STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185272	A. Building B. Wing	09/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Haven Nursing and Rehabilitation Center	867 McGuire Avenue Paducah, KY 42001

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33035 Based on observation, interview, record review, and facility policy review, it was determined the facility failed to treat three (3) of twenty (20) sampled residents (Residents #30, #39, and #52) with respect, dignity, and provide care in a manner that promotes maintenance or enhancement of his/her quality of life, recognizing each resident's individuality. Staff failed to ensure Resident #30's name was not displayed on his/her clothing visible to others, failed to answer Resident #39's call light in a timely manner which caused the resident to be incontinent, and failed to meet Resident #52's grooming needs to remove facial hair including mustache. The findings include: Review of the facility's policy titled, Quality of Life-Dignity, not dated, revealed each resident shall be treated for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Residents shall be treated with dignity and respect at all times. Treated with dignity meant the resident would be assisted in maintaining and enhancing his/her self-esteem and self-worth. Residents shall be groomed as they wish to be groomed (hair styles, nails, facial hair, etcetera). 1. Record review revealed the facility admitted Resident #39, on 07/02/2020 with diagnoses, which included Cerebrovascular Accident (CVA), and Hemiplegia, and Major Depressive Disorder. Review of the Admission MDS assessment, dated 07/09/2020, revealed the facility assessed Resident #39's cognition as intact with a BIMS score of thirteen (13) which indicated the resident was interviewable. Further review of the MDS, Section H: Bladder and Bowel revealed the facility assessed Resident #39 as occasionally incontinent of bladder and always incontinent of bowel. Interview with Resident #39, on 09/01/2020 at 8:39 AM, revealed the staff took too long to answer the call light, which resulted in episodes of bladder and bowel incontinence. Resident #39 stated, I know when I need to use the bathroom; however, by the time staff answers the call light it is too late, then I have to be cleaned up and this makes me feel degraded, less, than. I had a stroke, that's why I'm here, I need help. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Certified Nurse Aide (CNA) #2, on 09/03/2020 at 1:35 PM, revealed Resident #39 is incontinent and it takes ten (10) to fifteen (15) minutes, sometimes longer to answer a call light. CNA #2 stated, this could cause a resident to be incontinent if staff is not there to assist the resident with toileting. 2. Record review revealed the facility readmitted Resident #52, on 01/28/2020 with diagnoses, which included Parkinson's, Diabetes, and Morbid Obesity due to Excess Calories. Review of the Quarterly MDS assessment dated [DATE] revealed the facility assessed Resident #52's cognition as intact with a BIMS score of fifteen (15) which indicated the resident was interviewable. Further review of the MDS, Section G: Functional Status, revealed the facility assessed Resident #52 required extensive assistant of two (2) or more staff with personal hygiene. Observations on 09/01/20 at 10:58 AM and 09/03/20 at 8:18 AM, revealed Resident #52 had facial hair with a mustache on upper lip. Interview with Resident #52, on 09/01/2020 at 10:58 AM, revealed the resident stated I used to shave myself but unable too now. When I ask staff to shave me, I'm told they're too busy. I don't like for the hair to grow out on my face. I tell them to shave me when I get my shower which is scheduled twice a week; however, I choose to only take one a week at most times. Interview with CNA #2, on 09/03/2020 at 1:35 PM, revealed she was not aware Resident #52 wanted to be shaved on days he/she did not take a shower. Interview with the Director of Nursing (DON), on 09/04/2020 at 11:15 AM, revealed she expected Resident #39 to notify staff of any concerns related to dignity issues if staff is involved. The DON stated she expected Resident #52's facial hair, including mustache to be shaved at the resident's request to enhance the resident's dignity. 35748 3. Record review revealed the facility readmitted Resident #30 on 06/10/19 with diagnoses, which included Heart Failure and Hyperlipidemia. Review of the Quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of fifteen (15), indicating the resident was interviewable. Observations on 09/01/2020 at 11:25 AM, 2:14 PM, and 4:25 PM, revealed Resident #30 was in his/her wheelchair in the hallway with his/her name written in black ink/marker on the back of his/her shirt and visible to other residents. Interview with Resident #30, on 09/01/2020 at 4:25 PM, revealed he/she was unaware his/her name was written on the outside of his/her shirt. Resident #30 stated he/she did not like it and would like name placed on the inside of his/her clothes. Interview with Licensed Practical Nurse (LPN) #5, on 09/04/2020 at 8:26 AM, revealed it was inappropriate to have residents' names displayed on the outside of their clothing, as it can be considered a dignity issue. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with CNA #17 on 09/04/2020 at 8:35 AM,, revealed the facility staff normally label clothes on the inside tags. She stated staff should not write on resident's clothing and their names should be on the inside labels. Interview with the DON on 09/04/2020 at 11:03 AM, revealed she would expect residents clothing to be labeled on the inside tags and not visible to everyone in order to maintain the dignity and privacy of each resident.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 35748 Based on observation, interview, and record review, it was determined the facility failed to ensure reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents, for one (1) of twenty (20) sampled residents (Resident #45). Observations revealed Resident #45's call light was not accessible to him/her. The findings include: Interview with the Director of Nursing (DON), on 09/04/2020 at 11:03 AM, revealed the facility did not have a policy directly related to call lights. She stated the facility followed state and federal guidelines related to resident accommodations. Record review revealed the facility readmitted Resident #45 on 04/16/2020 with diagnoses which included Major Depressive Disorder and Heart Failure. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 07/07/2020, revealed the resident had a Brief Interview for Mental Status (BIMS) score of eight (8), which indicated the resident was interviewable. Further review of the MDS revealed the resident required extensive assist for activities of daily living (ADLs). Observation, on 09/01/2020 at 9:53 AM, 10:35 AM, and 12:01 PM, revealed Resident #45 was sitting up in his/her wheelchair, with a bedside table in front of him/her and at 12:01 PM voiced concerns of a need for pain medication to the surveyor. Further observation revealed the call light was wrapped around the bed rail, was not in his/her reach and he/she was unable to call for assistance. Interview with Certified Nurse Aide (CNA) #17, on 09/04/2020 at 8:35 AM, revealed Resident #45's call light should have been within his/her reach, either clipped to his/her clothing or within reach and not wrapped around the bed rail. Interview with Licensed Practical Nurse (LPN) #5, on 09/04/2020 at 8:26 AM, revealed she expected the aides to put the call light within Resident #45's reach when he/she is out of bed, possibly clipped to his/her clothing. LPN #5 stated Resident #45 is able to use the call light to ask for assistance. Further interview with the DON, on 09/04/2020 at 11:03 AM, revealed her expectations were that all residents had access to the call light and it was everyone's responsibility to ensure the call lights were accessible to residents.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35748 Based on observation, interview, and review of facility policy, it was determined the facility failed to provide housekeeping services necessary to maintain a clean, comfortable, and homelike interior in two (2) of fourteen (14) residents' rooms on the one-hundred (100) hall. Observations, of rooms #113-B and 117-A, on 09/01/2020 and 09/02/2020, revealed debris and dried matter on the floors. The findings include: Review of the facility policy, Resident Rights, not dated, revealed the resident had a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Review of the facility policy, 5-Step Daily Room Cleaning, not dated, revealed the entire accessible flooring area of resident rooms needed to be dust mopped and damp mopped, ensuring the floor area under the bed was also cleaned. 1. Observations of room [ROOM NUMBER]-B, on 09/01/20 at 12:07 PM, revealed the floor was covered with scattered paper debris, dried brown stain, and food wrappers. Further observations of room [ROOM NUMBER]-B on 09/02/2020 at 9:19 AM, revealed the same debris on the floor. Observation of room [ROOM NUMBER]-A on 09/01/2020 at 3:15 PM, revealed food crumbs on the floor, dried spill and a pair of medical gloves on the floor under the bed. Telephone interview with Housekeeper #1, on 09/03/20 at 4:28 PM, revealed he had worked the one-hundred (100) hall, on 09/01/2020, and stated he had cleaned room [ROOM NUMBER] but when he attempted to clean room [ROOM NUMBER], the resident was unpleasant, cursed and asked me to get out. Housekeeper #1 further stated he was unable to clean the room at that time. He stated he was called into assist the facility with housekeeping services and was just there to help out from his usual facility. He stated he was not familiar with the residents or certified nurse aides on duty but should have asked for assistance in distracting or redirecting the resident in room [ROOM NUMBER]. Housekeeper #1 further stated he failed to make his supervisor aware he did not complete his duties. Interview with the Housekeeping Supervisor, on 09/03/20 at 3:08 PM, revealed resident rooms were cleaned daily and housekeeping staff were in the building seven days a week, on day shift. She stated after housekeeping left the certified nurse aides were responsible for cleaning up spills or large debris from the floor. The housekeeping supervisor further revealed if staff were unable to clean a residents room they should make her aware so other arrangements could be made to ensure the room was cleaned.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32162 Based on interview, record review, review of facility investigation, and facility policy review, it was determined the facility failed to conduct interviews with staff who worked with the alleged perpetrator or might have knowledge of the incident related to an allegation of abuse to ensure a thorough investigation was completed for one (1) of three (3) sampled residents (Resident #2). The findings include: Review of a facility policy titled, Abuse Investigations last revised April 2010, revealed a completed copy of documentation forms and written statements from witnesses, if any, must be provided to the Administration. Individuals conducting the interviews of the allegation will at a minimum interview any witnesses to the incident, the resident, the attending physician, all staff members (on all shifts) who have had contact with the resident during the period of alleged incident. Witness reports will be obtained in writing, and witnesses will be required to sign and date such reports. Review of a facility policy titled, Abuse Prohibitions Standard of Practice, last revised March 2019, revealed investigations should include interviews of all involved persons, including alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations with information documented. Record review reveals Resident #2 was admitted to the facility on [DATE] with diagnoses which included Disorganized Schizophrenia, Major Depressive Disorder, and Need for Assistance with Personal Care. Review of the facility investigation provided by the Administrator concerning Resident #2's allegation that Certified Nurse Aide (CNA) #3 was mean to the resident revealed there was documented interviews conducted with CNA #3, a Physical Therapy Assistant (PTA), and interviewable residents with a BIMS greater than (8) eight. However, there was no documented evidence any staff who worked with the alleged perpetrator were interviewed to see if they were aware of the CNA being mean to any residents. Interview with facility Administrator dated 09/15/2020 at 3:45 PM revealed she had questioned other staff concerning allegation of Resident #2 but that she had not documented anything regarding the interviews.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 35748 Based on interview, record review, and review of the Resident Assessment Instrument (RAI) Version 3.0 User Manual, it was determined the facility failed to ensure one (1) of twenty (20) sampled residents received an accurate assessment, reflective of the resident's status at the time of the assessment (Resident #18). The facility inaccurately coded Resident #18's Section E of the Admission Minimum Data Set (MDS) Assessment as a 1, indicating Resident #18's behavior had improved as compared to the previous assessment when there was no previous assessment. The findings include: Review of the RAI Version 3.0 User Manual on Coding instructions for E1100, Changes in Behavior or Other Symptoms, revealed prior to coding in this section all of the symptoms assessed in items E0100 through E 1000 should be considered. Further review of the instructions for Section E1100 revealed a 3 should be coded if there was no prior MDS assessment for comparison. Record review revealed the facility admitted Resident #18, from an acute hospital on 06/18/2020, with diagnoses, which included Morbid Obesity and Peritoneal Abscess. Review of Resident #18's Admission MDS Assessment, dated 06/25/2020, revealed Section E1100 was coded 1, indicating the residents behaviors had improved. However, there was no prior MDS assessment for comparison. Interview with the MDS Coordinator,on 09/03/2020 at 2:44 PM, revealed the previous Social Services Director (SSD) had made an error when coding Resident #18"s behaviors as improved as it should have been coded as three (3) because there was no prior assessment for comparison. She stated she used the RAI manual for instructions on completing the MDS assessments for residents. Telephone interview with the previous SSD,on 09/04/2020 at 8:17 AM, revealed she must have made an error when coding the MDS assessment because if there was no previous assessment for comparison a 3 should be marked as indicated. Interview with the Director of Nursing (DON), on 09/04/2020 at 11:03 AM, revealed she expected the MDS Coordinator to code resident assessments per the RAI manual.

