STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235004	A. Building B. Wing	10/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld Muskegon	1061 W Hackley Ave Muskegon, MI 49441

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 This citation pertains to intake # MI00129663 & MI000132013 Based on interview and record review, the facility failed to protect one residents' right to be free from neglect (Resident #800) resulting in an Immediate Jeopardy when beginning on [DATE], the facility failed to prevent neglect for Resident #800. This deficient practice led to Resident #800 being found unresponsive after choking on vomit, requiring emergency medical intervention, and subsequent death and the potential for further residents to experience serious harm, injury and/or death if not corrected. Findings Include: Resident #800 (R800) Review of an Admission Record revealed R800 was a [AGE] year old female, last admitted to the facility on [DATE], with pertinent diagnoses of morbid obesity, chronic obstructive pulmonary disease (COPD), weakness, contracture of the left hand, and history of a stroke causing left sided weakness and paralysis. R800 required extensive assistance from 2 staff person for bed mobility, transfers in and out of bed, and bathing. Review of Advance Directive documents revealed that R800 was full code status. During an interview on [DATE] at 2:04 PM, R800's roommate R reported the following details related to the evening of [DATE] and R800's death: roommate R (a) went out to the desk multiple times and begged Registered Nurse (RN) C to come help R800 who was vomiting and choking (b) roommate Rattempted at one point to scoop vomit out of R800's mouth with a wash cloth to try and help R800, (c) each time roommate R went to the desk to try and get help for R800, RN C told roommate R to mind her own business and go back to her room, and (d) reported that RN C did not come to the room at any time to check on R800 until an aide came in and saw that R800 was already dead and called a code blue. I told the aide that she was too late (R800) was already dead. Roommate R then went on to say that Certified Nurse Aide (CNA) E then told the two roommates if you knew (R800) was in trouble, why didn't you sit her up. Roommate R indicated I'm still traumatized, was sobbing while discussing the details of R800's death, and she was my friend and I had to listen to her choke on her vomit and die. Roommate R went on to say that RN C continued to work at the facility, and she did not feel safe at the facility and initiated a quick discharge home. I can't believe they would let (RN C) still work there after letting (R800) die. I had to get out of there. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Social Service progress notes, dated [DATE], reflected roommate R requested to be discharged immediately to home, AMA (against medical advice) if needed. Progress Notes reflected that roommate R discharged home on [DATE]. During an interview on [DATE] at 3:30 PM, R800's roommate S stated the following regarding the unexpected death of R800 on the night of [DATE]: (a) it was awful, we couldn't help her, but we could hear her throwing up and choking (b) roommate R kept going out to get the nurse to help but (RN C) just yelled at her to go back to our room and mind her own business, it was loud, I could hear the yelling, (c) RN C did not check on R800 until the aide called a code blue, and (d) the administrator spoke to me about what happened, I told her what happened, and she told me not to talk about it with anyone. During an interview on [DATE] at 5:36 PM, CNA G reported the following regarding the care of R800 the evening of [DATE]: (a) heard roommate R tell RN C several times that R800 needed help and that RN C just told (roommate R) to go back to her room, (b) went to R800's room, R800's mouth was full of vomit, the head of the bed was flat, (c) raised the head of bed and helped R800 get the vomit out of her mouth, (c) cleaned up R800, obtained a set of vitals, and told RN C that R800 was sick and had not been feeling well that afternoon and evening and R800 did not eat dinner, (d) at the end of shift (10 PM) on [DATE], CNA G left an emesis basin next to R800 and told RN C that R800 was really sick and needed to be sent out. (RN C) doesn't listen to our opinions. Review of a vitals record for R800 reflected that the last set of vitals that were taken by staff on [DATE] occurred at 7:22 PM. Vital signs were within normal limits. During an interview on [DATE] at 8:17 AM, CNA E reported working the night of [DATE] from 10 PM to 6 AM on [DATE] and noted the following regarding the unexpected death of R800: (a) roommate R came out of the room because R800 needed something, (b) CNA E went into the room, the light was on, R800's eyes were weird and lips were blue, (R800) was gone. (c) CNA E called a code blue, got the nurse (RN C) and (RN C) came in and started working on R800, (d) CNA E indicated that this was the first time RN C had checked on R800 since (CNA E) coming on shift at 10 PM, (e) stated staff were all shocked when (R800) died , it's not like she was at the end of her life. During an interview on [DATE] at 11:30 AM, Licensed Practical Nurse (LPN) D stated the following regarding the events related