece respirator is fit tested prior to initial use of the respirator, whenever a different respirator facepiece (size, style, model or make) is used, and at least annually thereafter. Observation and interview on 8/3/2022 at 9:22 a.m., Licensed Practical Nurse (LPN) Manager AA, who was wearing an N95 mask, indicated staff had to wear an N95 mask in the hallway and full PPE in rooms that had stop signs on the door, which indicated the residents in those rooms were on isolation precautions. LPN Manager AA indicated this started on Monday, 8/1/2022, because a new admission from the hospital had tested positive. The LPN Manager indicated N95 masks were individually packaged and were obtained at the front desk. LPN Manager AA indicated she had not been fit tested for the mask she was wearing. Interview on 8/3/2022 at 11:04 a.m., the DON indicated N95 masks were required on all floors. When asked about the N95 fit testing for staff, the DON indicated the masks came in a standard size and further stated that no one had complained the masks did not fit. Observation and interview on 8/3/2022 at 1:50 p.m., LPN CCC was passing medications to residents on the third floor of the facility without wearing a face mask. She stated she had taken her mask off and forgot to put it back on. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview on 8/7/2022 at 9:35 a.m., the DON indicated her expectation was for all staff to wear PPE appropriately. The DON indicated N95 masks, goggles, gown, and gloves were to be worn on the unit in COVID-positive residents' rooms. The DON indicated face coverings should always be worn in the building, either a 3-ply mask when downstairs (the non-resident-occupied floor of the facility), or an N95 when in patient care areas. 20958 4. Review of a facility policy titled, Pandemic Event Emergency Procedure Coronavirus (COVID-19) Respiratory Disease Infection, dated as revised 3/20/2020, revealed, Residents, employees, contract employees and visitors should be evaluated daily for symptoms. Employees should self-report symptoms and exposure. Symptoms of Respiratory Infections including COVID-19 are: -Fever -Cough -Shortness of Breath. The policy also indicated, All Employees - Screen all Employees by obtaining temperatures and assessing for coughing, and sore throat symptoms, chest discomfort or shortness of breath. If temperature is greater than 100 degrees Fahrenheit, and/or employee reports respiratory type symptoms the employee will not be allowed to start work duty and will need to follow up with their healthcare provider immediately. Review of the policy titled, Facility Testing Requirements for Staff and Residents, revised 9/24/2021, revealed, Facility staff and individuals entering facility will be screened upon entering the facility for signs and symptoms of COVID-19, vaccination status and potential exposure risk. Observation on 8/2/2022 at 8:00 a.m. revealed signage posted at the facility entrance directing everyone to be screened upon entering the building. Review of the facility's Employee and Essential Worker COVID-19 Screening Log revealed the staff COVID-19 screenings included taking the employee's temperature, as well as determining the following: - Whether the employee had any of the following symptoms: loss of smell or taste, nausea, diarrhea, vomiting, fever, cough, shortness of breath, sore throat. - Whether, in the past 14 days, the employee had traveled internationally. - Whether, in the past 14 days, the employee had any contact with any person with known COVID-19 infection or was under evaluation for exposure to COVID-19, or a person with respiratory illness. - Whether, in the past 14 days, the employee had worked in or entered a facility with suspected or confirmed COVID-19 infection (and if so, whether the employee wore appropriate PPE). Interview on 8/5/2022 at 9:40 a.m., Certified Nursing Assistant (CNA) PP stated the screening process was for each person to check their temperature and answer the screening questions. CNA PP indicated there was a screening form for visitors and a different form for staff. Per CNA PP, she had forgotten to screen and started work before screening but later remembered and went back to complete the screening. Interview on 8/5/2022 at 10:40 a.m., CNA EE stated the screening process included a temperature check and signing the book located at the main entrance to 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	Interview on 8/5/2022 at 10:55 a.m., Licensed Practical Nurse (LPN) FF stated the screening process included a temperature check and answering questions every time she came to work. LPN FF stated the front entrance was the only entrance