STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345126	A. Building B. Wing	03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	228 Smith Chapel Road Mount Olive, NC 28365

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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** 39731 Based on resident and staff interviews and record review the facility failed to treat a resident in a dignified manner when assistance was requested with toileting resulting in the resident feeling angry and frustrated for 1 of 6 resident reviewed for dignity (Resident #61). The findings included: Resident #61 was admitted to the facility on [DATE]. Resident #61 ' s admission Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact and was assessed as total dependence with activities of daily living including toilet use, locomotion, and personal hygiene. Review of a statement written by Nurse #2 on 3/17/22 revealed she overheard NA #3 tell Resident #61 to back it up in a very disrespectful manner on 3/17/22 at 4:30 PM. An interview was conducted with Resident #61 on 3/18/22 at 8:41 AM who stated on 3/17/22 at approximately 4:00 PM she requested assistance from Nurse Aide #3 (NA) to use the bedpan. NA #3 told her she would have to wait until she came back from her break. Resident #61 reported she saw NA #3 sitting at the nurse ' s station and she asked again to use the bedpan. The resident stated NA #3 got a lift and told Resident #61 to come on. The resident stated as NA #3 attempted to use the lift it was dangling in her face, and she was almost hit in her face and Resident #96 asked her to stop. She stated then NA #3 began to have a bad attitude and she asked for someone else to help her. Resident #61 called for Nurse #2 to help her. She reported she saw NA #3 go into Resident #387 ' s room and overhead her yelling and cursing at Resident #387. She reported she was angry and frustrated at the treatment she received from NA #3 but stated she was fine after the nurse aide left the building. During an interview with NA #3 she stated Resident #61 was in her doorway asking for a bed pan. She reported the resident stated two people were needed to assist. NA #3 stated someone walked by and she asked for her assistance. She further stated she asked Resident #61 to back up so she could get in the room. She added that she knew Resident #61 was able to push herself back. NA #3 stated Resident #61 told her she was unable to back up and that she didn ' t need to be so snappy. NA #3 stated she told Resident #61 to let it go. She further stated Nurse #2 told her that she was disrespectful when talking with Resident #61. NA #3 stated she was then asked to leave. (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	Attempts to interview Nurse #2 were unsuccessful on 3/18/22 at 9:00 AM, 10:30 AM and 1:00 PM. During an interview with NA #4 on 3/18/22 at 9:05 AM she stated she was asked by NA #3 to assist with Resident #61 on 3/17/22. She stated NA #3 was moving the lift around and overhead NA #3 tell the resident I am not going to go back and forth either get in bed and stay or not. She reported that she left the room at that point and went to the nurse ' s station. NA #4 stated she told Nurse #2 that NA #3 was talking rudely to the resident. She reported that after speaking with the nurse she pushed Resident #61 to the front of the building at Resident #61 ' s request. She reported she was present when Resident #61 described the incident and gave a statement as well to the Senior Nurse Aide. An interview was conducted with the Senior Nurse Aide on 3/18/22 at 10:10 AM she reported Resident #61 approached her at approximately 5:30 PM on 3/17/22 and told her that NA #3 talked rudely to her and behaved aggressively. She reported she asked for assistance with the bedpan and NA #3 told her she would have to wait until she went off break. She further stated Resident #61 indicated NA #3 became upset when she was not able to move her wheelchair. An interview was conducted with the Administrator on 3/18/22 at 8:30 AM. She reported an agency nurse aide spoke disrespectfully to a resident on 3/17/22 at 4:30 PM. She indicated it was reported and an investigation was begun. The Administrator stated the nurse aide had just started that day and was escorted out of the building after the incident.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on observations, record review, resident representative interview and staff interviews, the facility failed to update the care plan to address range of motion recommendations by physical therapy for 1 of 1 resident (Resident #79) reviewed for position and mobility. Findings included: Resident #79 was admitted to the facility on [DATE]. His diagnoses included brain stem stroke syndrome. The quarterly assessment dated [DATE] indicated no change in Resident #79's cognitive state and continued to require total assistance with all activities of daily living due to impairments to both upper and lower extremities. Resident #79's s care plan dated 2/3/2022 revealed a care plan focus for providing total care for all activities of daily living(ADLs), and