to R800's unexpected death on [DATE]: (a) was down on her assigned hall assisting a resident off a bed pan when LPN D heard the code blue called, (b) quickly finished with the resident and went to R800's room on the 400 hall, (c) entered R800's room, RN C was at bedside, and RN C reported that R800 was not breathing, (d) observed R800's lying flat in the bed, lips were blue, and there was vomit in R800's mouth that RN C was trying to clear out, (e) called for a back board, initiated chest compressions initially without the back board, the back board arrived and was placed, and resumed chest compressions, (f) RN C was bagging (providing oxygen and ventilation's) R800 and vomit was coming out of R800's mouth, (g) EMS arrived and took over bagging, and needed suction to get the vomit out of R800's mouth and throat, (h) staff brought the suction machine but it was not working and had to go get the other one from the other crash cart, and (i) LPN D stayed in the room with EMS in case they needed something, and until R800 was pronounced dead. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of an Emergency Cart and Oxygen Inventory Checklist for the 400 hall, with instructions to check equipment on top of the cart every day on 3rd shift. Any missing or non-operating equipment should be replaced immediately, revealed the cart was not checked 18 days in [DATE] and 13 of 17 days in [DATE]. During an interview on [DATE] at 9:02 AM, LPN I stated the following regarding the events related to R800's unexpected death on [DATE]: (a) was working on another hall on the other side of the building when she heard a code blue was called on 400 hall, (b) immediately went to 400 hall, no one could say for sure if 911 had been called, so LPN I called 911, (c) entered R800's room to find LPN D doing chest compressions and RN C bagging R800, (d) took turns with LPN D doing chest compressions on R800, and (d) while being bagged R800 had vomit coming out of her mouth and throat, staff turned R800 on her side to get the vomit out and then went back to doing chest compressions. LPN I indicated that when EMS arrived, she went back to her unit to continuing caring for residents. Review of ambulance/emergency medical services (EMS) run sheet reflected the following times and disposition for response to the facility call on [DATE] for assistance with R800: dispatch received 911 call from facility at 11:17 PM, EMS at the facility at 11:24 PM, EMS at R800's bedside at 11:26 PM and life saving measures initiated by EMS, and R800 was pronounced dead at the facility at 11:57 PM on [DATE]. During an interview on [DATE] at 11:00 AM, RN C reported the following related to the evening of [DATE] and the unexpected death of R800: (a) a CNA notified RN C that R800 had vomited, not sure of time but it was evening and after dinner, (b) RN C gave R800 a PRN (as needed) dose of Zofran (a medication used to treat nausea/vomiting) and assessed lung sounds which were clear and vital signs which were within normal limits, (c) CNA E approached the medication cart (can't recall the exact time) and stated that R800 was not doing well and was unresponsive, (d) RN C went to R800's room and found the resident with no pulse, not breathing and immediately called a code (blue), (e) EMS was notified, the AED (automatic external defibrillator) was brought in, nursing staff started CPR (cardiopulmonary resuscitation), and when EMS (emergency medical services) arrived, RN C left R800's room, and (f) EMS came out of the room just before midnight and pronounced (R800) dead. When asked specifically if roommate R had been concerned about R800 and had alerted staff that R800 was throwing up and needed help, RN C stated yes she did come for help, but (roommate R) had been a care aide in the past and was always crying wolf about something being wrong with the roommate. When asked specifically about the amount of vomit and how many times R800 had thrown up, RN C replied, just that one time when I gave the Zofran and it wasn't a ton. RN C indicated that after receiving the Zofran, R800 nodded that she felt better and that was the only time she vomited. Review of an Emar (electronic medication administration record) for R800, dated [DATE], reflected the following medication was given: Zofran Oral Tablet 4 mg (milligrams), one tablet by mouth every 6 hours as needed for nausea/indigestion was given by RN C on [DATE] at 8:42 PM. Review of a nursing progress note, written by RN C on [DATE] reflected .Cna reported resident was unresponsive. Resident immediately assessed and found to be asystole and without respirations. Code blue called. CPR started and EMS called. Ems arrived at 2220 (this documented time is incorrect per EMS run sheet) and took over cpr/code. Um (unit manager) notified. Ems stopped code and called time of death at 23:57 (11:57 PM) . MD called and report given with order received for release of remains. Family called and notified of mothers passing with several family members coming in to visit. After family left funeral home called and arrived to take residents remains to their facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the last physician progress note in R800's electronic medical record (EMR), dated [DATE], reflected that R800 was non-toxic and clinically