to enter the facility. On 8/4/2022, the surveyor reviewed and compared the facility's screening log and time report. The number of staff who had clocked in for work was compared to the number of staff who had completed their COVID-19 screenings. The results were as follows: - On 7/20/2022, 68 staff clocked in for work and only 49 staff completed the COVID-19 screening. - On 7/21/2022, 71 staff clocked in for work and only 32 staff completed the COVID-19 screening. - On 7/23/2022, 35 staff clocked in for work, and only 29 staff completed the COVID-19 screening. - On 7/25/2022, 62 staff clocked in for work, and only 29 completed the COVID-19 screening. - On 7/26/2022, 71 staff clocked in for work, and only 37 completed the COVID-19 screening. - On 7/31/2022, 36 staff clocked in for work, and only 16 completed the COVID-19 screening. Interview on 8/4/2022 at 10:38 a.m., Human Resources (HR) Staff BBB compared the above lists to a daily number of staff on payroll and reported the same results as calculated by the surveyor. Interview on 8/7/2022 at 8:12 a.m., the DON stated she expected staff to continue screening for COVID-19 when entering the building and not just walk through. The DON indicated the Staff Development Coordinator would be responsible for auditing the screening forms. Interview on 8/7/2022 at 10:16 a.m., Receptionist DDD stated when staff and visitors entered the facility, they were to stop at the front desk for screening. She stated there had been occasions when staff sneaked into the facility through a rear entrance. The Administrator was not available for interview. Removal Plan: 1. Root cause completed with (DON) Director of Nursing. From the root cause analysis, systems were identified that required an immediate action plan to correct deficient practices. The root cause analysis findings were reported to the Ad Hoc Quality Improvement Performance Improvement Committee. This committee reviewed and approved the (IJ) Immediate Jeopardy removal plan on August 6, 2022. Members of the Ad Hoc QAPI [Quality Assurance Performance Improvement] committee consisted of Medical Director and LNHA [Licensed Nursing Home Administrator] via phone, DON, Regional Director, and Department Heads. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	2. A Quality improvement tool was developed and initiated which will be monitored weekly by DON or designee to ensure proper N95 [sic] are used, proper PPE are used by staff and residents, and anyone who enters the facility will complete covid-19 screening. Initial audit results were not all employees have been fit tested , some residents and staff not wearing masks to cover nose and mouth, and not all visitors/staff had screened properly. These deficient practices have been reported to the QAPI AD HOC committee and corrective measure taken to ensure compliance has been taken. Future audits will be completed weekly X 8 weeks and then monthly X3 months. DON will report findings in QAPI X 3 months or until a period of compliance is achieved. 3. 55 employees participated in N-95 fit (re)testing with the medical clearance forms on 8/5/2022. The DON has been trained to perform the fit tests. Anyone who cannot physically complete the fit testing will have documentation that they cannot medically complete the testing. 4. On 8/5/2022 The DON or her designee will educate 124 staff on proper N95 use, proper PPE use by staff and residents. Anyone who enters the facility will complete covid-19 screening. The DON will audit screening process daily by comparing the screening logs to the schedules to verify compliance of the deficient practice. Any staff member who has not completed education and COVID-19 testing will be unable to work until it has been completed. 68 employees out of 124. 5. On 8/5/2022 all residents were supplied with a mask for use and explained that the mask was necessary while out of room. Additional face masks available on each nursing unit for clinical and non-clinical staff to distribute to residents. 6. On 8/5/2022 regional director educated DON, Infection preventionist and Administrator on proper N95 use, proper PPE use by staff and residents, and anyone who enters the facility will complete covid-19 screening. 7. Facility respiratory protection program, PPE utilization and visitor and staff screening procedures per CDC recommended guidelines were reviewed by the Medical Director, Administrator, Director of Nursing and Regional Director of Clinical Operations during an Ad Hoc QAPI meeting on 8/5/2022. The Infection Control and Prevention policy was reviewed on 8/5/2022 and no changes were made. 8. All corrections were completed on August 5, 2022. 