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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** 32162 Based on interview, record review, hospital record review, and facility policy review, it was determined the facility failed to ensure the person centered comprehensive care plan was implemented for one (1) of four (4) sampled residents (Resident #1). The facility care planned Resident #1 as a choking risk due to behaviors of reaching and grabbing food not on his/her diet, The resident required a pureed diet. In addition, one to one (1:1) supervision, when out of bed. The facility failed to implement the nursing care plan interventions to prevent Resident #1 from getting food not on his/her diet, nor the 1:1 supervision when out of bed. On [DATE], Resident #1 obtained a peanut butter sandwich from the snack tray on the medication cart. Resident #1 grabbed and consumed half of the half of peanut butter sandwich before staff intervention and choked. Staff performed the Heimlich maneuver (abdominal thrusts to remove object causing to choke) and Resident #1 coded with staff initiating Cardiopulmonary Resuscitation (CPR) (chest compressions often with artificial ventilation). Resident #1 was transferred to an acute care facility where he/she was intubated, placed on a ventilator (machine that provides mechanical ventilation {air/breaths}), and a (Nasogastric tube) feeding tube was placed. The facility's failure to implement the care plan has caused or was likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on [DATE] and determined to exist on [DATE]. The facility was notified of the Immediate Jeopardy on [DATE]. An acceptable Credible Allegation of Compliance (AoC), related to the Immediate Jeopardy was received on [DATE] alleging the Immediate Jeopardy was removed on [DATE]. The State Survey Agency validated the AoC and determined the Immediate Jeopardy was removed on [DATE]. The Scope and Severity was lowered to a D while the facility develops and implements the Plan of Correction (PoC); and, the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes. The findings include: Review of facility policy titled, Comprehensive Care Plan, revealed the Comprehensive Care Plan was developed to promote communication of the resident's needs, goal, and interventions to promote successful goal attainment. Each residents care plan was designed to incorporate identified problem areas, and identify the professional services that were responsible for each element of care. Record review revealed the facility readmitted Resident #1, on [DATE] with diagnoses which included Dementia, Encephalopathy, Unspecified Psychosis, Anoxic Brain Damage, Altered Mental Status (AMS), Aphasia, and Dysphagia. Review of the Quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of three (3), which indicated the resident was not interviewable. Further review revealed the resident required supervision with meal setup. (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 Resident #1's Comprehensive Care Plan, dated [DATE], revealed the resident was at risk for Nutritional Decline. The Care Plan stated the resident exhibited alterations in mood/behavior of attempting to bite, grab, and scratch staff and other residents. The interventions directed staff to provide 1:1 supervision until further notice, when out of bed (dated [DATE]), and to supervise meals as indicated for reaching in and getting food not on his/her diet. However, interview with Licensed Practical Nurse (LPN) #1, on [DATE] at 9:46 AM and 11:45 AM; and on [DATE] at 2:25 PM, revealed Resident #1 was supposed to be on 1:1 supervision and she tried to call a Certified Nurse Aide (CNA) into work to provide the 1:1 supervision, but was unsuccessful. LPN #1 stated she did not have enough staff to assign a 1:1, so she tried to keep the resident by the medication cart while she administered medications and handed out snacks. She stated she had the tray of snacks on top of the medication cart. She revealed while she was pouring water to administer a resident's medications, Resident #1 grabbed a half peanut butter sandwich off the snack tray and ate half of it before she could get it away from the resident. She stated the resident choked and she provided the Heimlich maneuver unsuccessfully and Resident #1 coded requiring CPR. She stated Emergency Medical System was called and Resident #1 was transferred to hospital. Further interview with LPN #1 revealed she was aware Resident #1 was care planned for 1:1 supervision and was on the list of residents who grab food in the nurses book at the nursing station. LPN #1 stated it was the nurse who determined staff assignment of the 1:1, but when doing 1:1 staff still had other duties. She stated she did not think the resident could reach the top of the med cart to grab the sandwich off the snack tray. Review of hospital records dated [DATE], revealed Resident #1 was admitted to hospital via the emergency room (ER) after choking on a peanut butter sandwich. Resident #1 was intubated at 10:07 PM on [DATE]. Interview with Administrator, on [DATE] at 3:45 PM revealed the resident was still in the hospital and remained intubated with a tracheotomy, on a ventilator, and a nasogastric tube for feeding. Interviews with CNA #1, on [DATE] at 7:41 AM; and, CNA #2 on [DATE] at 9:27 AM, and [DATE] at 3:31 PM, revealed they were attending to other duties and not really paying any attention to Resident #1 sitting on the hallway. The CNA's stated they were aware that Resident #1 was care planned to be on 1:1 when out of bed and someone was to be with him/her at all times and within touching distance, but there was not enough staff to provide the required 1:1 supervision. The CNA's revealed there was not enough staff to sit with the resident 1:1, so no one does 1:1, we just watch resident while doing care on the hall and sometimes the nurse watched the resident. The CNA's stated Resident #1 would grab anything in reach. Interview with Director of Nursing (DON), on [DATE] at 12:00 PM, revealed care plans were to be followed related to dietary needs and supervision. Interview with Administrator, on [DATE] at 4:12 PM, and [DATE] at 4:42 PM, revealed 1:1 supervision was provided depending on why the resident was placed on 1:1. She stated Resident #1 was care planned for 1:1 supervision due to grabbing and scratching other residents; so the staff only had to keep the resident in line of sight to ensure the resident was not within reaching distance of another resident. She further revealed she was not aware Resident #1 would grab at everything and was care planned for reaching in and getting food not on his/her diet. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility implemented the following to remove the Immediate Jeopardy: 1. Resident #1 was transferred from the facility on [DATE] and has not returned to the facility. 2. The Dietary Manager provided a list of all current residents on mechanical altered diets (17 residents) on [DATE]. The Administrator completed a review of the care plans of residents with mechanical soft and pureed diets in regard for the potential for reaching for food not on their meal tray. 3. The Administrator, Social Service Director, and/or licensed nurse completed a review of psychosocial/behavior care plans for any resident currently identified as requiring 1:1 supervision, on [DATE]. There were no additional residents at this time requiring 1:1 supervision. This was completed on [DATE]. 4. The Regional Director of Operations provided education to the Administrator on [DATE] regarding: One-to-one supervision regarding one staff member dedicated to the supervision of one resident with no other assigned duties during the time. 5. The Regional Quality Manager (RQM) provided education to the Director of Nursing (DON) on [DATE] regarding: One to one supervision requires one staff member dedicated to the supervision of one resident with no other assigned duties during this time. Dietary staff would hand off snacks to the nursing staff. If for any reason the nursing staff was unavailable, the snack pass was to be placed in the secured nourishment station. Dietary would provide a list of mechanically altered diets and thickened liquids with each snack pass delivery. All snacks would be placed in a covered container by the dietary staff prior to handling off to nursing staff. A closed container system would now be used for snack pass versus an open tray. Following snack pass, the closed container of snacks should be returned to dietary. 6. The DON provided education to assigned licensed nurses (4) and director of medical records/medication technician (a train the trainer education) on [DATE] through [DATE] regarding: One to one supervision requires one staff member dedicated to the supervision of one resident with no other assigned duties during this time. To notify the Administrator and/or the Director of Nursing when there was a need to add a care plan intervention for 1:1 supervision of a resident. The care plan was to be implemented as indicated for 1:1 supervision. Dietary staff would hand off snacks to the nursing staff. If for any reason the nursing staff was unavailable, the snack pass was to be placed in the secured nourishment station. Dietary would provide a list of mechanically altered diets and thickened liquids with each snack pass delivery. All snacks would be placed in a covered container by the dietary staff prior to handling off to nursing staff. A closed container system would now be used for snack pass versus an open tray. Following snack pass, the closed container of snacks should be returned to dietary. 7. Education was provided to the facility nursing staff, (licensed nurses and nursing assistants), and facility dietary staff by the DON, Administrator, and Regional Quality Manager beginning [DATE] through [DATE], regarding: Dietary staff would hand off snacks to the nursing staff. If for any reason the nursing staff was unavailable, the snack pass was to be placed in the secured nourishment station. Dietary would provide a list of mechanically altered diets and thickened liquids with each snack pass delivery. All snacks would be placed in a covered container by the dietary staff prior to handling off to nursing staff. A closed container system would now be used for snack pass versus an open tray. Following snack pass, the closed container of snacks should be returned to dietary. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. Verbal acknowledgement of understanding along with signed education was obtained after the inservice. The facility employs no agency staff. Employed nursing or contracted dietary staff currently on leave or newly hired to the facility will receive this education from the DON or assigned facility manager before assuming duties. 9. The Regional Quality Manager provided education to the DON on [DATE] regarding: To notify the Administrator and/or the DON when there was a need to add a care plan intervention for 1:1 supervision of a resident. The care plan was to be implemented as indicated for 1:1 supervision. 10. The DON provided education (train the trainer) to the staff development Coordinator on [DATE] regarding: One to one supervision requires one staff member dedicated to the supervision of one resident with no other assigned duties during this time. To notify the Administrator and/or the DON when there was a need to add a care plan intervention for 1:1 supervision of a resident. The care plan was to be implemented as indicated for 1:1 supervision. Dietary staff would hand off snacks to the nursing staff. If for any reason the nursing staff was unavailable, the snack pass was to be placed in the secured nourishment station. Dietary would provide a list of mechanically altered diets and thickened liquids with each snack pass delivery. All snacks would be placed in a covered container by the dietary staff prior to handling off to nursing staff. A closed container system would now be used for snack pass versus an open tray. Following snack pass, the closed container of snacks should be returned to dietary. 