stable. During an interview on [DATE] at 1:00 PM, Family Member (FM) T reported (a) visiting with R800 2 weeks prior to her death and that R800 was up in a wheelchair laughing and joking, (b) R800 was remembering details about their youth, they were raised in the same house, and was clear as a bell, and (c) R800 looked so good and was happy. During an interview on [DATE] at 2:06 PM, Family Member (FM) U reported (a) just saw R800 2 days prior to her unexpected death and we talked, she was perfect and (b) after visiting the body at the facility in the early hours of [DATE], was told that if the family wanted an autopsy, they would have to pay for it. So, the family chose not to have an autopsy. On [DATE], the Administrator was verbally notified and received written notification of the immediate jeopardy at F600, identified on [DATE] and that began on [DATE], due to the facility's failure to protect a resident from neglect that lead to death. On [DATE] the surveyor verified the following interventions had been put into place and were effective to remove the immediacy: -On [DATE] the facility terminated the employment of RN C and reported the allegation of neglect to the State Agency -On [DATE] all resident's were rounded on by clinical staff to ensure all needs were met. The ADM (administrator) and DON (Director of Nursing) audited current grievance logs for any concerns related to unmet resident needs. The DON reviewed all records of resident's that had expired in the past 30 days or who had an acute change in condition, for any unmet needs. -On [DATE] the RNC (Regional Nurse Consultant) educated the ADM and DON on the Abuse/Neglect Policy and Procedure. The DON then initiated education with all facility personnel regarding the Abuse/Neglect Policy and Procedure. -On [DATE] the RNC educated the ADM and DON on the Emergency Situations and Care of Resident's Policy and Procedure. The DON then initiated educating nursing personnel on the Emergency Situations and Care of Resident's Policy and Procedure. Any staff absent will be in-serviced prior to their next scheduled shift. Special focus was given to staff (a) ensuring that each resident received timely medical attention to prevent neglect and (b) responding timely to emergency events. -The DON will review residents with acute changes in condition weekly and then monthly to ensure adherence to the Abuse/Neglect Policy and Procedure and the Emergency Situations and Care of Resident's Policy and Procedure. QAA committee will review audits for ongoing compliance. Although the immediate jeopardy was removed on [DATE], the facility remained out of compliance at a scope of isolated and severity of actual harm due the fact that not all facility staff have received education and sustained compliance has not been verified by the State Agency.

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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 - Minimal harm or potential for actual harm Residents Affected - Some	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** 37577 This citation pertains to intake # MI00129663 Based on observation, interview, and record review, the facility failed to prevent repeated falls for one resident (Resident #806) and failed to maintain call light placement accessible to three vulnerable/at risk resident's (Resident #803, Resident #805, Resident #808), resulting in (a) the potential for serious injury as the result of a fall and (b) vulnerable resident's unable to alert staff if assistance was needed urgently. Findings: Resident #806 (R806) Review of an Admission Record revealed R806 was a [AGE] year-old male, originally admitted to the facility on [DATE], following a fall at home that resulted in a brain bleed and the need for surgical intervention (craniotomy). R806 had pertinent diagnoses of high blood pressure, history of seizures, and required extensive assistance from two staff persons for bed mobility, transfers and to use the bathroom. A Brief Interview for Mental Status (BIMS) reflected R806 had severe cognitive impairment. Review of a nursing Admission Screening/History dated 09/10/22 revealed R806 was assessed to have an unsteady gait, poor balance, and a history of falling/recent fall. Review of an admission Fall Risk assessment dated [DATE], revealed R806 was assessed to be a high risk for falls. Review of a form CMS-802 (Resident Matrix) provided to the surveyor upon entry to the facility on [DATE] did not indicate that R806 had any recent falls. Review of a Baseline Care Plan (a care plan initiated within 48 hours of admission to provide care givers a plan of care to follow until a formal care plan was completed) for R806 revealed that several risk factors were not checked when staff assessed R806 for risk of falls. The only risk factor for falls checked for R806 was new environment. Risk factors not checked but applicable to R806 were (1) history of fall in the month prior to the admission, (2) cognitive impairment, (3) gait/balance/strength concerns, (4) medical conditions (high blood pressure and seizure history), and (5) high risk medications (three blood pressure medications and an opioid pain control medication- all known to cause sudden drops in blood pressure with position changes-othostatic hypotension). Review of the same Baseline Care Plan reflected the only intervention selected for R806 to reduce the risk of a fall was .be sure call light is within reach, provide cueing and reminders for use as appropriate due to level of cognition. Review of an Incident/Accident Report for R806, dated 09/15/22 at 2:15 PM, revealed R806 had an unwitnessed fall and .