interventions included assisting with bed mobility and mechanical transfers. A review of the Interdisciplinary Physical Therapy screening dated 2/16/2022 revealed Resident #79 had no functional movement and was dependent on nursing for movement. Treatments consisted of range of motion (ROM), functional motor movement and transfers, and nursing was educated on performing passive ROM while performing ADLs and repositioning in bed. Range of motion was not listed as a task in the resident care card on the electronic medical record for the nursing assistants to performed for Resident #79. Resident #79 was observed on 3/15/2022 at 3:48 p.m. lying on his right side with head of bed elevated. Both arms were observed extended straight at the elbows and rolled hand towels were positioned in both hands. Both lower extremities were extended straight at the knees and the feet were flexed in the downward position. On 3/15/2022 at 4:13 p.m. in an interview with Nurse #3, he stated the nursing staff did not have an order to perform range of motion on Resident #79, and he had not been informed by physical therapy to conduct passive range of motion for Resident #79. On 3/15/2022 at 4:30 p.m. in an interview with the Director of Nursing, she stated a recommendation from physical therapy for passive ROM would need an order and would be communicated to the nursing staff on the resident care card. She stated passive ROM was not listed on Resident #79's care card and was not on his care plan. She stated physical therapy should had informed the MDS nurse of the recommendation for passive range of motion to be added to Resident #79's plan of care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/16/2022 at 12:37a.m. in an interview with Nurse Aide(NA) #1, she stated she had performed range of motion on Resident #79 during his bath. She stated she had been a NA for over ten years and knew to perform ROM when residents were unable to move themselves. She stated ROM was not part of Resident #79 ' s care card, and she was not able to document in Resident #79 ' s electronic medical record ROM was conducted. On 3/18/2022 at 9:03 am in an interview with MDS Nurse #1, she stated physical therapy (PT) was unable to update resident care plans, and PT notified the MDS Nurse to update care plans. She stated she was not notified of the recommendation for ROM for Resident #79. She stated Resident #79 needed ROM, and ROM should had been added to his care plan as an intervention with ADLs.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41516 Based on record review and staff interviews the facility failed to complete non-pressure wound dressing changes as ordered by the physician for 1 of 2 residents reviewed for wound care (Resident #33). The findings included: Resident #33 was admitted to the facility on [DATE] with a diagnosis of venous insufficiency and lymphedema. The quarterly Minimum Data Set, dated dated dated [DATE] revealed Resident #33 was cognitively intact, and he was independent with activities of daily living. He had no pressure ulcers/injuries but was at risk for developing them. Resident #33 ' s care plan updated on 1/21/22 revealed he was care planned for chronic venous stasis, dermatitis of both lower extremities and risk for further skin breakdown related to limited mobility, shearing, and friction. A review of the physician orders for Resident #33 revealed the following order dated 3/9/22: cleanse wounds to left and right posterior thigh with wound cleanser, pat dry, apply a wound barrier to the surrounding tissue, apply a wound dressing to the wound bed and secure with gauze and a transparent dressing every day shift and as needed. A review of the Treatment Administration Record (TAR) revealed Resident #33 ' s dressing change was not documented as being completed on 3/15/22 and 3/16/22. On 3/14/22 at 10:00 AM an interview was conducted with Resident #33. He stated his dressing changes were not getting completed. On 3/17/22 at 10:37 AM an interview was conducted with Nurse #1 who worked with Resident #33 on 3/16/22. She stated she did not do the dressing change for Resident #33. She stated she ran out of time and didn ' t tell anyone his dressing needed changing. On 3/17/22 at 11:26 AM an interview was conducted with Nurse #2 who worked 3/15/22 and was caring for Resident #33. He stated he did not complete the dressing change for Resident #33. He stated he did not have time to do the dressing change and didn ' t recall if he let anyone know Resident #33 ' s dressing needed to be changed. A second interview was conducted with Resident #33 on 3/18/22 at 10:10 AM. He stated his wound care was completed on 3/17/22. An interview was conducted with the Director of Nursing on 3/18/22 at 10:36 AM. She stated she expected dressing changes to be completed as ordered and documented in the TAR.