11. The Regional Quality Manager, the DON and or Staff Development Coordinator (SDC) provided education to the licensed nursing staff on [DATE] regarding: One to one supervision requires one staff member dedicated to the supervision of one resident with no other assigned duties during this time. To notify the Administrator and/or the DON when there was a need to add a care plan intervention for 1:1 supervision of a resident. The care plan was to be implemented as indicated for 1:1 supervision. 12. Verbal acknowledgement of understanding along with signed education was obtained after the inservices. The facility employs no agency staff. Employed nursing or contracted dietary staff currently on leave or newly hired to the facility will receive this education from the DON or assigned facility manager before assuming duties. 13. An ad-hoc meeting was held on [DATE] to review the summary of Immediate Jeopardy findings and discuss the development of the action items to be completed. This meeting included the Administrator, DON, Social Services, Activities, Dietary, Therapy, and MDS. This information was reviewed with the facility Medical Director by the Administrator via the phone on [DATE]. 14. The Administrator, Assistant Administrator, DON, and/or Weekend Department Manager Supervisor would observe five (5) times (X) a week on various shifts to include weekends for two (2) weeks, then three (3) X week for two (2) weeks, then two (2) X week for four (4) weeks for the following: All snacks would be placed in a covered container by dietary staff. Dietary staff would hand off snacks to the nursing staff. If for any reason the nursing staff was unavailable, the snack pass was to be placed in the secured nourishment station. The nursing staff member would place the container on the ice chest cart and begin snack pass to the residents. A closed container system would now be used for snack pass versus an open tray. Following snack pass, the closed container of snacks should be returned to dietary. (continued on next page)

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	185272	A. Building B. Wing	09/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Any identified concern will be addressed at the time of discovery by the monitor. The audit began on [DATE]. 15. In the morning clinical meeting beginning [DATE], the Administrator, the DON, and/or assigned licensed nursing staff would review the plan of care for all residents requiring 1:1 supervision. 16. The Administrator or the DON would review and sign off on the staffing assignments sheets daily in regards to potential need for any 1:1 supervision. A review of the weekend staffing sheet would be completed on Fridays. The Administrator, the DON was to be notified at any time a resident required a 1:1 supervision. 17. Beginning [DATE], the DON and/or assigned licensed staff would audit five (5) residents requiring 1:1 supervision, risk for diet non-compliance, and/or (if no 1:1 supervision) with mechanically altered diets weekly times four (4) weeks for: Care plans interventions in place and observe the resident for care plan implementation as written in the plan of care 18. The results of the monitoring would be reviewed at a minimum of weekly in the QAPI meetings being held to track the facility's progress toward regulatory compliance. 19. A second ad hoc QAPI meeting was held on [DATE], to review the initial audit findings of the list of residents with mechanically altered diets and subsequent care plan review. This meeting included the Administrator, DON, Social Services, Dietary, Activities, and MDS. This information was reviewed with the facility Medical Director by the Administrator via the phone, on [DATE]. The State Survey Agency validated the corrective actions taken by the facility as follows: 1. Review of Notice of Emergency Transfer and Nurses Progress, dated [DATE] at 8:20 PM, revealed Resident #1 was sent to hospital via EMS (emergency management services) related to choking incident. Interview with Administrator, on [DATE] at 3:45 PM, revealed Resident #1 had not returned from the hospital. 2. Interview with Dietary Manager on [DATE] at 11:40 AM revealed she provided a list of residents who were on a mechanically altered diet to the Administrator. Review of care plans of residents that were identified as on mechanically altered diets revealed the Administrator reviewed the care plans, on [DATE] to ensure if resident was known to grab food; it was addressed on the resident's care plan. Interview on [DATE] at 3:45 PM, with Administrator revealed she had reviewed dietary needs of residents with mechanical soft and pureed diets in regard for the potential for reaching for food not on their meal tray. 3. Interviews on [DATE] with Administrator at 3:45 PM, Social Service Director at 10:15 AM, and Director of Nursing (DON) at 12:00 PM revealed there were no additional residents at this time requiring 1:1 supervision. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Interview on [DATE] at 3:05 PM, with Regional Quality Manager, revealed the Regional Director of Operations provided education to the Administrator, on [DATE]. Interview with Administrator, on [DATE] at 3:45 PM, revealed she was educated by the Regional Director of Operations to ensure staffing would be provided for 1:1 supervised residents with no other duties assigned to that staff member. Review of education documentation revealed the Administrator signed the form indicating she had received education related to one staff member dedicated to the supervision of one resident with no other assigned duties during the time provided on [DATE] 5. Interview with the Regional Quality Manager (RQM) revealed she provided education to the Director of Nursing (DON), on [DATE]. Interview with DON, on [DATE] at 12:00 PM, revealed she was educated by RQM to ensure if there was 1:1 supervision of a resident, then a staff member would be assigned and have no other duties. She stated in addition she was educated on the new process of dietary delivering, and nursing storing and delivering dietary snacks. 6. Interview with DON, on [DATE] at 12:00 PM, revealed she provided education to SDC, LPN #4 and weekend staff, on [DATE] through [DATE], to ensure they knew the requirements for the 1:1 supervision and snack pass process. Interviews on [DATE] with LPN #1 at 11:20 AM, LPN #2 at 3:11 PM, CNA #1 at 2:25 PM, and CNA #2 at 3:28 PM, revealed they were educated on 1:1 supervision, the new snack pass process and snack requirement, and care plan implementation. They also stated they were educated to call DON and/or Administrator when a resident was placed on 1:1. 7. Interviews on [DATE] with LPN #5 at 4:20 PM, LPN #7 at 4:27 PM, and LPN #3 at 4:30 PM; on [DATE] with Dietary Manager at 11:40 AM, Dietary Aide #1 at 2:30 PM, Dietary Aide #2 at 2:50 PM, SDC at 10:15 AM, SSD at 10:15 AM, KMA#1/Director of Medical Records/Central Supply at 11:00 AM, LPN #1 at 11:20 AM, DON at 12:00 PM, UM #2 at 2:50 PM, RQM at 3:05 PM, LPN #2 at 3:11 PM, CNA #1 at 2:25 PM, CNA #2 at 3:28 PM, and CNA #4 at 1:58 PM revealed they were educated on the new process for resident snack delivery and storage. Observation on [DATE] at 2:10 PM, revealed staff followed the new snack pass guidelines. 8. Review of education documentation revealed all nursing staff and dietary staff signed the education to acknowledge understanding of education. Additionally, interview with LPN #7 (new hire), on [DATE] at 4:27 PM, revealed she was educated on the new process for snacks, 1:1 resident supervision and care plan implementation. 9. Interview on [DATE] at 3:05 PM, with Regional Quality Manager, revealed she provided education to the DON, on [DATE], to ensure she was aware she and/or the Administrator should be notified when a resident was placed on 1:1, and the care plan was to be implemented, as indicated for 1:1 supervision. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with DON, on [DATE] at 12:00 PM, revealed she was educated on being notified if a resident was placed on 1:1, and care plan implementation of 1:1 by RQM. Review of education documentation dated [DATE], revealed the DON signed the form indicating she understood the education provided by the RQM. 10. Review of education documentation (train the trainer) provided by DON to the Staff Development Coordinator (SDC), on [DATE], revealed the DON educated the SDC and the SDC signed the form indicating she understood the education. Interview with SDC, on [DATE] at 10:00 AM and 4:00 PM, revealed she was educated by the DON on the new snack process, that the DON and the Administrator must be notified if a resident was placed on 1:1 supervision, and that staff assigned to that resident would have no other duties but the 1:1. 11. Interviews on [DATE] with LPN #7 at 4:27 PM; on [DATE] with LPN #1 at 11:20 AM, LPN #2 at 3:11 PM, LPN #3 at 4:30 PM, and LPN #5 at 4:20 PM, revealed they were educated that staff assigned 1:1 supervision of a resident would not be assigned any other duties, nursing staff were to notify DON and/or the Administrator if a resident was placed on 1:1, and care plan implementation of the 1:1 supervision. Review of education documentation revealed all licensed nursing staff signed they understood the education provided on [DATE] 12. Interviews on [DATE] LPN #1 at 11:20 AM, LPN #2 at 3:11 PM, CNA #1 at 2:25 PM, and CNA #2 at 3:28 PM, revealed verbal acknowledgement of provision of education and signing of signature page for verification of education. 13. Interviews on [DATE] with Administrator at 3:45 PM, DON at 12:00 PM, SSD at 10:15 AM, Dietary at 11:40 PM; and Therapy at 2:15 PM revealed an ad-hoc meeting was held on [DATE] to review the summary of Immediate Jeopardy findings with discussion of action plan to address findings of Immediate Jeopardy. Interview with Administrator on [DATE] at 3:45 PM, and with Medical Director on [DATE] at 4:14 PM, revealed the Administrator made the Medical Director aware of the action plan and obtained his input. 14. Review of the Monitoring Tools for Snack Pass, revealed monitoring was conducted five times during the week of ,d+[DATE]-[DATE] and continued to be completed with no concerns identified. The monitors were signed by the DON/or weekend supervisor. 15. Interviews on [DATE] with Administrator at 3:45 PM, Administrator in Training (AIT) at 9:37 AM and at 3:45 PM, the DON at 12:00 PM, UM #2 at 2:50 PM, and MDS #1 at 4:06 PM revealed there were no residents on 1:1 at this time but were aware they would review care plans for all residents requiring 1:1 supervision. Review of a facility form that was developed to use to review the plans of care revealed a place to document Resident Name, Follow-up needed, Initials, Assigned to, and date. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	16. Interview on [DATE] with the DON at 3:45 PM, the AIT at 9:37 AM and 3:45 PM, and the Administrator at 3:45 PM, revealed they were to be notified at any time a resident required a 1:1 supervision, and that the staffing sheets were being reviewed daily and weekend staffing sheets reviewed on Friday, but at this time there were no residents on 1:1 supervision. A list of reviewed staffing sheets was present in the AOC binder for review 17. Interview on [DATE] at 12:00 PM, with DON, revealed she was auditing accuracy of care plans related to supervision of 1:1, dietary needs, and watched a meal of audited resident that day. 18. Review of documented QAPI meetings revealed a review of facility progress with discussion of any issues dealt with immediately upon point of discovery. Interview on [DATE] with DON at 12:00 PM, Administrator at 3:45 PM, AIT at approximately 9:37 AM and 3:45 PM, revealed they were meeting weekly to discuss any issues identified with during monitoring. 19. Interviews on [DATE] with SSD at 10:15 AM, Dietary Manager at 11:40 AM, DON at 12:00 PM, Administrator at 3:45 PM, AIT at 9:37 AM and 3:45 PM, MDS at 4:06 PM and Medical Director at 4:14 PM revealed there were ongoing reviews of facility's progress toward compliance.