(R806) is often confused and spontaneous, is not safety aware, standing without use of call light. A neurological evaluation form could not be located for the 09/15/22 fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Incident/Accident Report for R806, dated 09/18/22 at 3:30 PM, revealed R806 had an unwitnessed fall and .(R806) was confused at baseline. Review of a Post Fall Assessment for R806 dated 09/18/22 reflected that the previously initiated intervention to prevent falls for R806 was to lower the bed. It also reflected that the new intervention to be put into place for R806 to prevent falls was to initiate frequent safety/wellness checks. Record of the frequent safety/wellness checks could not be located. Review of an Incident/Accident Report for R806, dated 09/19/22 at 2:45 PM, revealed R806 had an unwitnessed fall and .(R806) was a frequent faller. Review of a Post Fall Assessment for R806 dated 09/19/22 reflected that the previously initiated intervention to prevent falls for R806 was low bed and helmet. It also reflected that the new intervention to be put into place for R806 to prevent falls was to initiate frequent safety checks. Record of the frequent safety checks could not be located. Review of an Incident/Accident Report for R806, dated 09/20/22 at 1:45 PM, revealed R806 had an unwitnessed fall and .(R806) was a frequent faller. Review of a Post Fall Assessment for R806 dated 09/20/22 reflected that the previously initiated intervention to prevent falls for R806 was a winged mattress, frequent checks, low bed and helmet. It also reflected that the new intervention to be put into place for R806 to prevent falls was to care plan R806 for falls. Record of the frequent checks could not be located. Review of an Incident/Accident Report for R806, dated 09/22/22 at 1:45 PM, revealed R806 had a witnessed fall but the report did not list that any witness to the fall was found. A neurological evaluation form could not be located for the 09/22/22 fall. Review of a Post Fall Assessment for R806 dated 09/22/22 reflected that the previously initiated intervention to prevent falls for R806 was maintain call light within reach and anticipate the resident's needs. It also reflected that the new interventions to be put into place for R806 to prevent falls was to keep bed in lowest position, place signs in the room to remind the resident to use the call light, and ensure resident has proper foot wear. Review of a Care Plan for R806, that included all revisions since admission, reflected the following interventions that were implemented to prevent falls: (1) anticipate and meet resident's needs-date initiated-09/22/22, (2) ensure resident is wearing appropriate footwear when ambulating-date initiated-09/23/22, (3) keep bed in lowest position when not performing care-date initiated-09/23/22, (4) reminder signs in room for call light use-date initiated-09/23/22, and (5) minimize risk factors in environment: areas free of spills and clutter, personal items within reach-date initiated-09/23/22. During an interview on 10/13/22 at 8:20 AM, R806 reported that he has not had any falls in the past week or two. Stated that when he was first admitted to the facility, he would need to go to the bathroom and would put on the call light, staff would come in to the room, turn off the call light and tell him that he was going to have to wait. That's not right. Resident #803 (R803) (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Admission Record revealed R803 was a [AGE] year old female, last admitted to the facility on [DATE] with pertinent diagnoses of multiple Sclerosis, chronic pain, gastroesophageal reflux disease (GERD), history of falls, expressive language disorder, and contracture's to both upper body limbs. R803 was completely dependent on staff for all activities of daily living and was unable to call for help if needed. During an observation on 10/12/22 at 10:35 AM, R803 laid in bed with the tube feed running and the touch pad call light Red-Alert sat on the top shelf of a plastic supply tower next to the bed, out of reach and out of sight of the resident. The privacy curtain was pulled so that R803 could not be seen by staff passing by the door from the hallway. During an observation on 10/17/22 at 8:35 AM, R803 laid in bed with the tube feed running and the touch pad call light sat on the top shelf of a plastic supply tower next to the bed, out of sight and out of reach of the resident. The privacy curtain was drawn and staff passing by the room could not see R803 from the hallway. During an observation on 10/17/22 at 12:05 PM, R803 laid in bed with the tube feed running and the touch pad call light sat on the top shelf of a plastic supply tower next to the bed, out of sight and out of reach of the resident. The privacy curtain was drawn and staff passing by the room could not see R803 from the hallway. Review of a Kardex (a quick glance reference for direct care