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41726 Based on observation, record review and resident and staff interviews, the facility failed to complete dressing changes for 1 of 2 residents (Resident #23) reviewed for pressure ulcers. Findings Included: Resident #23 was admitted to the facility on [DATE] with diagnoses which included lack of oxygen to the brain, heart failure, type II diabetes and stage IV sacral pressure ulcer. A review of the Admission Minimum Data Set (MDS) dated [DATE] revealed Resident #23 had moderate cognitive impairment and highly impaired vision. He understood others and was able to make himself understood. He had no behaviors directed towards others and no rejection of care during the look back period. The MDS assessment also revealed Resident #23 was admitted to the facility with a stage 4 sacral pressure ulcer. The assessment also revealed he required total assistance with two-person assist for transfers. A review of Resident #23's care plan last revised on 01/17/2022 revealed Resident #23 was care planned for being dependent for Activities of Daily Living (ADL) care for bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting related to limited mobility, anoxic brain injury, muscle spasms and severe muscle deconditioning. Resident #23 was also cared planned for increased nutrient needs related to wound healing of his pressure ulcer and decreased ability to feed himself. A review of the physician orders revealed an order was written on 12/22/2021 for Resident #23 to cleanse sacral pressure ulcer wound with skin integrity wound cleanser, apply calcium alginate to wound bed and secure with dry dressing every day on the 7a-3p shift. A review of Resident #23's Treatment Administration Record (TAR) for the month of December 2021 revealed the following dates were not documented as being completed: December 2, 2021 December 9, 2021 A review of Resident #23's Treatment Administration Record (TAR) for the month of January 2022 revealed the following dates were not documented as being completed: January 05, 2022 January 19, 2022 January 20, 2022 A review of the sacral would assessments for the months of December 2021 and January 2022 revealed the sacral pressure ulcer remained a stage IV. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the staff assignment sheets for the months of December 2021and January 2022 revealed Nurse #10 was assigned to Resident #23 on December 02, 2021, December 09, 2021 and January 5, 2022. Nurse #8 was assigned to Resident #23 on January 19, 2022 and January 20, 2022. An observation of a pressure ulcer dressing change on 03/18/2022 at 1:30 pm revealed physician orders were followed, and no concerns were identified. Attempts were made to reach Nurse #8 and Nurse #10 via phone but were unsuccessful because they no longer work at the facility and the phone numbers on record had been changed or unable to receive voice messages. An interview with Resident #23 on 03/15/2022 at 3:15 pm at 9:29 am revealed there were a few times when the nurses did not change his pressure ulcer dressing. Resident #23 stated he wasn't sure of the exact dates, but knew it was in late December and a few times in January. Resident #23 also stated he felt like the dressing changes had been getting done each day since then. An interview with the Director of Nursing (DON) on 03/17/2:09 PM revealed the nurses are responsible for completing the pressure ulcer dressing changes per physician order and documenting on the TAR that the dressing changes have been completed. The DON added the TARs for Resident #23 for the months of December 2021 and January 2022 indicated the pressure ulcer changes were not performed and stated, In nursing, if it's not documented it's not done.

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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** 39731 Based on observation, record review, police interview, and staff interviews the facility failed to prevent a resident with cognitive impairment and exit seeking behaviors from exiting the facility unsupervised on two occasions. On 1/30/21 Resident #125 exited the building from a first floor window and was found in a bush. This second incident on 5/21/21 resulted in Resident #125 being brought back to the facility by law enforcement after being found approximately a quarter of a mile from the facility. The facility also failed to implement the fall risk intervention of a fall mat at bedside (Resident #112), and to assess a resident (Resident #108) for safe smoking prior to allowing independent smoking and keeping smoking materials in her room. This was for 3 of 4 residents reviewed for accidents. Immediate Jeopardy began on 1/30/21 when Resident #125 exited the facility unsupervised through a first floor window. Immediate Jeopardy was removed on 9/1/21 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure interventions implemented are effective. Examples #2 and #3 were cited at scope and severity of D. Findings included: 1. Resident #125 was admitted to the facility on [DATE] with diagnoses that included dementia. Resident #125 ' s admission Minimum Data Set assessment dated [DATE] revealed she was moderately cognitively impaired with no behaviors. She was independent for bed mobility, transfers, walking, and locomotion on and off the unit. She was not coded for wandering. A nurse ' s progress note completed by Nurse #5 dated 1/24/21 revealed wandering occurred daily or almost daily. A wanderguard (an electronic alert system that alarms and locks the facility exit doors when cognitively impaired residents with wandering behaviors attempt to exit the building) was ordered on 1/24/21. There was no plan developed for Resident #125 for wandering when the wanderguard was initiated on 1/24/21. There were no elopement risk assessments completed for Resident #125 on admission or after the wanderguard was implemented on 1/24/21. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1a. A progress note written by Nurse #5 on 1/30/21 at 10:40 AM stated Resident #125 was seen at breakfast at approximately 8:30 AM on 1/30/21. When Nurse #5 went to administer medications at approximately 9:10 AM to Resident #125 she was not in her room. Nurse #5 did a sweep of the building twice and couldn ' t locate Resident #125. At that time Nurse #5 alerted her supervisor and an elopement alert (an elopement alert was when a building-wide alarm was activated notifying staff that a resident was unable to be located. All staff were to assist in searching the facility and grounds to locate the resident) was activated. Resident #125 was found outside of the window in the back of the building by Nurse #4. An event summary report completed by Nurse #4 for an incident on 1/30/21 read in part, Resident states she was going to her car to go home. Staff assisted her back inside facility, full body assessment completed. Resident placed on 1:1 observation due to elopement and resident had cut off wander guard prior to exiting facility. Compassionate care visit to be completed by family to assist in increased anxiety due to isolation from family [related to] COVID protocols. The report indicated during a full body assessment, scratches to lower extremities and hands were discovered. The event summary report also indicated Resident #125 was discovered missing at 9:10 AM on 1/30/21 and was found at 9:40 AM. Observation on 3/15/22 at 11:30 AM of the area behind the building where Resident #125 exited out of on 1/30/21 revealed an approximate two-foot drop from the window to the ground. The bushes outside the window were below the windowsill. The reported temperature on 1/30/21 was 35 degrees Fahrenheit at 9:00 AM (www.wunderground.com). The medical records department was approximately 25 feet from Resident #125 ' s room at the time. An interview was conducted with Nurse #4 on 3/15/22 at 11:20 AM who stated Resident #125 was found under a window in the back of the building. She reported the window was open. Nurse #4 stated Resident #125 was wearing a blouse and pants. Resident #125 had socks and shoes on. She reported Resident #125 ' s pants were pushed up to her knees as is the resident ' s usual preference. A phone interview was conducted with Nurse #5 on 3/15/22 at 1:52 PM who stated Resident #125 had attempted to exit the building since she was admitted to the facility on [DATE]. Nurse #5 stated she could not recall any details regarding Resident #125 being found in the bushes outside the back of the building. During an interview with the Corporate Maintenance Director (CMD) on 3/15/22 at 11:30 AM he stated a contractor was replacing some of the windows in the building on 1/30/21. He stated the windows in the Medical Records office had been replaced that day. The CMD reported when the contractor left, he zipped up the zip wall that had been placed at the door of Medical Records. Based on the investigation conducted by the facility it was determined Resident #125 entered the zip wall, opened the window, and pushed the window screen out to exit the building. She was found in the bushes under the window and the screen was ajar with the window raised. He reported locks were placed on the windows in the facility to ensure they are not able to be raised higher than six inches. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The care plan for Resident #125 had a focus area initiated 1/30/21 for wandering and at risk for elopement related to expressions of a desire to leave the facility and resident has made one or more attempts to leave the facility. Interventions included monitor resident ' s location with visual checks encourage participation in activity preferences, utilize and monitor security bracelet, and utilize diversional techniques to redirect resident when she verbalizes or exhibits the desire to leave the facility. During an interview with the Receptionist #1 on 3/16/22 at 10:01 AM she stated Resident #125 tried to exit the building daily since her admission. An interview was conducted with Receptionist #2 on 3/16/22 at 4:06 PM who stated she was familiar with Resident #125 and she did wander frequently. 