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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** 32162 Based on observation, interview, record review, hospital record review, review of Nurse's book, Staff Assignment Sheet, and facility education review, it was determined the facility failed to ensure one (1) of four (4) sampled residents (Resident #1) received adequate supervision to prevent accidents. The facility assessed Resident #1 required one to one (1:1) supervision when out of bed; however, the facility did not ensure this assessed need was met. Interviews and record review revealed, on [DATE], there was no staff to provide 1:1 supervision. One Certified Nurse Aide (CNA) was outside providing supervision during the residents' smoke break, one CNA was providing resident care in a resident room, and the nurse was administering medication. Resident #1 was sitting beside the medication cart while the nurse prepared medication to administer to a resident. There was a snack tray on the medication cart. Resident #1 grabbed a half of a peanut butter sandwich off the tray and ate half of the sandwich before the nurse could stop him/her. Resident #1 choked and staff provided Heimlich maneuver (abdominal thrusts to remove object causing to choke). Resident #1 coded and staff initiated Cardiopulmonary Resuscitation (CPR) (chest compressions often with artificial ventilation). Resident #1 was transferred to an acute care facility where he/she was intubated (insertion of a tube into the patient's body) and placed on a ventilator (machine that provides mechanical ventilation (air/breaths) and a feeding tube was placed. The facility's failure to provide adequate supervision to prevent accidents has caused or was likely to cause serious injury, harm, impairment, or death to a resident, Immediate Jeopardy was identified on [DATE] and determined to exist on [DATE]. The facility was notified of the Immediate Jeopardy on [DATE]. An acceptable Credible Allegation of Compliance (AoC), related to the Immediate Jeopardy was received on [DATE] alleging the Immediate Jeopardy was removed on [DATE]. The State Survey Agency validated the AoC and determined the Immediate Jeopardy was removed on [DATE]. The Scope and Severity was lowered to a D while the facility develops and implements the Plan of Correction (PoC); and, the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes. The findings include: Interview with Regional Quality Manager #2 (RQM), Administrator, Administrator in Training (AIT), and Director of Nursing (DON), on [DATE] at approximately 4:25 PM, revealed there was no facility policy that addressed 1:1 supervision. However, review of facility education documentation provided to staff on [DATE], [DATE], and [DATE] titled, Following Care Plans and Resident to Resident Procedure revealed when a resident was on 1:1 staffing, it was because the resident was evaluated as needing continuous supervision. This meant that the resident must always be in the line of sight of the staff member assigned to them and was a care-planned intervention. Further review of the education revealed not to leave the resident sitting, to attend to another resident or any other task unless someone else was watching them. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review revealed the facility readmitted Resident #1 on [DATE] with diagnoses, which included Dementia, Encephalopathy, Unspecified Psychosis, Anoxic Brain Damage, Altered Mental Status (AMS), Aphasia, and Dysphagia. Review of Resident #1's Comprehensive Care Plan for at risk for nutritional decline dated [DATE], revealed the resident was at risk due to Dementia, Behavior Disturbances, Psychosis, Depression, Anxiety, Pseudobulbar Affect, Anoxic Brain Damage, Encephalopathy, Cerebrovascular Disease, Muscle Weakness, Lack of Coordination, Altered Mental Status (AMS), Aphasia, Pain, Convulsions, Adult Failure to Thrive (AFTT), Bipolar, Risk for Malnutrition, Difficulty Chewing/Swallowing, and Edentulous. Further review of the care plan revealed a goal to tolerate diet without chewing or swallowing problems thru next review and an interventions for continual feeding assist at mealtimes, diet as ordered, and supervised meals as indicated for reaching in and getting food not on his/her diet. Review of Resident #1's Comprehensive Care Plan for alterations in mood/behavior and known for attempting to bite, grab, and scratch staff and other residents revealed an intervention dated [DATE] to provide 1:1 until further notice when out of bed. Review of 100 Hall Nurses Book revealed a list of residents that were identified as at risk of taking food. Resident #1 was on this list. Review of the Quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed the facility assessed Resident #1's cognition as as severely impaired with a Brief Interview of Mental Status (BIMS) score of three (3) which indicated the resident was not interviewable. Further review of the MDS assessment, revealed the resident required supervision and meal setup, and had behaviors of scratching, hitting, screaming, and disruptive sounds toward others. Review of Speech Therapy Evaluation and Plan of Treatment, dated [DATE], revealed Resident #1 was downgraded to a puree diet in [DATE], secondary to decreased toleration of mechanical soft diet. The evaluation revealed the resident's history included effects of anoxia with aphasia, mental impairments and decreased safety awareness; with background medical assessment to include combative and impulsive behaviors and resident has a habit of reaching out, and grabbing. Further review of the assessment revealed Resident #1 was at risk for aspiration, with recommendations of intake, puree consistencies; and close supervision. Review of [DATE] Physician Orders, revealed Resident #1 was to receive a Dysphagia Pureed Consistency diet, and to provide 1:1 supervision when out of bed. Review of the Staff Assignment Sheet, for [DATE] for 2:30 PM - 10:30 PM shift, revealed there was one nurse and two CNA's assigned to Resident #1's Unit. Review of a 1:1 documentation form, dated [DATE], revealed LPN #1 had initialed she provided 1:1 supervision to Resident #1 from 6:00 PM-8:00 PM. (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 Nursing Progress Note, dated [DATE] at 8:02 PM written by Licensed Practical Nurse (LPN) #1, revealed Resident #1 was in broda chair and was 1:1 with LPN #1, when LPN #1 witnessed resident taking a peanut butter sandwich from snack tray on cart in hallway. Resident #1 would not release sandwich and took a bite before LPN was able to remove from resident. Further review of the note revealed when LPN #1 attempted to redirect the resident, she saw the resident was showing signs of choking. LPN #1 encouraged resident to cough and resident unable to, so LPN attempted sweeping of mouth digitally, and then performed Heimlich maneuver multiple times and called for help. Resident produced small bolus of food from mouth but still showed signs of aspiration. Continued review of the note revealed LPN #2 (from another unit) came to assist LPN #1 with Heimlich; and an Automated External Defibrillator (AED) and Crash Cart were brought with O2 via nasal cannula applied and suction hooked up and provided. The physician was notified with orders received to send to emergency room (ER) and Emergency Medical System (EMS) called. The Nursing Note further revealed Resident became unconscious and cyanotic (bluish discoloration of skin related to an inadequate supply of oxygen being provided to the blood), pulse was not palpable, respirations ceased, and Resident's fingers and face began turning blue. Resident was full code so the LPN's initiated CPR. Resident gasped for air and began vomiting, was rolled to side, and resident color returned. Resident began using accessory muscles to breathe, pulse bounding, resident then began resisting care, kicking at staff while vomitus continued from mouth. Further review revealed at 8:18 PM, EMS was on site and took over care. Resident was kicking, coughing, and yelling while on stretcher and EMS left facility with emergency lights activated. Review of Emergency Department to Hospital Admission records, dated [DATE] at 8:30 PM, revealed Resident #1 from LTC (long term facility) apparently ate a peanut butter sandwich and became acutely choked and EMS was called, EMS retrieved a fair amount of peanut butter material out of oropharynx. However, resumption of normal oxygenation could not be accomplished and because of this Resident #1 was transported to hospital for further care. Resident was quite restless, and pulling at all equipment and fighting EMS and their ability to oxygenate resident. The last oxygen saturation EMS able to obtain was 71% and resident had blue lips upon arrival. Resident was intubated at 10:07 PM on [DATE], and placed on a respirator with resident admitted . Interview with LPN #1, on [DATE] at 9:46 AM and 11:45 AM, revealed there were two (2) CNA's and herself assigned to the unit. She stated she was administering medications, and one CNA was outside supervising resident smoke break and one CNA was providing care in a resident's room. She stated Resident #1 smokes but he/she was out of cigarettes so she was sitting to the left of the medication cart while she was administering medications and passing snacks since the two CNA's were busy. She stated while she was pouring a glass of water for another resident to take his/her medications, Resident #1 grabbed a half of a peanut butter sandwich off the snack tray on the med cart and took a bite (half of half of sandwich) before she was able to get the sandwich from him/her. LPN #1 revealed she saw Resident #1 was choking on the sandwich and saw CNA #1 coming up the hall and told her to get LPN #2 from the other hall. She stated they performed the Heimlich maneuver, and initiated CPR and tried to suction the resident because the resident had no pulse. She stated EMS arrived and took over care of the resident. LPN #1 stated Resident #1 was on 1:1 for a prior incident as he/she had grabbed another resident and given them a skin tear. She further revealed Resident #1 does get manic, upset, grabs at everything, and was an elopement risk as the resident tried to go to the door anytime he/she was up. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further interview with LPN #1, on [DATE] at 2:25 PM, revealed she had received training in [DATE] or [DATE], related to Resident #1's being on 1:1 anytime out of bed. She stated a staff member (nurse or aide) had to be present and ensure the resident was out of reach or grabbing distance of other residents. LPN #1 revealed when giving medications and watching the resident on 1:1 that she pulled the resident along in his/her wheelchair (w/c), keeping the resident beside the med cart. She stated most of the time residents would be in their w/c and she gave their meds at their room door but if she had to go into a room it was only for a minute. She stated the nurse determines who does the 1:1, and when staff were doing 1:1, they still have other duties. LPN #1 stated that she was aware Resident #1's care plan stated that resident would grab food from other residents, and the resident's name was in the nurse book at the desk indicating would grab food. She stated she had also seen Resident #1 grab food out of another residents lap. She further stated she did not think the resident could reach the top of the med cart to grab the sandwich off the snack tray. Interview with LPN #2, on [DATE] at 7:43 AM, and on [DATE] at 12:30 AM, revealed he was on another hall and LPN #1 was the nurse on Resident #1's hall. LPN #2 stated CNA #1 screamed to him that Resident #1 was choking and he responded. He stated he saw Resident #1 about midway down the hall, on the floor, on his/her bottom, but slouched over with head falling down. He stated the resident's eyes were shut, lips were pale, and was not breathing, LPN #2 stated they performed the Heimlich maneuver on the resident three (3) times with nothing coming up, so they initiated CPR because the resident did not have a pulse. He revealed when they started compressions the resident tried to cough the food up and they turned him/her to side and got some to come out. He stated he opened the resident's mouth to see if could swipe anything out and could not so he suctioned the resident. He revealed an ambulance was called and the resident was transferred to the hospital. He revealed he thought the incident happened about 8:00 PM, because he was passing meds when called. LPN #2 revealed Resident #1 was on 1:1 and had been for a while. He stated the aides watched him/her or if the aides were busy, the nurse watched the resident. LPN #2 further revealed Resident #1 was on 1:1, because he/she grabbed things, was real mobile and strong. The resident could grab on to things, people and all kinds of things like that. He stated the resident was on a pureed diet. Interview with CNA #1, on [DATE] at 12:17 PM, revealed she brought residents who smoke in from smoke break and was starting to get residents ready for the night when she came out of a resident's room and saw Resident #1 moving around on the hallway close to the medication cart. She stated she did not notice if Resident #1 had anything in his/her hand She revealed she thought LPN #1 was passing medications because the medication cart was at the back of the hallway. CNA #1 stated a little while after that she and CNA #2 were in hall talking about who we had left to take care of and which one would be taking break; when she observed LPN #1 and then heard her say Resident #1 was choking. She revealed she saw LPN #1 grab Resident #1 and do the Heimlich. She stated LPN #1 told her to get LPN #2 and she obtained crash cart and called 911. She stated the licensed staff had to perform CPR. She revealed Resident #1 was supposed to be on 1:1 when out of bed and someone was to be with him/her at all times and within touching distance. CNA #1 stated they do not have enough staff to provide 1:1. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Haven Nursing and Rehabilitation Center	867 McGuire Avenue Paducah, KY 42001