staff) for R803 reflected the following: (a) fall risk, (b) provide red paddle call light, and (c) aspiration precautions. Resident #805 (R805) Review of an Admission Record revealed R805 was a [AGE] year old female, last admitted to the facility on [DATE], with pertinent diagnoses of epilepsy, lack of coordination, and abnormal posture. R805 is completely dependent on staff for all activities of daily living. During an observation on 10/13/22 at 8:45 AM, R805 laid in bed with the tube feed running and the touch pad call light sat on the top of a plastic supply tower, out of sight and out of reach of the resident. Review of a Kardex for R805 reflected the following: provide red paddle call light and be sure call light is within reach. Resident #808 (R808) Review of an Admission Record revealed R808 was an [AGE] year old female, last admitted to the facility on [DATE], with pertinent diagnoses of dementia, lack of coordination, difficulty walking, chronic kidney disease, anxiety disorder, and insomnia. R808 relied on staff to meet all of her care needs. A BIMS revealed R808 had severe cognitive impairment. During an observation on 10/10/22 at 12:02 PM, R808 laid in bed resting with eyes closed and the call light laid on the floor, under the privacy curtain, out of reach and out of sight of the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 10/13/22 at 8:48 AM, R808 laid in bed resting with eyes closed and the call light laid on the floor out of reach and out of sight of the resident. During an observation on 10/13/22 at 10:27 AM, R808 laid in bed resting with eyes closed and the call light laid on the floor on the right side of the bed, out of reach and out of sight of the resident. During an observation on 10/13/22 at 12:47 AM, R808 laid in bed and the call light laid on the floor out of reach and out of sight of the resident. During an observation on 10/13/22 at 1:44 PM, R808 laid in bed and the call light laid on the floor on the right side of the bed (where it had been observed since the observation this morning at 8:48 AM) out of sight and out of reach of the resident. Review of a Kardex for R808 reflected: be sure call light is within reach. During an interview on 10/13/22 at 8:50 AM, Certified Nurse Aide (CNA) V indicated that the expectation for direct care staff was to make sure that call lights were within reach of the resident's and they check them each time they go into a room.

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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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 This citation pertains to intake # MI00129663 Based on interview and record review, the facility Administrator failed to follow established risk management and abuse/neglect prevention policies and procedures, resulting in an Immediate Jeopardy when beginning on [DATE], the Administrator did not (a) report and investigate the sudden and unexpected death of Resident #800 and (b) report and investigate an allegation of neglect that resulted in the death of Resident #800. This deficient practice resulted in the potential for the Administrator to continue to arbitrarily not report allegations of abuse and neglect and not follow established risk management guidelines for sudden and unexpected deaths and policies and procedures for reporting and investigating allegations of Abuse/Neglect and ensuring the safety of all residents during an investigation. This deficient practice has the high likelihood to cause serious injury, harm, and/or death to further residents if the administrator does not follow established policies and procedures to protect them from abuse or neglect. Findings: Review of a Nursing Progress Note dated [DATE] reflected that Resident #800 (R800) had died suddenly and unexpectedly that evening. During an interview on [DATE] at 11:15 AM, Social Worker (SW) A recalled that the morning of [DATE], at the leadership team meeting, the following related to the unexpected death of R800 was discussed: (a) all staff were very upset as (R800) was very well liked, and (b) the Administrator directed staff to bring any concerns related to the death of (R800) straight to her. She didn't want us looking into anything. Review of the facility policy/procedure Risk Management Guidelines, last updated [DATE], reflected the following: Trigger events are unusual situations or adverse events that meet one or more of the following criteria: (1) require reporting to the state agency or law enforcement, and/or (2) result in harm or have the potential for serious harm, and/or (3) have any likelihood or potential for civil, criminal, or regulatory action. These events necessitate discussion and guidance in the handling, documenting, and/or resolution of such situations or events. The Nurse Consultant (Regional Nurse Consultant H) should immediately be notified via phone call by Administrator for the following types of triggered events .sudden or unexpected death. The Administrator will send an email to the appropriate risk management group and inform the risk management team of the triggered event. The Administrator will entirely complete the Risk Management Report in point click care . The following are examples of trigger events and should not be considered all-inclusive: unexpected resident death .choking requiring intervention with negative outcome . any allegation of neglect. During an interview on [DATE] at 3:45 PM, the Administrator reported not following Risk Management Guidelines and did not report the sudden and unexpected death of R800. When asked why it was not reported, the Administrator shook her head, shrugged her shoulders, and stated I don't know. (continued on next page)