9. The immediacy of the IJ was removed on August 6, 2022. Onsite Verification: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The IJ was removed on 8/6/2022 after the survey team performed onsite verification that the Removal Plan had been implemented. COVID-19 positive residents were verified to have been moved to the second floor and were not placed with COVID-19 negative residents. Review of sign-in sheets and testing records revealed staff education was ongoing and N95 fit testing was completed. Interviews were conducted with random staff, who correctly verbalized the requirements regarding the need to always wear N95 masks in resident areas, as well as gown, gloves, and face shield/goggles to be worn in the rooms of COVID-positive residents or persons under investigation for COVID-19. The screening process was observed on 8/7/2022, and an audit was completed to verify COVID-19 screening was completed for all staff on duty. The DON's audits were reviewed and verified to have been completed. The DON's education by the Regional Director was verified to have been completed. On 8/7/2022, staff from both shifts were interviewed to confirm education and corrective measures including: - Knowledge of the COVID-19 screening process. - When each interviewed staff member was last tested for COVID-19. - Whether each interviewed staff member had been fit tested for an N95 mask. - Knowledge of the proper PPE for entering the rooms of COVID-positive residents or persons under investigation for COVID-19.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35808 Based on record review, interviews and review of policy titled Influenza and Pneumonia Vaccine, the facility failed to update the policy with current Centers for Disease Control and Prevention (CDC) recommendations and failed to provide education, offer, or provide pneumonia vaccinations for five of five residents (R) (R#1, R#81, R#90, R#93, and R#146) reviewed for pneumonia vaccinations. Specifically, Pneumococcal vaccines 13-valent pneumococcal conjugate vaccine (Prevnar13) PCV13, 15-valent pneumococcal conjugate vaccine (Vaxneuvance) PVC15, 20-valent pneumococcal conjugate vaccine (Prevnar20) PVC20, and 23-valent pneumococcal polysaccharide vaccine (Pneumovax) PPSV23 were not offered or provided to applicable residents. The census was 175. Findings included: Review of the policy titled, Influenza and Pneumonia Vaccination, reviewed in 6/2021, revealed the policy was outdated according to the Centers for Disease Control and Prevention (CDC) Pneumococcal Vaccine Timing for Adults, dated 4/1/2022. The outdated policy indicated the standard of practice of the facility to offer and administer immunization to the resident unless it is medically contraindicated to prevent and minimize house acquired infection, unnecessary hospitalization , and even death in the elderly population associated with influenza and incidence of pneumonia. Further review revealed administration of the influenza and pneumonia vaccination will be made in accordance with current Center for Disease Control (CDC) recommendations at the time of the vaccination. All residents will be offered the pneumococcal vaccination to aid in preventing pneumococcal infections. Review of the CDC's Pneumococcal Vaccine Timing for Adults, dated 4/1/2022 revealed the CDC recommends pneumococcal vaccinations for adults [AGE] years old and adults ages 19 through [AGE] years old with underlying medical conditions or other risk factors. Continued review of the recommendations revealed there were four pneumococcal vaccinations listed: PCV13, PCV15, PCV20, and PPSV23. Interview on 8/5/2022 at 9:00 a.m., the Assistant Director of Nursing (ADON), stated it was the responsibility of the ADON and the Director of Nursing (DON) to track immunizations and ensure they were offered to the applicable residents. She stated the pneumonia vaccinations consent and education forms should be in the resident's electronic medical record (EMR) under a miscellaneous tab and in the admission packet. Interview on 8/5/2022 at 9:05 a.m., the DON stated the immunization education and consent forms should be in either the admission packet or the resident's EMR. She stated if a vaccination was given it would be recorded in the Immunization tab in the EMR. The DON stated the admission packet had not been updated to reflect the CDC's new adult immunization schedule for 2022. 1. Review of the clinical record for R#1 revealed she was admitted to the facility on [DATE], was [AGE] years old with diagnoses of acute respiratory failure with hypoxia, epilepsy, chronic systolic heart failure, and dysphagia. There was no indication that the pneumonia vaccine was offered or administered to the resident. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Review of the clinical record for R#81 revealed he was admitted to the facility on [DATE], was [AGE] years old with diagnoses of acute embolism and thrombosis, atrial fibrillation, diabetes mellitus type 2, and chronic kidney disease. R#81 had received one dose of a pneumonia vaccine on 8/9/16. There were no additional pneumonia vaccines listed. 3. Review of the clinical record for R#90 revealed he was admitted to the facility on [DATE], was [AGE] years old with diagnoses of peripheral vascular disease, hemiplegia, and asthma. There was no indication that the pneumonia vaccine was offered or administered to the resident. 4. Review of the clinical record for R#93 revealed she was admitted to the facility on [DATE], was [AGE] years old with diagnoses which included COVID-19, peripheral vascular disease, and acute respiratory failure. There was no indication that the pneumonia vaccine was offered or administered to the resident. 5. Review of the clinical record for R#146 revealed she was admitted to the facility on [DATE], was age [AGE] years old with diagnoses which included cerebral vascular disease, hemiplegia, and chronic viral hepatitis. R#146 had received one dose of pneumonia vaccine on 5/13/13. There were no additional pneumonia vaccines listed. Interview on 8/5/2022 at 11:08 a.m., the Business Office Manager revealed she reviewed the facility's pharmacy order requisitions from January 2022 to July 2022 and there were no orders for pneumonia vaccinations. Interview on 8/5/2022 at 11:47 a.m., the Pharmacy Director stated the facility had not ordered any pneumonia vaccines since May of 2021. She stated the pharmacy sent individual-use pneumonia vaccination vials and once the dose was administered, the vial would be discarded. She stated that in May of 2021, the facility ordered six individual doses of pneumonia vaccine and stated there were no purchase orders since then. Interview on 8/7/2022 at 9:35 a.m., the DON stated the facility expectation included screening and offering pneumonia vaccinations on admission and as needed.

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	115585	A. Building B. Wing	09/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Transitional Care & Rehabilitation	460 Auburn Avenue N.E. Atlanta, GA 30312

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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** 40141 Based on record review, interviews, and policy review, the facility failed to conduct routine and outbreak testing for COVID-19 for all staff and residents in accordance with Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid Services (CMS) requirements, which potentially caused delays in identifying, treating, and isolating COVID-19 positive residents and staff on 3 of 3 resident-occupied floors of the facility (second floor, third floor, and fourth floor). Specifically, the facility failed to quarantine and test one of 11 newly admitted residents (R) R#233; failed to conduct outbreak testing/contract tracing for employees and residents upon identifying a COVID-19 outbreak in the facility; and failed to ensure unvaccinated or staff not up to date with COVID-19 vaccines were routinely tested twice weekly per CDC guidance when the community transmission level was high in the county where the facility was located. On 8/4/2022, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility's Administrator was informed of the Immediate Jeopardy (IJ) on 8/4/2022 at 5:24 p.m. The noncompliance related to the IJ was identified to have existed on 7/25//2022. A removal plan (Credible Allegation of Compliance) was received on 8/6/22. The survey team conducted observations, reviewed training records, and interviews with staff and residents to verify elements of the facility's removal plan were implemented. The immediacy of the Immediate Jeopardy was removed on 8/6/22. The facility remained out of compliance while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). This oversight process includes the analysis of facility staff's conformance with the facility's policies and procedures. In-service materials and records were reviewed. Observations and interviews were conducted with staff to ensure they demonstrated knowledge of the facility's policies and procedures. Findings included: Review of a CMS Quality/Survey and (&) Oversight (QSO) Group memorandum, Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements, QSO-20-38-NH, revised 3/10/22, indicated, Routine Testing of Staff, Routine testing of staff, who are not up-to-date, should be based on the extent of the virus in the