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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	Interview with CNA #2, on [DATE] at 9:27 AM and [DATE] at 3:31 PM, revealed Resident #1 was on 1:1 supervision when out of bed but there was not enough staff to provide 1:1 care. CNA #2 stated the last time she saw Resident #1, he/she was roaming hallway. She revealed staff were not allowed to put the brakes on the resident's chair because it was considered a restraint. CNA #2 stated the nurse was in a room administering medication at the back of the hall, Resident #1 was roaming the hall, and she was in the shower room disposing of dirty laundry. CNA #2 stated when she came out of shower room, she saw the nurse place something on the medication cart, push the cart away, grab Resident #1, and perform the Heimlich maneuver on the resident. She stated she did not see the resident grab the sandwich and did not see any remains of peanut butter sandwich or the plastic bag it came in. She revealed LPN #1 told her that Resident #1 had grabbed a peanut butter sandwich. CNA #2 stated the snack tray was on the end of the med cart, because the nurse served the nighttime snacks as she passed meds. CNA #2 stated Resident #1 was acting like he/she was choking and his/her color went from pink to blue. She revealed LPN #2 and LPN #1 provided CPR when Resident #1 coded. She stated EMS was called and arrived to transport Resident #1 to the hospital. CNA #2 stated we do not have the staff to sit with the resident 1:1, so no one does 1:1, we just watch resident while doing care on the hall and sometimes the nurse watched the resident. CNA #2 further stated Resident #1 grabbed staff and residents, and anything else in reach. Interview with hospital Advanced Registered Nurse Practitioner (ARNP), on [DATE] at 10:05 AM, revealed Resident #1 was brought into ER with blue lips, O2 in 70's and restless but alert and altered level of consciousness (ALOC). She stated a video assisted intubation was provided, and the resident was admitted to hospital with acute hypoxic respiratory failure, aspiration, and was put on ventilator for hypoxic respiratory failure at time of intubation. She stated she consulted an ear/nose/throat (ENT) specialist for trach but it has not been done yet, the plan was for [DATE]. She revealed she did not know when the resident would be discharged as he/she may have to go to long term acute care at the hospital to get off the ventilator Interview with Registered Nurse (RN) #2, on [DATE] at 12:40 AM, revealed 1:1 meats the resident was at least in eyesight; if not right beside staff. She stated she did not think there was enough staff to provide 1:1 supervision for Resident #1. RN #2 revealed the few times that she provided care for Resident #1 it was a struggle. She stated the resident's behavior was to grab anything off the desk or carts. In addition, the resident would pull things out of staff pockets, and would pull lanyard off of staff's neck. She further revealed the resident would grab anything within reach, even in his/her room, the resident would reach and try to pull his/her TV off the table. Interview on [DATE] at 5:51 PM, with CNA #16, revealed when Resident #1 was out of bed the resident was supposed to be 1:1, because the resident was feisty and would grab people and stuff. Interview with Social Services Director (SSD) #2, on [DATE] at approximately 3:35 PM, revealed Resident #1 had been on 1:1 for quite some time, and was constantly reaching out grabbing residents. She stated the resident had scratched them, was a constant wanderer, and would try to get out the doors. She stated the resident needed staff within arms length of him/her at all times while out of bed (OOB). She stated she was sure Resident #1 grabbed food, as he/she liked to grab just about anything, and she believed Resident #1 was on a mechanical soft or pureed diet. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Staff Development Coordinator (SDC), on [DATE] at 3:36 PM, revealed Resident #1 must be constantly observed when up. She stated the resident was care planned for 1:1 supervision and needed to be constantly observed. She stated staff needed to be pretty close as that was the reason for 1:1 supervision. Interview with Administrator, on [DATE] at 3:20 PM, [DATE] at 9:45 AM and [DATE] at 4:42 PM, revealed when asked what 1:1 entailed for a resident she stated it depended on the reason the resident was on 1:1. She stated Resident #1 was care planned for 1:1 supervision when out of bed due to grabbing and scratching other residents, so the staff only had to keep the resident in line of sight to ensure the resident was not within reaching distance of another resident. She stated she was not aware the resident would constantly grab items and people and was care planned for grabbing food not on his/her diet. Further interview with Administrator, on [DATE] at 3:45 PM, revealed Resident #1 was still in the hospital and remained intubated with a tracheotomy, on a ventilator, and a nasogastric tube for feeding. The Administrator further revealed the facility had identified the snacks were being left on the medication cart while the nurse was passing medications which enabled residents to have access to food that was not on their prescribed diets. She stated staff had been educated to ensure snacks were kept at nursing station and each snack passed out from there by a staff member so snacks were not left unsupervised with residents having access to them. However, observation on [DATE] at 10:02 AM, revealed a dietary staff delivered the snacks to the nurse on the 200 hall. The nurse went down the hall and placed the snack tray on the med cart. Further observation revealed the nurse obtained a snack from the tray then delivered the snack to resident in their room, leaving snack tray on the cart unsupervised. There was a half peanut butter sandwich and peanut butter crackers still on the snack tray. The facility implemented the following to remove the Immediate Jeopardy: 1. Resident #1 was transferred from the facility on [DATE] and has not returned to the facility. 2. The Dietary Manager provided a list of all current residents on mechanical altered diets (17 residents) on [DATE]. The Administrator completed a review of the care plans of residents with mechanical soft and pureed diets in regard for the potential for reaching for food not on their meal tray. 3. The Administrator, Social Service Director, and/or licensed nurse completed a review of psychosocial/behavior care plans for any resident currently identified as requiring 1:1 supervision, on [DATE]. There were no additional residents at this time requiring 1:1 supervision. This was completed on [DATE]. 4. The Regional Director of Operations provided education to the Administrator on [DATE] regarding: One-to-one supervision regarding one staff member dedicated to the supervision of one resident with no other assigned duties during the time. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. The Regional Quality Manager (RQM) provided education to the Director of Nursing (DON) on [DATE] regarding: One to one supervision requires one staff member dedicated to the supervision of one resident with no other assigned duties during this time. Dietary staff would hand off snacks to the nursing staff. If for any reason the nursing staff was unavailable, the snack pass was to be placed in the secured nourishment station. Dietary would provide a list of mechanically altered diets and thickened liquids with each snack pass delivery. All snacks would be placed in a covered container by the dietary staff prior to handling off to nursing staff. A closed container system would now be used for snack pass versus an open tray. Following snack pass, the closed container of snacks should be returned to dietary. 6. The DON provided education to assigned licensed nurses (4) and director of medical records/medication technician (a train the trainer education) on [DATE] through [DATE] regarding: One to one supervision requires one staff member dedicated to the supervision of one resident with no other assigned duties during this time. To notify the Administrator and/or the Director of Nursing when there was a need to add a care plan intervention for 1:1 supervision of a resident. The care plan was to be implemented as indicated for 1:1 supervision. Dietary staff would hand off snacks to the nursing staff. If for any reason the nursing staff was unavailable, the snack pass was to be placed in the secured nourishment station. Dietary would provide a list of mechanically altered diets and thickened liquids with each snack pass delivery. All snacks would be placed in a covered container by the dietary staff prior to handling off to nursing staff. A closed container system would now be used for snack pass versus an open tray. Following snack pass, the closed container of snacks should be returned to dietary. 7. Education was provided to the facility nursing staff, (licensed nurses and nursing assistants), and facility dietary staff by the DON, Administrator, and Regional Quality Manager beginning [DATE] through [DATE], regarding: Dietary staff would hand off snacks to the nursing staff. If for any reason the nursing staff was unavailable, the snack pass was to be placed in the secured nourishment station. Dietary would provide a list of mechanically altered diets and thickened liquids with each snack pass delivery. All snacks would be placed in a covered container by the dietary staff prior to handling off to nursing staff. A closed container system would now be used for snack pass versus an open tray. Following snack pass, the closed container of snacks should be returned to dietary. 8. Verbal acknowledgement of understanding along with signed education was obtained after the inservice. The facility employs no agency staff. Employed nursing or contracted dietary staff currently on leave or newly hired to the facility will receive this education from the DON or assigned facility manager before assuming duties. 9. The Regional Quality Manager provided education to the DON on [DATE] regarding: To notify the Administrator and/or the DON when there was a need to add a care plan intervention for 1:1 supervision of a resident. The care plan was to be implemented as indicated for 1:1 supervision. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	10. The DON provided education (train the trainer) to the staff development Coordinator on [DATE] regarding: One to one supervision requires one staff member dedicated to the supervision of one resident with no other assigned duties during this time. To notify the Administrator and/or the DON when there was a need to add a care plan intervention for 1:1 supervision of a resident. The care plan was to be implemented as indicated for 1:1 supervision. Dietary staff would hand off snacks to the nursing staff. If for any reason the nursing staff was unavailable, the snack pass was to be placed in the secured nourishment station. Dietary would provide a list of mechanically altered diets and thickened liquids with each snack pass delivery. All snacks would be placed in a covered container by the dietary staff prior to handling off to nursing staff. A closed container system would now be used for snack pass versus an open tray. Following snack pass, the closed container of snacks should be returned to dietary. 11. The Regional Quality Manager, the DON and or Staff Development Coordinator (SDC) provided education to the licensed nursing staff on [DATE] regarding: One to one supervision requires one staff member dedicated to the supervision of one resident with no other assigned duties during this time. To notify the Administrator and/or the DON when there was a need to add a care plan intervention for 1:1 supervision of a resident. The care plan was to be implemented as indicated for 1:1 supervision. 12. Verbal acknowledgement of understanding along with signed education was obtained after the inservices. The facility employs no agency staff. Employed nursing or contracted dietary staff currently on leave or newly hired to the facility will receive this education from the DON or assigned facility manager before assuming duties. 13. An ad-hoc meeting was held on [DATE] to review the summary of Immediate Jeopardy findings and discuss the development of the action items to be completed. This meeting included the Administrator, DON, Social Services, Activities, Dietary, Therapy, and MDS. This information was reviewed with the facility Medical Director by the Administrator via the phone on [DATE]. 14. The Administrator, Assistant Administrator, DON, and/or Weekend Department Manager Supervisor would observe five (5) times (X) a week on various shifts to include weekends for two (2) weeks, then three (3) X week for two (2) weeks, then two (2) X week for four (4) weeks for the following: All snacks would be placed in a covered container by dietary staff. Dietary staff would hand off snacks to the nursing staff. If for any reason the nursing staff was unavailable, the snack pass was to be placed in the secured nourishment station. The nursing staff member would place the container on the ice chest cart and begin snack pass to the residents. A closed container system would now be used for snack pass versus an open tray. Following snack pass, the closed container of snacks should be returned to dietary. Any identified concern will be addressed at the time of discovery by the monitor. The audit began on [DATE]. 15. In the morning clinical meeting beginning [DATE], the Administrator, the DON, and/or assigned licensed nursing staff would review the plan of care for all residents requiring 1:1 supervision. 16. The Administrator or the DON would review and sign off on the staffing assignments sheets daily in regards to potential need for any 1:1 supervision. A review of the weekend staffing sheet would be completed on Fridays. The Administrator, the DON was to be notified at any time a resident required a 1:1 supervision. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	17. Beginning [DATE], the DON and/or assigned licensed staff would audit five (5) residents requiring 1:1 supervision, risk for diet non-compliance, and/or (if no 1:1 supervision) with mechanically altered diets weekly times four (4) weeks for: Care plans interventions in place and observe the resident for care plan implementation as written in the plan of care 18. The results of the monitoring would be reviewed at a minimum of weekly in the QAPI meetings being held to track the facility's progress toward regulatory compliance. 19. A second ad hoc QAPI meeting was held on [DATE], to review the initial audit findings of the list of residents with mechanically altered diets and subsequent care plan review. This meeting included the Administrator, DON, Social Services, Dietary, Activities, and MDS. This information was reviewed with the facility Medical Director by the Administrator via the phone, on [DATE]. The State Survey Agency validated the corrective actions taken by the facility as follows: 1. Review of Notice of Emergency Transfer and Nurses Progress, dated [DATE] at 8:20 PM, revealed Resident #1 was sent to hospital via EMS (emergency management services) related to choking incident. Interview with Administrator, on [DATE] at 3:45 PM, revealed Resident #1 had not returned from the hospital. 2. Interview with Dietary Manager on [DATE] at 11:40 AM revealed she provided a list of residents who were on a mechanically altered diet to the Administrator. Review of care plans of residents that were identified as on mechanically altered diets revealed the Administrator reviewed the care plans, on [DATE] to ensure if resident was known to grab food; it was addressed on the resident's care plan. Interview on [DATE] at 3:45 PM, with Administrator revealed she had reviewed dietary needs of residents with mechanical soft and pureed diets in regard for the potential for reaching for food not on their meal tray. 3. Interviews on [DATE] with Administrator at 3:45 PM, Social Service Director at 10:15 AM, and Director of Nursing (DON) at 12:00 PM revealed there were no additional residents at this time requiring 1:1 supervision. 4. Interview on [DATE] at 3:05 PM, with Regional Quality Manager, revealed the Regional Director of Operations provided education to the Administrator, on [DATE]. Interview with Administrator, on [DATE] at 3:45 PM, revealed she was educated by the Regional Director of Operations to ensure staffing would be provided for 1:1 supervised residents with no other duties assigned to that staff member. Review of education documentation revealed the Administrator signed the form indicating she had received education related to one staff member dedicated to the supervision of one resident with no other assigned duties during the time provided on [DATE] (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. Interview with the Regional Quality Manager (RQM) revealed she provided education to the Director of Nursing (DON), on [DATE]. Interview with DON, on [DATE] at 12:00 PM, revealed she was educated by RQM to ensure if there was 1:1 supervision of a resident, then a staff member would be assigned and have no other duties. She stated in addition she was educated on the new process of dietary delivering, and nursing storing and delivering dietary snacks. 6. Interview with DON, on [DATE] at 12:00 PM, revealed she provided education to SDC, LPN #4 and weekend staff, on [DATE] through [DATE], to ensure they knew the requirements for the 1:1 supervision and snack pass process. Interviews on [DATE] with LPN #1 at 11:20 AM, LPN #2 at 3:11 PM, CNA #1 at 2:25 PM, and CNA #2 at 3:28 PM, revealed they were educated on 1:1 supervision, the new snack pass process and snack requirement, and care plan implementation. They also stated they were educated to call DON and/or Administrator when a resident was placed on 1:1. 7. Interviews on [DATE] with LPN #5 at 4:20 PM, LPN #7 at 4:27 PM, and LPN #3 at 4:30 PM; on [DATE] with Dietary Manager at 11:40 AM, Dietary Aide #1 at 2:30 PM, Dietary Aide #2 at 2:50 PM,