1b. An event summary report prepared by Nurse #5 for an incident that occurred on 5/21/21 read in part, Dinner trays were served, and resident [Resident #125] was not able to be located for dinner. Resident had been refusing to be in her room for most of the day. Resident wanting to hang out in front lobby throughout the day. Resident last seen sitting in lobby on the couch. Staff completed a search throughout the building and notified proper authorities. Resident was located by local authorities and brought back to the facility. There were no injuries. A phone interview was conducted with Nurse #5 on 3/15/22 at 1:52 PM. She stated she recalled the resident had eloped and was brought back to the facility by the police on one occasion. Nurse #5 stated she could not recall any additional details about e the 5/21/21 incident. An interview was conducted with the facility Social Worker on 3/16/22 at 9:35 AM. She reported she observed Resident #125 on the afternoon of 5/21/21. She stated Resident #125 attempted to exit the building via the front door but was unable to do so due to her wander alarm at approximately 5:30 PM. She revealed she had not informed any other staff members that Resident #125 attempted to exit through the front door. The social worker indicated the receptionist was present and the wander alarm prevented her from opening the door so was not concerned at that time. The Social Worker stated she was in her office at approximately 5:55 PM and received a phone call from the kitchen staff regarding the alarm going off on one of the dining room doors. She stated she went to the dining room and found the door ajar and turned the alarm off. She stated she looked out the door but did not see anyone so returned to her office. The Social Worker stated she immediately recalled Resident #125 had been at the front door. The Social Worker stated she did not see Resident #125 so she asked the charge nurse to help locate her at 5:56 PM. Resident was unable to be found in the facility or on the grounds so local law enforcement was contacted. Resident #125 was returned to the facility at 6:33 PM by local law enforcement. The Social Worker stated she was advised by local law enforcement Resident #125 was located at the intersection of a nearby street. The resident was confirmed to be absent from the facility grounds for 38 minutes. She revealed the law enforcement indicated the location Resident #125 was found was across the highway. When measured by the corporate Maintenance Director the likely path taken by Resident #125 measured 1,407 feet (0.26 miles). Observation on 3/16/22 at 9:30 AM of the facility revealed the facility front door faced a two-lane highway with a speed limit of 35 miles per hour. The recorded temperature on 5/21/21 at 6:00 PM was 81 degrees Fahrenheit (www.wunderground.com). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with a former kitchen staff member on 3/16/22 at 7:00 PM she stated she recalled Resident #125 leaving the building on 5/21/21. She reported Resident #125 tried to enter the kitchen several times on that day. The kitchen staff member stated they locked the door to prevent Resident #125 ' s entry. She reported she was unaware of Resident #125 ' s exit from the building until the social worker contacted her after Resident #125 was discovered absent from the facility. She further stated the alarm on the dining room door was not her responsibility and was unaware Resident #125 exited from that door. The former kitchen staff member stated she did not advise anyone of Resident #125 ' s had attempts to enter the kitchen on 5/21/21. An interview with the local law enforcement agency on 3/15/22 at 4:05 PM revealed no report was filed by the agency and no one recalled the incident. The Administrator was notified of Immediate Jeopardy on 3/16/22 at 3:48 PM. On 3/18/22 the facility provided an acceptable credible allegation of Immediate Jeopardy removal that included: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: Facility failed to prevent Resident # 125 from exiting the facility unsupervised on 1/30/21 and 5/21/21. A. On 1/30/21, Resident #125 exited the facility through an open window in an unlocked office on Wing 3 that had been under construction. The window had been removed during construction and the construction crew working on this room had left the office door unsecured. Resident # 125 had last been seen at breakfast approximately 8:30 a.m. Nurse went to give a.m. medications and noted resident was not in room. Search initiated, unable to locate resident in the facility, search expanded to exterior and Elopement Code (overhead announcement of an elopement for all staff to respond according to policy to search for missing resident). called at 9:10 a.m. Staff members looked for resident and supervisor found resident outside in a bush behind the building outside of window, all belongings including clothes, walker and cane were outside as well. Resident assessed outside to determine if any major injuries incurred, resident able to move all extremities with no issue no gross injuries noted, resident escorted back inside, resident had total body check performed to further determine no injuries incurred, resident noted to have 2 scratches to right hand, 2 scratches to left hand and smaller scratches noted to bilateral lower extremities. ADON (Assistant Director of Nursing), DON (Director of Nursing) and administrator notified, family notified. Immediate Action for the 1/30/21 unsupervised exit included: An Immediate plan of correction was initiated on 1/30/21 which included placing resident # 125 on 1:1 supervision, followed by implementation of 15 minute checks. Resident #125 had an updated Elopement Assessment completed on 1/30/21 and Wander Guard alert bracelet was placed on resident. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	228 Smith Chapel Road Mount Olive, NC 28365