community. Staff, who are up-to date, do not have to be routinely tested . Facilities should use their community transmission level as the trigger for staff testing frequency. Table 2: Routine Testing Intervals by County COVID-19 Level of Community Transmission Level of COVID-19 Community Transmission/Minimum Testing Frequency of Staff who are not up to date+ Low (blue) = Not recommended Moderate (yellow) = Once a week (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Substantial (orange) = Twice a week High (red) = Twice a week + Staff who are up to date do not need to be routinely tested . Review of the CDC guidance titled, Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 [severe acute respiratory syndrome coronavirus 2] Spread in Nursing Homes, dated 2/2/2022, revealed, In nursing homes, newly admitted residents should be tested immediately. Review of a facility policy titled, Facility Testing Requirements for Staff and Residents, revised 9/24/2021, revealed Residents will be tested upon admission for COVID-19. 1.Review of R#233's clinical record revealed he was admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy, diabetes mellitus type 2, and cerebral infarction. Review of a Detailed Census Report, revealed R#233 was initially admitted to a room on the second floor. On 7/23/2022, the resident was moved to another room on the second floor. Review of the Resident COVID Line Testing, dated 7/26/2022, revealed R#233 tested positive for COVID-19. The Detailed Census Report indicated the resident was moved to a third room on the second floor on this date. The resident remained in this room at the time of the survey. Review of the Resident COVID Line Testing, dated 8/1/2022, revealed a total of four residents (R#14, R#4, R#232 and R#60) who had been R#233's roommates between 7/21/2022 and 7/26/2022 had tested positive for COVID-19. Interview on 8/3/2022 at 11:04 a.m., the Director of Nursing (DON) and the Assistant DON (ADON) stated they were sharing the Infection Preventionist (IP) role. The DON indicated residents on the second floor were tested on [DATE], and two residents tested positive. The ADON indicated new admissions were to be tested for COVID-19 upon admission and all residents had physician's orders for as-needed (PRN) testing. 2. Review of a Resident COVID Line Testing, dated 7/25/2022, revealed 14 residents on the third floor tested positive for COVID-19. There was no evidence outbreak testing was immediately initiated for residents on other floors or for facility staff. No contact tracing efforts were documented. Review of a Resident COVID Line Testing, dated 7/26/2022, revealed two residents on the second floor tested positive for COVID-19. Review of a Resident Covid Line Testing, dated 7/29/2022, revealed four residents on the third floor tested positive for COVID-19. There was no evidence facility staff and residents residing on the fourth floor had been tested as a result of the ongoing COVID-19 outbreak in the facility. Review of a Resident COVID Line Testing, dated 8/1/2022, revealed the same four residents on the third floor tested positive for COVID-19. (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 a Resident COVID Line Testing, dated 8/1/2022, revealed a total of 11 residents on the second floor tested positive for COVID-19. There was still no evidence facility staff and residents residing on the fourth floor had been tested as a result of the ongoing COVID-19 outbreak in the facility. Review of a Resident COVID Line Testing, dated 8/2/2022, revealed one resident on the fourth floor tested positive for COVID-19. There was no evidence outbreak testing had been initiated for facility staff. Interview on 8/3/2022 at 11:04 a.m., with the DON and the ADON revealed outbreak testing had started on 7/25/2022, when two residents on the third floor had signs and symptoms of COVID-19. The DON indicated all residents on the third floor were tested , and 14 were positive. The DON stated no staff members had been tested . She confirmed that the facility did not test all employees during an outbreak. She stated the facility tested staff based on COVID symptoms, and none of the staff had exhibited symptoms. The DON indicated residents on the second floor were tested on [DATE] and there were two COVID-positive residents. During further interview, the DON stated the residents on the fourth floor were tested on [DATE] and there was one COVID-positive resident. She indicated the facility had not tested the fourth-floor residents prior to 8/2/2022 because there had been no residents on that floor exhibiting signs or symptoms of COVID-19. The DON indicated the third floor had been retested on [DATE], and four of the 14 residents remained positive. The DON indicated from 7/25/2022 to 8/3/2022, one staff (who was tested as part of the weekly testing of unvaccinated staff) had tested positive. Interview on 8/3/2022 at 11:16 a.m., the ADON confirmed unvaccinated staff were tested for COVID-19 routinely, but other employees were only tested if they had signs and symptoms of COVID-19. Interview on 8/4/2022 at 8:50 a.m., the DON stated she did perform contact tracing during the current COVID-19 outbreak. She stated she made a floor grid and looked to see if there were any common factors with the positive rooms. She stated she determined if there were any visitors who visited the positive residents and she looked to determine if the staff who worked with the positive residents had worked with any other residents in the facility. She stated she decided after the first two positive residents were identified to assign designated staff to work on the units and not work on any of the other units during the outbreak. She stated she could not pinpoint any common factors related to the first two positive residents. She stated there were no visitors for the first two positive residents. She also indicated none of the staff who had taken care of the two COVID-positive residents were COVID-positive. When asked how she determined this, since the facility only tested unvaccinated staff or staff who were symptomatic, the DON could not explain and stated, You are right. I would not be able to determine that; we are not testing all staff. The DON confirmed the facility had not effectively implemented and completed contact tracing during the COVID-19 outbreak. She stated she had not documented the contact tracing she had performed. The DON stated the only COVID-positive employee identified to date was an activity aide who had worked on the fourth-floor unit for the past two weeks. Interview on 8/7/2022 at 9:35 a.m., the DON indicated she expected contact tracing to be conducted and for staff and residents to be tested per CDC guidance. The Administrator was not available for interview. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	3. Review of the CDC guidance titled, Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 [severe acute respiratory syndrome coronavirus 2] Spread in Nursing Homes, dated 2/2/2022, revealed in nursing homes, HCP [healthcare personnel] who are not up to date with all recommended COVID-19 vaccine doses should continue expanded screening testing based on the level of community transmission. The guidance indicated in nursing homes located in counties with substantial to high community transmission, HCP should have a viral test twice a week. Review of the Centers for Disease Control and Prevention (CDC) Covid Data Tracker for 8/3/2022 revealed the county where the facility was located had a high COVID-19 community transmission level. On 8/3/2022 at 11:04 a.m., the DON and the ADON were interviewed as the Infection Preventionists (IP). The DON indicated unvaccinated staff were being tested on ce per week, every Wednesday. Interview on 8/7/2022 at 9:35 a.m., the DON indicated the facility would follow CDC guidance and expected unvaccinated staff to be tested twice weekly. Removal Plan: 1. Root cause completed with (DON) Director of Nursing. From the root cause analysis, systems were identified that required an immediate action plan to correct deficient practices. The root cause analysis findings were reported to the Ad Hoc Quality Improvement Performance Improvement Committee. This committee reviewed and approved the (IJ) Immediate Jeopardy removal plan on August 6, 2022. Members of the Ad Hoc QAPI [Quality Assurance Performance Improvement] committee consisted of Medical Director and LNHA [Licensed Nursing Home Administrator] via phone, DON, Regional Director, and Department Heads. 2. A Quality improvement tool was developed and initiated which will be monitored weekly by DON or designee to ensure effective testing procedures COVID-19, appropriate cohorting, and completion of contact tracing staff sign in sheets. An audit was completed on August 5, 2022, on 20 COVID-19 positive residents. Initial audit results where contact tracing employee signature forms were needed on the rooms of those 20 COVID-19 positive residents and have been reported to the QAPI AD HOC committee and corrective measure taken to ensure compliance of COVID19 testing and proper cohorting and isolation precautions have been taken. Daily audits will be conducted on newly admitted residents, or those returning from extended leaves of absences. Future audit will be completed weekly X [times] 8 weeks and then monthly X 3 months. DON will report findings in QAPI X 3 months or until a period of compliance is achieved. 