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32162 Based on interview, record review, review of the Staff Assignment Sheet, facility education documentation, hospital records, and facility policy review, it was determined the facility failed to ensure sufficient staff had the appropriate competencies and skill sets to provide nursing and related services to ensure one (1) of four (4) sampled residents (Resident#1) safety as determined by resident assessments and care plans. The facility assessed and care planned Resident #1 with a history of grabbing food off trays, was at risk for choking, and required 1:1 supervision when out of bed. However, on [DATE], the facility did not assign staff to provide 1:1 supervision, due to insufficient staffing. Interview with Licensed Practical Nurse (LPN) #1 revealed Resident #1 was kept within line of sight during medication pass due to not having enough staff to implement the required 1:1 supervision. In addition, LPN #1 stated she placed a tray of snacks on top of the medication cart with Resident #1 near the cart. Resident #1 grabbed a half of a peanut butter sandwich off the tray and consumed half the sandwich before staff intervention. Resident #1 became choked with staff providing Heimlich (abdominal thrusts to remove object causing to choke) and Cardiopulmonary Resuscitation (CPR) (chest compressions with artificial respirations). Resident #1 was transferred to an acute care facility where he/she was intubated, placed on a ventilator and a (Nasogastric tube) feeding tube was placed. The facility's failure to provide sufficient staff to provide nursing and related services has caused or was likely to cause serious injury, harm, impairment, or death to a resident, Immediate Jeopardy was identified on [DATE] and determined to exist on [DATE]. The facility was notified of the Immediate Jeopardy on [DATE]. An acceptable Credible Allegation of Compliance (AoC), related to the Immediate Jeopardy was received on [DATE] alleging the Immediate Jeopardy was removed on [DATE]. The State Survey Agency validated the AoC and determined the Immediate Jeopardy was removed on [DATE]. The Scope and Severity was lowered to a D while the facility develops and implements the Plan of Correction (PoC); and, the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes. The findings include: Interview with the Administrator, on [DATE] at 3:45 PM, revealed the facility did not have a staffing policy. Review of facility policy titled, Facility Assessment Tool Record dated [DATE], revealed care provision was monitored on a daily basis to ensure that each resident received the care and services that were dictated by the plan of care. Staffing patterns were reviewed on a daily basis. The facility worked to cover the needs of residents on a daily basis, including accounting for call-ins, etc. This was an approach to staffing to ensure sufficient staff to meet the needs of the residents at any given time based on resident population and their needs for care and support. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of facility education documentation provided to staff, on [DATE], [DATE], and [DATE], titled, Following Care Plans and Resident to Resident Procedure, revealed when a resident was on 1:1 staffing it was because they have been evaluated as needing continuous supervision. This meant that these residents must always be in the line of sight of the staff member assigned to them. Staff cannot leave the resident sitting unattended while attending to another resident or any other task unless someone else was watching them. Record review revealed the facility admitted Resident #1 on [DATE] and readmitted on [DATE] with diagnoses, which included Dementia, Encephalopathy, Unspecified Psychosis, Anoxic Brain Damage, Altered Mental Status (AMS), Aphasia, and Dysphagia. Review of a Speech Therapy Evaluation dated [DATE]; a Comprehensive Care Plan for at risk for nutritional decline, dated [DATE]; and a Comprehensive Care Plan for alterations in mood/behavior revealed, Resident #1 was was assessed and care planned to require 1:1 Supervision due to grabbing food not on his/her diet, and having behaviors of scratching, hitting, and grabbing others. Review of Daily Staffing Sheet, dated [DATE], revealed there was one nurse and two Certified Nurse Aides (CNA's) assigned to Resident #1's unit on the 2:30 PM-10:30 PM shift. Further review revealed there was no one assigned for 1:1 supervision of Resident #1. Review of Nurses Note, dated [DATE] at 8:02 PM by LPN #1, revealed LPN #1 witnessed Resident #1 take a peanut butter sandwich from snack tray on medication cart in hallway and take a large bite of sandwich before LPN #1 could get sandwich from resident. The Resident choked and licensed staff performed the Heimlich maneuver multiple times, and the resident coded with staff providing CPR with success. EMS arrived and took over care of Resident #1 and transported resident to hospital. Review of Emergency Department to Hospital Admission Records dated [DATE] at 8:30 PM and interview with hospital Advanced Registered Nurse Practitioner (ARNP), on [DATE] at 10:05 AM, revealed Resident #1 had to be intubated and placed on respirator and admitted to hospital with acute hypoxic respiratory failure and aspiration. An ear/nose/throat (ENT) specialist was consulted for a tracheotomy and it was planned for [DATE]. Resident may have to be discharged to go to long-term acute care at the hospital to get off the vent. Interview with Administrator, on [DATE] at 3:45 PM, revealed the resident was still in the hospital and remained intubated with a tracheotomy, on a ventilator, and a nasogastric tube for feeding. Interview with LPN #1, on [DATE] at 9:46 AM, 11:45 AM and on [DATE] at 2:25 PM, revealed, Resident #1 required 1:1 supervision and she did not have enough staff to provide 1:1. She stated she tried to call another CNA into work to provide the 1:1, with no success. She stated one CNA was supervising resident smoke break outside, one CNA was providing resident care in room, and she was administering medications and had placed the snack tray on the medication cart, so she could administer snacks at the same time. She revealed Resident #1 smoked but was out of cigarettes so she had no choice but to try to keep Resident #1 by the medication cart while she administered the medications and passed snacks. She stated as she was pouring a cup of water to administer another resident's medications, Resident #1 grabbed a half of a peanut butter sandwich off of med cart and had eaten half of it before she could stop the resident. LPN #1 stated the facility had sitters for Resident #1, but the sitters were done away with, and the routine scheduled staff had to provide 1:1 supervision along with the duties they already had. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with CNA #1, on [DATE] at 7:41 AM, and CNA #2 on [DATE] at 9:27 AM and [DATE] at 3:31 PM, revealed CNA #1 was outside providing supervision for residents' smoke break and CNA #2 was in a resident's room providing resident care. The CNA's stated Resident #1 was sitting in the hallway but they were not paying attention to Resident #1. The CNA's revealed Resident #1 was supposed to be on 1:1 when out of bed and someone was to be with him/her at all times and within touching distance. The CNA's stated they did not have enough staff to provide 1:1 to the resident so the resident wandered up and down the hall and the staff on the hall tried to keep an eye on the resident. CNA #2 revealed the facility used to have a sitter for Resident #1, but now staff have to watch the resident but there was no one to assign to watch the resident on their shift. Interview with Registered Nurse (RN) #2, on [DATE] at 12:40 AM, revealed she did not think there was enough staff to do 1:1 with Resident #1. RN #2 stated the few times that she provided care for Resident #1 it was a struggle. She revealed the resident's behavior was to grab anything off the desk or a cart. She stated the resident would pull things out of staff pockets, and would pull lanyard off staff's neck. She stated the resident would even reach from the bedside to grab the television and try to pull it off the table in his/her room. Interview with Unit Manager (UM) #1, on [DATE] at 2:10 PM, revealed the staff for each hall stayed the same on the Day Shift (6AM-6:00 PM), with one nurse and three aides for halls 100 and 200; and one nurse and two aides on 300 hall. She stated when there was a resident that required 1:1 supervision they were able to pull the Hospitality Aide, Restorative Aide or transportation aide when needed. She stated on Night Shift (6:00 PM-6:00 PM) there were five (5) CNA's and three nurses in building and a Kentucky Medication Assistant, four nights a week. She stated the hospitality aide, restorative aide, and transportation aide would not be available on night shift. She further revealed if there is not enough staff to provide 1:1, the nurse could call a CNA into work. She stated staff were not necessarily assigned to do 1:1 with other duties, but if able to watch the resident and keep in view, it would be okay. She stated Resident #1 was mobile in his/her broda chair and would grab staff, residents and other items when saw them. She was not aware the resident would grab food. Interview with the Director of Nursing (DON) (hired [DATE]) and Administrator, on [DATE] at 11:20 AM, revealed the Unit Managers and Staff Development Coordinator do the daily staffing sheets. The DON stated staffing was determined by the amount of activity going on. The DON revealed staff had been moved around since COVID, as all three (3) halls used to have the same amount of staff. She stated since the 300 hall was now used mainly for new admits and possible COVID residents, there were less residents on the hall and the 300 hall had less staff. She stated when there was a resident on 1:1, it was handled with staff throughout the building not just that unit. The Administrator and DON both were not able to describe exactly how they determined the number of staff that were required on each unit. The facility implemented the following to remove the Immediate Jeopardy: 1. Resident #1 was transferred from the facility on [DATE] and has not returned to the facility. 2. The Dietary Manager provided a list of all current residents on mechanical altered diets (17 residents) on [DATE]. The Administrator completed a review of the care plans of residents with mechanical soft and pureed diets in regard for the potential for reaching for food not on their meal tray. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of education documentation revealed the Administrator signed the form indicating she had received education related to one staff member dedicated to the supervision of one resident with no other assigned duties during the time provided on [DATE] 5. Interview with the Regional Quality Manager (RQM) revealed she provided education to the Director of Nursing (DON), on [DATE]. Interview with DON, on [DATE] at 12:00 PM, revealed she was educated by RQM to ensure if there was 1:1 supervision of a resident, then a staff member would be assigned and have no other duties. She stated in addition she was educated on the new process of dietary delivering, and nursing storing and delivering dietary snacks. 6. Interview with DON, on [DATE] at 12:00 PM, revealed she provided education to SDC, LPN #4 and weekend staff, on [DATE] through [DATE], to ensure they knew the requirements for the 1:1 supervision and snack pass process. Interviews on [DATE] with LPN #1 at 11:20 AM, LPN #2 at 3:11 PM, CNA #1 at 2:25 PM, and CNA #2 at 3:28 PM, revealed they were educated on 1:1 supervision, the new snack pass process and snack requirement, and care plan implementation. They also stated they were educated to call DON and/or Administrator when a resident was placed on 1:1. 7. Interviews on [DATE] with LPN #5 at 4:20 PM, LPN #7 at 4:27 PM, and LPN #3 at 4:30 PM; on [DATE] with Dietary Manager at 11:40 AM, Dietary Aide #1 at 2:30 PM, Dietary Aide #2 at 2:50 PM, SDC at 10:15 AM, SSD at 10:15 AM, KMA#1/Director of Medical Records/Central Supply at 11:00 AM, LPN #1 at 11:20 AM, DON at 12:00 PM, UM #2 at 2:50 PM, RQM at 3:05 PM, LPN #2 at 3:11 PM, CNA #1 at 2:25 PM, CNA #2 at 3:28 PM, and CNA #4 at 1:58 PM revealed they were educated on the new process for resident snack delivery and storage. Observation on [DATE] at 2:10 PM, revealed staff followed the new snack pass guidelines. 8. Review of education documentation revealed all nursing staff and dietary staff signed the education to acknowledge understanding of education. Additionally, interview with LPN #7 (new hire), on [DATE] at 4:27 PM, revealed she was educated on the new process for snacks, 1:1 resident supervision and care plan implementation. 9. Interview on [DATE] at 3:05 PM, with Regional Quality Manager, revealed she provided education to the DON, on [DATE], to ensure she was aware she and/or the Administrator should be notified when a resident was placed on 1:1, and the care plan was to be implemented, as indicated for 1:1 supervision. Interview with DON, on [DATE] at 12:00 PM, revealed she was educated on being notified if a resident was placed on 1:1, and care plan implementation of 1:1 by RQM. Review of education documentation dated [DATE], revealed the DON signed the form indicating she understood the education provided by the RQM. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	10. Review of education documentation (train the trainer) provided by DON to the Staff Development Coordinator (SDC), on [DATE], revealed the DON educated the SDC and the SDC signed the form indicating she understood the education. Interview with SDC, on [DATE] at 10:00 AM and 4:00 PM, revealed she was educated by the DON on the new snack process, that the DON and the Administrator must be notified if a resident was placed on 1:1 supervision, and that staff assigned to that resident would have no other duties but the 1:1. 11. Interviews on [DATE] with LPN #7 at 4:27 PM; on [DATE] with LPN #1 at 11:20 AM, LPN #2 at 3:11 PM, LPN #3 at 4:30 PM, and LPN #5 at 4:20 PM, revealed they were educated that staff assigned 1:1 supervision of a resident would not be assigned any other duties, nursing staff were to notify DON and/or the Administrator if a resident was placed on 1:1, and care plan implementation of the 1:1 supervision. Review of education documentation revealed all licensed nursing staff signed they understood the education provided on [DATE] 12. Interviews on [DATE] LPN #1 at 11:20 AM, LPN #2 at 3:11 PM, CNA #1 at 2:25 PM, and CNA #2 at 3:28 PM, revealed verbal acknowledgement of provision of education and signing of signature page for verification of education. 13. Interviews on [DATE] with Administrator at 3:45 PM, DON at 12:00 PM, SSD at 10:15 AM, Dietary at 11:40 PM; and Therapy at 2:15 PM revealed an ad-hoc meeting was held on [DATE] to review the summary of Immediate Jeopardy findings with discussion of action plan to address findings of Immediate Jeopardy. Interview with Administrator on [DATE] at 3:45 PM, and with Medical Director on [DATE] at 4:14 PM, revealed the Administrator made the Medical Director aware of the action plan and obtained his input. 14. Review of the Monitoring Tools for Snack Pass, revealed monitoring was conducted five times during the week of ,d+[DATE]-[DATE] and continued to be completed with no concerns identified. The monitors were signed by the DON/or weekend supervisor. 15. Interviews on [DATE] with Administrator at 3:45 PM, Administrator in Training (AIT) at 9:37 AM and at 3:45 PM, the DON at 12:00 PM, UM #2 at 2:50 PM, and MDS #1 at 4:06 PM revealed there were no residents on 1:1 at this time but were aware they would review care plans for all residents requiring 1:1 supervision. Review of a facility form that was developed to use to review the plans of care revealed a place to document Resident Name, Follow-up needed, Initials, Assigned to, and date. 16. Interview on [DATE] with the DON at 3:45 PM, the AIT at 9:37 AM and 3:45 PM, and the Administrator at 3:45 PM, revealed they were to be notified at any time a resident required a 1:1 supervision, and that the staffing sheets were being reviewed daily and weekend staffing sheets reviewed on Friday, but at this time there were no residents on 1:1 supervision. A list of reviewed staffing sheets was present in the AOC binder for review (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	17. Interview on [DATE] at 12:00 PM, with DON, revealed she was auditing accuracy of care plans related to supervision of 1:1, dietary needs, and watched a meal of audited resident that day. 18. Review of documented QAPI meetings revealed a review of facility progress with discussion of any issues dealt with immediately upon point of discovery. Interview on [DATE] with DON at 12:00 PM, Administrator at 3:45 PM, AIT at approximately 9:37 AM and 3:45 PM, revealed they were meeting weekly to discuss any issues identified with during monitoring. 19. Interviews on [DATE] with SSD at 10:15 AM, Dietary Manager at 11:40 AM, DON at 12:00 PM, Administrator at 3:45 PM, AIT at 9:37 AM and 3:45 PM, MDS at 4:06 PM and Medical Director at 4:14 PM revealed there were ongoing reviews of facility's progress toward compliance.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 35748 Based on observation, interview, and review of the facility's policy and procedure, it was determined the facility failed to ensure drugs used in the facility were labeled in accordance with currently accepted professional principles. On 09/02/2020, observation of medication room refrigerator revealed a medication vial with an open date of 07/17/2020, was still available for use. The findings include: Review of the facility's policy titled, Storage of Medications, not dated, revealed the facility shall not use outdated drugs or biological's and all such drugs shall be returned to the dispensing pharmacy or destroyed. Observation of the refrigerator in the 300 hall Medication Room, on 09/02/2020 at 4:17 PM, revealed one (1) vial of Tubersol (tuberculin protein derivative) solution, dated opened on 07/17/2020 which was expired due to being opened more than thirty (30) days prior. Interview with Licensed Practical Nurse (LPN) #7, on 09/02/2020 at 4:23 PM, revealed the vial of Tubersol should have been discarded because it expired thirty (30) days after opening. Interview with the Director of Nursing (DON), on 09/04/2020 at 11:09 AM, revealed she expected the nurses to discard expired medications such as Tubersol because the solution expired thirty (30) days after opening.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 32635 Based on observation, interview, facility menu review, and review of facility policy, it was determined the facility failed to follow the standardized four (4) week cycle menus as determined by menu changes not assessed by the Dietitian for prior approval. The findings include: Review of the facility policy titled Menus, not dated, revealed facility menus were planned in advance to meet the nutritional need of Residents in accordance with established national guidelines. Menus would be developed to meet the criteria through the use of an approved menu planning guide. A Registered Dietitian/Nutritionist (RDN) or other clinically qualified nutritional professional reviews and approved the menus. The RDN or other clinically qualified nutrition professional would adjust the individual meal plan to meet the individual requests including cultural, religious, or ethnic preferences, as appropriate. Review of the facility menus titled, Week-AT-A-Glance Southern 2020, week 1 through week 4, not dated, revealed the menus were not followed. The posted weekly menu for the last weekend of August 2020 and the first week of September 2020 did not correspond to any of the standardized four (4) cycle menus. Further review and comparison of the weekly-posted menu with the standardized four (4) week cycle menus revealed the individual menu's food items changed or were removed from the original standardized menu. Observation on 09/01/2020 at 4:00 PM, of the posted weekly menu, revealed the menu did not appear within the current set of four (4) week cycle menus. Interview on 09/02/2020 at 3:50 PM, with Account Manager, revealed she followed the menus, however, she wrote out the menu for the week. She stated she discussed substitutions with the dietitian and she selected, each meal from the four (4) week cycle menus, to create her own weekly menu. She continued to reveal she selected some menus from week four (4) and some menus from the other weeks to create the current weekly posted menu. Interview on 09/02/2020 at 2:30 PM, with the Registered Dietitian, Licensed Dietitian (RD) (LD) revealed she had instructed the account manager concerning substitutions. She stated she was not aware the Account Manager was creating her own menu from the four (4) week cycle menus. She further revealed the Account manager needed RD approval for any changes to the menu prior to posting the menu for the week. She stated she expected the cycle menus to be followed and there to be prior approval by the RD for any changes. Interview on 09/04/2020 at 10:55 AM,with Administration, revealed she expected the menus to be followed and any changes pre-approved by the dietitian.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33035 Based on observation, interview, record review, dietary meal slip review, and facility policy review, it was determined the facility failed to honor one (1) of twenty (20) sampled residents meal preferences (Resident #52). The facility identified Resident #52 disliked green beans, green peas, spinach, and greens; however, served the resident lima beans, on 09/01/2020. The findings include: Review of the facility policy titled, Resident Food Preferences, not dated, revealed nutritional assessments would include an evaluation of individual food preferences. The Dietician would discuss resident food preferences with the resident when such preferences conflict with a prescribed diet. The residents clinical record (orders, care plan, or other appropriate locations) would document the resident's likes and dislikes and special dietary instructions or limitations such as altered food consistency and caloric restrictions. Record review revealed the facility readmitted Resident #52 on 01/28/2020 with diagnoses which included Hypothyroidism, Parkinson's, Diabetes, Hypertension, Hyperlipidemia, Non-Rheumatic Mitral Valve Insufficiency, and Morbid Obesity due to Excess Calories. Review of the Quarterly MDS dated [DATE], revealed the facility assessed the resident as cognitively intact with a BIMS score of fifteen (15) which indicates the resident was interviewable. Observation of Lunch meal, on 09/01/2020 at 12:06 PM, revealed Resident #52 was served his/her meal in his/her room which consisted of Hamburgers, Tater Tots, and Lima Beans. However, review of Resident #52's dietary meal slip revealed in capitalized letters **NO GREENS, **NO SPINACH, **NO GREEN BEANS, **NO GREEN PEAS. Interview with Resident #52 on 09/01/2020 at 12:45 PM revealed the resident stated they know I do not like any green vegetables, I'm not eating any green beans or green vegetables. Observation revealed Certified Nurse Aide (CNA) #2 set up the resident's tray. Further observation revealed Resident #52 did not eat the Lima Beans and was not offered an alternative choice. Interview CNA #2, on 09/03/2020 at 1:35 PM, revealed Dietary was supposed to ensure trays were accurate and honored likes and dislikes. She stated staff serving the resident's meal was supposed to also check prior to delivering tray to resident. She stated I looked at the slip to ensure the resident received the appropriate tray and diet but I did not identify lima beans as green beans or offer the resident an alternative choice. Interview with the Dietary Account Manager, on 09/03/2020 at 2:20 PM, revealed he would expect dietary and the staff member serving the resident's tray to identify if the resident would eat lima beans. Interview revealed if the resident's dietary meal slip listed **NO GREEN BEANS** staff should offer the resident an alternate, not lima beans. (continued on next page)

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	185272	A. Building B. Wing	09/15/2020

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing on 09/04/2020 at 11:15 AM revealed if Resident #52's dietary meal slip likes/dislikes listed **NO GREEN BEANS** she would expect staff tp offer the resident an alternate, and not serve lima beans.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32162 Based on observation, interview, record review, and Dietary Meal Slip review, it was determined the facility failed to ensure adaptive equipment was provided to two (2) of twenty (20) sampled residents (Resident #36 and Resident #372). Observations revealed the facility failed to provide a black-foam built up utensils for Resident #372 and double handed cup for Resident #36. The findings include: Interview with the Administrator and Director of Nursing (DON) on 09/04/2020 at 8:40 AM revealed there is no policy for adaptive equipment. 1. Record review revealed Resident #36 was admitted to the facility on [DATE] with diagnoses which included Hypothyroidism, Alzheimer's Disease, Carotid Artery Syndrome, Hyperlipidemia, and Diabetes. Review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of two (2) which indicated the resident was not interviewable. Review of Resident #36's Dietary Meal Slip, dated 12/02/19 revealed resident to have handled cup with lid, divided dish, and built up utensils. However, observation of the supper meal in dining room on 08/17/2020 at approximately 5:30 PM revealed Resident #36's tray did not have a double handled cup per meal slip requirement. Interview on 08/17/2020 at approximately 5:35 PM and on 08/18/2020 at approximately 12:35 PM with Certified Nurse Aide (CNA) #4 revealed the meal ticket did say double handled cup and asked another CNA to bring the cup. Additionally, CNA #4 stated that the tray should have everything resident needs and that it should be checked in the kitchen. 33035 2. Record review revealed the facility admitted Resident #372 on 08/15/2020, with diagnoses which included Myoneural Disorder, Extrapyramidal and Movement Disorder, Bipolar Disorder, and Unspecified Open-Angle Glaucoma, Severe Stage. Review of the Admission Minimum Data Set (MDS) assessment, dated 08/22/2020, revealed the facility assessed #372's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of zero (0) which indicated the resident was not interviewable. Review of Resident #372's Dietary Meal Slip revealed the resident required a red divided plate, and black foam handled utensils However, observation on 08/17/2020 at approximately 5:50 PM revealed the resident had a regular plate instead of divided plate; and on 09/01/2020 at 12:15 PM; 09/02/2020 at 8:20 AM and 5:10 PM; and 09/03/2020 at 8:30 AM, revealed Resident #372 feeding himself/herself with regular utensils. There was no black foam built up spoon and fork on the resident's meal tray. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with CNA #2 on 09/04/2020 at 10:20 AM, revealed Dietary is responsible to ensure adaptive equipment is on the resident's meal tray and staff that serve the resident's tray is responsible to make sure the meal tray matches the dietary meal slip. CNA #2 stated she could not remember who served the resident breakfast and lunch tray on the dates and times listed. Interview with Unit Manager #3 on 08/17/2020 at 5:06 PM revealed dietary checks meal tickets in kitchen to ensure tray contain adaptive equipment when tray prepared, and the CNA's check the meal ticket with tray prior to providing tray to resident to ensure correct. Interview with the Dietary Account Manager on 09/03/2020 at 2:20 PM, revealed Dietary staff receive orders from therapy and/or nursing staff for a resident to have adaptive equipment. She stated if a residents dietary meal slip has adaptive equipment listed, he would expect dietary and the staff that served the resident's tray to ensure utensils were available for the resident to use. Interview with the DON on 09/04/2020 at 11:15 AM, revealed residents with adaptive equipment listed on their meal card should have utensils available for eating and drinking. She stated she expected dietary and staff serving meal tray to follow the listed items on the meal slip.