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility leadership completed a head count on 1/30/21 of all current residents and all residents were accounted for. The office door was locked to prevent further egress. Maintenance completed an egress audit on 1/30/21 to ensure all doors and windows were secure. Windows were secured with metal locking tabs. B. On 5/21/21 Resident # 125 resident exited the center through the dining room door. The dining room door alarmed at approximately 5:55 pm and the Director of Social Services responded, turned off the alarm, she then asked a nurse for assistance. At 5:58 Elopement Code was called and search initiated. Resident was unable to be located at the facility and the local Police Department as notified at 6:10 p.m. of a missing resident. Resident was found by the police and returned to the facility at approximately 6:33 p.m. Immediate Action for the 5/21/21 unsupervised exit included: On 5/21/21 Immediate plan of correction started and education initiated. On the evening of 5/21/21 the Maintenance Director came into the facility to inspect the dining room door and found the door plunger was malfunctioning and provided an immediate repair to the door. While in the facility on the evening of 5/21/21 the Maintenance Director completed an audit of all doors to ensure secure/function. On 5/21/21 Facility leadership completed a head count of all current residents and all residents were accounted for. Resident # 125 remains in the center and has had no Elopements since 5/21/21. Resident # 125 remains an Elopement Risk and has a Wander Guard alert bracelet. All residents who wander and those identified at risk for Elopement have potential to be effected. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. On 1/30/21 Maintenance Director added Window checks to the TELs system to ensure that windows are checked monthly. TELs system is an electronic system that maintenance work orders are entered into and routine maintenance assigned tasks are entered into and documented for compliance by the facility Maintenance Director. On 02/01/21 Education was completed on Elopement, by the Assistant Director of Nursing. This education included a review of the Elopement Policy and Procedure which includes: ensuring a heightened awareness with all staff of the residents at risk for elopement and the systemic measures to prevent unsupervised exits. Policy/ Procedure also includes monitoring and supervising residents who wander. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Wander Guard Audit completed on 1/30/21 and 5/21/21 by nursing leadership on residents identified at risk to ensure that the Wander Guard was on per order and that it was properly functioning, no concerns noted. On 5/21/21 Education was completed with dietary staff on responding immediately to alarms sounding, by the Assistant Director of Nursing. On 5/21/21 Re-Education was initiated on Elopement Policy, by the Assistant Director of Nursing for all staff to include full time, part time, as needed (PRN), and contracted staff. This education was a review of the Elopement Policy and Procedure which includes ensuring a heightened awareness with all staff of the residents at risk for elopement and the systemic measures to prevent unsupervised exits. Policy/ Procedure also includes monitoring and supervising residents who wander. Education completed on 5/28/21. Alleged Date of immediate jeopardy removal: 5/29/21 The credible allegation of immediate jeopardy removal was verified on 3/18/22 by onsite validation. During the verification process it was revealed training was not fully completed until 8/31/21. Staff were interviewed and confirmed they received training from the Assistant Director of Nursing and Corporate Maintenance Director pertaining to elopements. An observation on 3/18/22 at 9:00 AM revealed Resident #125 interacted with staff in the hallway. An interview was conducted with the Administrator on 3/17/22 at 5:15 PM who stated the last of the employees were educated on 8/31/21 by the Corporate Maintenance Director when an elopement drill was conducted. An interview was conducted with Maintenance Worker #1 on 3/18/22 at 9:23 AM. He confirmed he received education regarding elopements on 8/31/21 from the Corporate Maintenance Director. The facility ' s immediate jeopardy removal date was determined to be 9/1/21 based on the validation. 