3. On 8/5/2022 45 staff tested for COVID-19. 44 of staff test results negative. 1 staff test results positive. Staff members who have not completed COVID-19 testing will be unable to work until COVID19 testing has been completed. 4. On 8/5/2022 167 in-house residents were be tested for COVID-19. 147 test results negative. 20 test results positive. 5. On 8/5/2022 all new admissions tested . 1 tested with negative test results for COVID-19. Any new admissions/readmissions will be tested for COVID-19 going forward. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	6. On 8/5/2022 (20) Residents tested positive have been cohorted with other residents that tested positive and placed in transmission-based precautions. The following rooms have COVID positive residents in transmission-based precaution isolation. [Room numbers listed]. 7. On 8/5/2022 (30) residents that tested negative and were in close contact or assigned to the same room as a resident who tested positive will be cohorted with other residents who also tested negative and were in close contact or assigned to the same room as a resident who tested positive and placed on transmission-based precautions as PUIs [Persons Under Investigation]. (30) of residents meet CDC criteria for possible exposure risk and are categorized as a PUI. The following rooms are identified as persons under investigation for COVID19 due to their possible exposure risk. [Room numbers listed]. 8. On 8/5/2022 all new admissions who are unvaccinated placed with other new admissions who are unvaccinated and placed on transmission-based precautions as PUIs. (1) new admissions were tested and assigned to appropriate rooms based on test results. Any unvaccinated new admissions going forward will be placed in PUI with other unvaccinated new admissions, following CDC guidelines. 9. On 8/5/2022 all rooms with any resident that tested positive or were in close contact or assigned to the same room as a resident who tested positive will have a staff contact tracing sign in log attached to their door. [Room numbers listed]. 10. All residents who have tested positive were notified by the Unit Managers and/or Social Services on the day they tested positive. 11. On 8/5/2022 DON or her designee (who has been educated by the DON) will educate 124 staff members on COVID-19 testing policy, cohorting practices, PUI practices, and contact tracing. Any staff member who has not completed education and COVID-19 testing will be unable to work until it has been completed. 68 employees out of 124. 12. Contact tracing signage were [sic] placed on the doors of all residents testing positive and all PUI. [Room numbers listed]. 13. On 8/5/2022 regional director educated the DON, Infection preventionist and Administrator on COVID-19 testing policy, Cohorting practices, PUI practices, and contact tracing. 14. Facility COVID-19 testing policy, Facility Respiratory Protection Program, CDC recommendations for transmission-based practices to prevent the spread of COVID-19 including cohorting guidelines, persons under investigation related to possible exposure to COVID-19, Contact Tracing procedures were reviewed with the Medical Director, Administrator, Director of Nursing and Regional Director of Clinical Operations during an Ad Hoc QAPI meeting on 8/5/2022. The Infection Control and Prevention policy was reviewed on 8/5/2022 and no changes were made. 15. All corrections were completed on August 5, 2022. 16. The immediacy of the IJ was removed on August 6, 2022. Survey Agency validated removal of the Immediate Jeopardy as follows: (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The IJ was removed on 8/6/2022 after the survey team performed onsite verification that the Removal Plan had been implemented. COVID-19 positive residents had been moved to the second floor and were not placed with negative residents. Sign-in sheets for staff were observed to have been placed outside resident room doors as per the removal plan. Implementation of the removal plan was verified through observations, staff interviews, and record reviews. Staff and resident COVID-19 testing was verified through record review and interview. Inservice sign-in sheets were reviewed to verify staff education was provided per the removal plan. The DON audits were reviewed. Review of education records verified the DON's education by the Regional Director was completed. Staff members from both shifts were interviewed regarding when they were last tested for COVID-19 and whether they were aware of the purpose of the sign-in sheets posted on the residents' room doors.