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	235004	A. Building B. Wing	10/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld Muskegon	1061 W Hackley Ave Muskegon, MI 49441

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

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Nursing Progress Note dated [DATE], and written by 3rd shift Licensed Practical Nurse (LPN) Q revealed the following: Went in resident's room and the second I walked in, this resident and her roommate began expressing their concern over their other roommates death (R800) two days ago. Both resident's very upset. Expresses desire to talk to management. During an interview on [DATE] at 6:10 PM, LPN Q reported the following regarding the death of R800 on [DATE] and the conversation had with the roommates of R800 on [DATE] when LPN Q first spoke with the roommates after coming on shift: (a) both roommates wanted to talk about what happened and both were very upset, (b) both roommates shared concerns about the manner in which R800 died , (c) both reported that they had tried to get help for R800 on the evening of [DATE], but staff would not listen, (d) one of the roommates went out into the hallway several times to get staff to help but was told to return to her room and mind her own business, and (e) LPN Q wrote up a Grievance Form for each of the roommates, that evening, and placed the grievance forms under the Administrator's door. Review of two grievance forms date [DATE], reflected LPN Q wrote the above mentioned forms for each of R800's roommates and placed them under the door of the Administrator's office. During an interview on [DATE] at 3:25 PM, the Administrator reported not receiving or seeing the two grievance forms that were written by LPN Q on [DATE] on behalf of R800's roommates. During an interview on [DATE] at 3:30 PM, R800's roommate S stated that the Administrator came to speak with roommate S in her room, roommate S shared concerns with the Administrator about the care of R800 on the evening of [DATE] and the Administrator asked roommate S to not share that information with anyone else. During an interview on [DATE] at 3:30 PM, the Regional Nurse Consultant (RNC H) reported being first made aware of any concerns related to death of R800 during a staff in-service on [DATE]. LPN Q asked RNC H during the in-service if RNC H knew anything about the investigation into R800's death. RNC H immediately reported the concern to the Administrator. During the same interview, the Administrator confirmed that RNC H did report an allegation of neglect on [DATE] regarding the death of R800. The Administrator then indicated the allegation was not reported to the State Agency as required. When asked why the allegation of neglect was not reported to the State Agency, the Administrator responded I could have reported it but I did not. The Administrator did state that an investigation was started on [DATE] and provided the survey team with written statements from staff regarding the death of R800. Review of written statements by staff regarding the death of R800 revealed the following: (a) written statements were received from RN C (the nurse on duty the evening of [DATE] and responsible for the care of R800) and dated [DATE], (b) written statements were not obtained from LPN D and LPN I, both of whom were present during the code blue that was activated when R800 was found unresponsive, not breathing, and had no heartbeat, (c) a written statement was obtained from LPN Q after the Administrator advised LPN Q of not seeing or receiving the two grievance forms that LPN Q reported to have filled out on behalf of R800's two roommates the evening of [DATE], (d) a written statement was obtained from CNA G, dated [DATE], that detailed concerns regarding the care of R800 on the evening of [DATE], and (e) no interview statements were taken from either of R800's roommates. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3:30 PM, RNC H indicated that on [DATE] RNC H asked the Administrator if the allegation of neglect related to R800's death had been reported to the State Agency and was told by the Administrator that the allegation had not been reported to the State Agency. During the same interview, the Administrator confirmed that the above conversation occurred. RNC H asked the Administrator again on [DATE] and [DATE] if the allegation had been reported to the State Agency. The Administrator responded that it had not been reported as required. The Administrator confirmed that the conversations with RNC H did in fact occur on [DATE] and [DATE]. During the same interview on [DATE] at 3:30 PM, the Administrator reported that RN C was suspended from work on [DATE] and [DATE] pursuant to the investigation into the allegation of neglect. The Administrator also reported not making HR (human resources) aware of the suspension and