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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. 32635 Based on observation and interview, it was determined the facility failed to prepare food under sanitary conditions. Observation during initial kitchen tour revealed dusty ceiling vents over the production area. The findings include: Observation on 09/01/2020 at 9:59 AM, during the initial kitchen tour revealed a build up of dust on the air vents over the production area. Interview on 09/04/2020 at 9:15 AM, with Certified Dietary Manager, revealed the maintenance department was responsible for cleaning the kitchen ceiling air vents. Interview on 09/03/2020 at 4:50 PM, with Maintenance, revealed maintenance was not responsible for cleaning the kitchen ceiling air vents. Interview on 09/04/2020 at 10:55 AM, with Administration, revealed maintenance dusted the high ceiling areas and dietary dusted the lower areas of the ceiling that were in reach.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35748 Based on observation, interview, record review, review of the facility's policies/procedures, and review of the Centers for Disease Control and Prevention (CDC) guidelines, it was determined the facility failed to prevent the possible spread of COVID-19. Observations revealed personal protective equipment (PPE) was not available on hall, and multiple staff failed to don PPE prior to entering residents' rooms who were on isolation precautions (due to being newly admitted and/or possibly exposed to COVID-19). In addition, one staff failed to remove PPE prior to exiting resident room. The findings include: Review of facility policy titled, Infection Prevention and Control Policy and Procedure: Subject: Novel Coronavirus (2020-nCoV), last revised 03/25/2020, revealed Coronavirus were a large family of viruses that were common in people. The incubation time was 2-14 days and the virus could be transmitted from asymptomatic patients. The length of time the virus could live on surfaces was not clear at present. The facility would conduct education, surveillance and infection control and prevention strategies to reduce the risk of transmission of the virus. The facility would implement actions according to CDC, DOH, and the World Health Organization Review of facility policy titled, Isolation- Categories of Transmission-Based Precautions, not dated, revealed Droplet Precautions may be implemented for an individual documented or suspected to be infected with microorganisms transmitted by droplets (generated by cough/sneeze/talking). Masks would be worn when entering the room and gloves, gown, and goggles should be worn if there was a risk of spraying respiratory secretions. Review of facility inservice records dated 03/16/2020, provided by Staff Development Coordinator SDC/Infection Control Nurse (IFC) revealed staff were educated per CDC guidelines of removal of PPE (including gown) before exiting resident rooms. Further review revealed they were educated the type of PPE would vary based on level of precautions required, with instruction for donning of gown, gloves, mask, goggles, respirator or shield provided. Review of the CDC Preparing for COVID-19 in Nursing Homes, guidance, updated 06/25/2020, revealed HCP (Health Care Professional) should wear N95 or higher level respirator, eye protection (goggles or a face shield that covered the front and sides of the face), gloves, and gown when caring for these residents. 1. Tour with SDC/Infection Control Nurse on 08/17/2020 at approximately 4:00 PM, revealed bins on hall 300 with no PPE supplies for isolation rooms. Observation of isolation room [ROOM NUMBER] on 200 hall, revealed there was no PPE available for staff to provide care to residents in room. Interview on 08/17/2020 at 4:00 PM with Licensed Practical Nurse (LPN) #3, revealed the bins on the hall did not have needed PPE in them for staff to provide care to the residents on isolation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/17/2020 at 3:58 PM, with Certified Nursing Assistant (CNA) #7, revealed there were no gowns on the hall available for use. Interview on 08/18/2020 at 4:08 PM, with LPN #3, revealed the IFC/SDC was responsible to put the gowns in the bins. LPN #3 stated there were no gowns in bin at Isolation room [ROOM NUMBER], and she had to go all the way up to room [ROOM NUMBER] to obtain the gowns. Interview on 08/17/2020 with Staff Development Coordinator/Infection Control Nurse (ICN) at 4:13 PM, 4:25 PM at 5:15 PM, revealed the isolation rooms were supposed to have the required PPE (gown/gloves/masks) in the bins at each room. She stated she needed to educate the staff that when they run out they need to get some from the nurses. She stated Central Supply (CS) was responsible for ensuring PPE was available in the bins. Interview on 08/18/2020 at 3:45 PM with CS revealed she had not been told and did not know she was responsible to put PPE (gowns/goggles/mask) in the supply bins at the isolation rooms. 32162 2. Observation of signs posted at isolation rooms on 300 hall, on 08/17/2020 at 3:45 PM revealed gown, gloves and mask required related to droplet precautions. Observation on 08/17/2020 at 5:30 PM, revealed CNA #5 exited room [ROOM NUMBER] (Resident #41{dialysis Resident on isolation}) with gown on and untied and carrying supper tray. CNA #5 then went to meal cart and placed meal tray on cart. Interview on 08/17/2020 at 5:30 PM with CNA #5, revealed she should have taken gown off in room before coming into the hallway. 3. Observation on 08/24/2020 at 11:40 AM, revealed Maintenance Director in room [ROOM NUMBER] not wearing any PPE and resident in room. The Maintenance Director was observed leaning over and touching bed while addressing plug in and attempting to plug in a cord to the socket and touching the A/C Unit in room. Interview on 08/24/2020 at 3:10 PM, with Maintenance Director revealed he had not thought about wearing PPE when coming into contact with the bed of resident, while checking his/her air conditioner and plug ins. 4. Observation on 08/17/2020 at approximately 5:50 PM, revealed CNA #5 sitting in a resident room with (2) new Residents (Resident #370 and #372) who were new admits and persons under investigation (PUI) for exposure to COVID-19) with no gown on feeding Resident #370. In addition, there was no sign on the door to indicate the residents were on isolation or gloves, gown, and masks were required. Interview with CNA #5, on 08/17/2020 at 5:15 PM and on 09/01/2020 at 5:15 PM, revealed there was no PPE available and that the residents were admitted over the weekend. In addition, there was not a sign on the door, but they were on isolation because they were new admits. Observation on 08/24/2020 at 5:17 PM, revealed CNA #4 and CNA #6 exited Resident #370's and #372's room carrying a meal tray with no gloves or gown on while in room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interviews with CNA #4, on 08/24/2020 at approximately 5:20 PM, revealed they had fed Resident #370, and did not wear gloves or gown while in room. Interview with CNA #6, on 08/27/2020 at 10:08 AM, revealed she did not realize she needed to wear gloves and gown while in the room providing direct care. She stated the facility did not communicate needed information, and the sign was not there and no one had told her to wear PPE in that room. Observation on 08/24/2020 at approximately 11:40 AM, revealed Physical Therapist (PT) #1 was helping Resident #370 in bathroom for continent care and was not wearing the appropriate PPE. Interview on 09/24/2020, at approximately 11:45 AM with Physical Therapist #1, revealed that he had been in the room helping Resident #370 with bathroom care and was not wearing any PPE at the time. Observation on 08/18/2020 at approximately 4:29 PM, revealed CNA #7 in Resident #370's and #372's room without gown on while in room. Interview on 08/18/2020 at approximately 4:20 PM, with CNA #7, revealed that she should have put a gown on prior to going into a resident's room due to the resident being on isolation precautions. Interview on 08/18/2020 at approximately 4:29 PM with LPN # 3, revealed staff should put a gown on prior to entering Resident #370's and #372's room. Interview on 09/01/2020 at approximately 4:05 PM, with LPN #4, revealed staff was to wear gown, gloves, and mask when going into a room, and the PPE should be taken prior to exiting room. In addition, supplies should be available in the bins for staff to wear in rooms. Interview on 08/24/2020 at 11:55 AM with DON revealed if staff was providing direct patient care staff needed to wear PPE. Interview on 08/18/2020 at 5:15 PM, with Administrator revealed there was no need for staff to wear gowns unless there was potential for staff to come in contact with body fluids, such as doing incontinent care, or come into contact with residents. 5. Observations on 09/02/2020 at 8:13 AM, revealed signage on Resident #21's room indicating isolation and PPE outside the resident's doorway. LPN #7 entered Resident #21's isolation room without donning the appropriate personal protective equipment (PPE) to provide care to the resident. Further observation revealed LPN #7 standing over Resident #21 and administering medications. Interview with Licensed Practical Nurse (LPN) #7, on 09/02/2020 at 8:15 AM, revealed she should have taken appropriate precautions to include the use of goggles and gloves when administering medications to residents on the isolation unit. LPN #7 further stated the resident was on droplet precautions and wearing the PPE keeps staff and residents safe. Interview with the Director of Nursing (DON), on 09/04/2020 at 11:23 AM, revealed she expected staff to follow the CDC guidelines and facility policy when providing care to residents on the isolation unit. The DON further stated signs are posted outside the door and PPE is available for staff.