not placing any paperwork in RN Cs personnel file related to the suspension. The Administrator indicated that notifying HR of a suspension and filling out paperwork regarding the suspension was standard practice. When asked why the Administrator did not report the suspension to HR nor fill out any paperwork regarding the suspension, the Administrator shook her head, shrugged her shoulders and stated I don't know. During the same interview, the Administrator reported that the allegation of neglect had not been reported to law enforcement and that RN C was allowed to return to work on [DATE] because the Administrator found no concerns related to the death of R800. Review of a staff schedule report for RN C reflected that RN C had not been previously scheduled to work on [DATE] and [DATE]. The staff schedule report did reflect that RN C worked on [DATE] and [DATE] despite an investigation being initiated on [DATE] into the alleged neglect of R800 by RN C. During an interview on [DATE] at 11:00 AM, RN C reported receiving a message from the facility and was advised not to answer any calls from the State until the facility was able to speak with RN C about the work days of [DATE] and [DATE]. Review of the facility policy/procedure Abuse and Neglect, last revised [DATE], revealed: POLICY- It is the policy of this facility to provide professional care and services in an environment that is free from any type of abuse .neglect or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. These guidelines include compliance with the (7) seven federal components of prevention and investigation. DEFINITIONS-Neglect is the failure to provide necessary and adequate (medical, personal, or psychological) care. Neglect is the failure to care for a person in a manner, which would avoid harm and pain, or the failure to react to a situation which may be harmful. Neglect may or may not be intentional. Examples of neglect include .Ignoring call lights or cries for help. If neglect/abuse is suspected the facility will: (1) take immediate steps to assure the protection of the resident's. This may involve separation from the alleged abuser .(2) Notify the appropriate/designated authority (State Agency) that an investigation is being initiated immediately following intervention for the resident's safety, (3) conduct a careful and deliberate investigation centering on facts, observations and statements from the alleged victim, (4) notify law enforcement authorities and press charges if indicated, (5) report the investigation findings to the appropriate State agencies, as required by law .the facility will investigate all allegations of abuse/neglect. the facility will protect resident's from harm during the investigation by- if the alleged perpetrator is an employees, the employee will be immediately suspended from working pending the result of the investigation. The alleged staff will not be allowed back to work until the final investigation is forwarded to the appropriate State Agencies. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], Regional Nurse Consultant (RNC) H was verbally notified and received written notification of the immediate jeopardy at F835, identified on [DATE] and that began on [DATE], due to the Administrator's failure to report and investigate the sudden and unexpected death of R800 and report and investigate an allegation of neglect. On [DATE] the surveyor verified the following interventions had been put into place and were effective to remove the immediacy: -On [DATE] the facility terminated the employment of RN C and reported the allegation of neglect to the State Agency -On [DATE] all resident's were rounded on by clinical staff and interviewed to ensure any allegations of abuse/neglect are immediately reported to the Administrator. The Administrator will immediately report any allegation of abuse/neglect to the State Agency. The Administrator will inform the Regional Director of Operations (RDO) of any allegation of abuse/neglect. The RDO will provide oversight to ensure adherence to the Abuse/Neglect Policy. -On [DATE] the Administrator and Director of Nursing will ensure all facility staff are interviewed to ensure any allegation of abuse/neglect had been reported to the Administrator. -On [DATE] the RNC educated the ADM and DON on the Emergency Situations and Care of Resident's Policy and Procedure. The DON then initiated educating nursing personnel on the Emergency Situations and Care of Resident's Policy and Procedure. Any staff absent will be in-serviced prior to their next scheduled shift. Special focus was given to staff (a) ensuring that each resident received timely medical attention to prevent neglect and (b) responding timely to emergency events. -The DON will review residents with acute changes in condition weekly and then monthly to ensure adherence to the Abuse/Neglect Policy and Procedure and the Emergency Situations and Care of Resident's Policy and Procedure. QAA committee will review audits for ongoing compliance. Although the immediate jeopardy was removed on [DATE], the facility remained out of compliance at a scope of isolated and severity of actual harm due the fact that not all facility staff have received education and sustained compliance has not been verified by the State Agency.