41726 2. Resident #112 was admitted to the facility on [DATE] with diagnoses which included chronic kidney disease, cerebral vascular infarction with hemiplegia (CVA), diabetes mellitus and hypertension. Resident #112 had a history of falls. The Annual Minimum Data Set (MDS) dated [DATE] revealed Resident #112 was cognitively intact and demonstrated no moods or behaviors. He required extensive assistance with 1 staff physical assistance with bed mobility related to one-side impairment for upper and lower body, transfer, dressing and toileting. A review of the care plan dated 03/02/2022 revealed Resident #112 was at risk for falls related to CVA with hemiplegia, lack of safety awareness, a history of falls, and required 1 staff assist with transfers. Interventions included a floor mat to the left side of his bed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility falls incident report dated 03/06/2022 revealed Resident #112 attempted to transfer from his bed to electric wheelchair and the wheelchair was not locked. The wheelchair rolled backward, and Resident #112 fell on the floor. Education was provided to Resident #112 to make sure his wheelchair is turned off and locked before transferring to and from the wheelchair. The report also revealed there was not a fall mat beside his bed at the time of the fall. An interview with Resident #112 on 03/15/2022 at 11:55 am revealed he remembered his fall on 03/06/2022 when he tried to get in his electric wheelchair from his bed. He stated he thought he could do it himself, but he didn't make it. An interview with Nurse #3 on 03/15/2022 at 12:06 pm revealed Resident #112 had a recent fall on 03/06/2022 after he attempted to transfer to his electric wheelchair from his bed, the wheelchair rolled out from under him, and he fell . Nurse #3 stated there was not a fall mat beside Resident #112's bed at the time of the fall. Interview with Nurse #6 on 03/17/2022 at 9:09 am revealed Resident #112 had moved rooms on 03/11/2022 and his fall mat didn't make it to his new room and was aware he was care planned to have a fall mat beside his bed. Interview with the Director of Nursing (DON) on 03/17/2022 at 9:17am revealed Resident #112 should have had a fall mat beside his bed as outlined in his care plan. The DON stated nursing is responsible for making sure the care plans are followed. 44377 3. Review of the facility's smoking policy reviewed 11/4/19 indicated that the admitting nurse would conduct a Smoking Evaluation on all persons wishing to smoke, the person would only be able to smoke with direct supervision until evaluated by the interdisciplinary team, smoking status would be documented in the Care Plan, and if deemed independent, the resident would not be able to maintain own cigarettes and lighters unless the facility chose to provide a lock box. Resident #108 was admitted to the facility on [DATE] with diagnoses that included cancer and lung disease. Resident #108's admission Minimum Data Set (MDS) indicated she was cognitively intact and independent for transfers, locomotion on and off unit, and other activities of daily living. Her MDS did not indicate tobacco use. A Nursing Admission assessment dated [DATE] revealed Resident #108 used tobacco products daily or almost daily for the past year. A Quarterly Recreation Progress Note dated 3/1/22 indicated that Resident #108 enjoyed smoking. Record review for Resident #108 did not reveal a Smoking Evaluation. Record review of Resident #108's Care Plan did not indicate she used tobacco. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation on 3/16/22 at 10:25 AM, Resident #108 were observed smoking in the designated smoking area of the courtyard. During an interview on 3/16/22 at 10:30 AM, Resident #108 revealed she was able to smoke independently, and she kept her cigarettes and lighter in her room in her drawer or her jacket pocket. She indicated she received instruction from the other residents not to share cigarettes with other residents. She had not received instructions from staff or been asked about her smoking. During an interview on 3/16/22 at 11:10 AM, the Director of Nursing (DON) indicated that independent smokers were encouraged to provider lighters to staff to put into a lock box. She revealed residents are asked at admission if they smoked and the admitting nurse would complete a Smoking Evaluation. During an interview on 3/18/22 at 9:20 AM, Nurse #1 revealed when she had filled out the Admission Nursing Assessment, Resident #108 said she was going to quit smoking since she had been in the hospital for so long. Nurse #1 indicated she did not fill out the Smoking Evaluation because Resident #108 said she was not going to smoke. She further revealed she did not know when Resident #108 started smoking again because she no longer worked on that floor. During an interview on 3/18/22 at 9:25 AM, Resident #108 revealed she had been smoking in the facility since the day after she arrived. She indicated she had not had an intention to quit smoking. During an interview on 3/18/22 at 9:50 AM, the Administrator indicated most residents did not have the lock boxes in their room and were able to keep the cigarettes in their room but were encouraged to give lighters to staff. She further revealed the smoking policy likely needed to be revised to better fit the facility. The administrator revealed that Resident #108 had only recent started smoking again and that was why she did not have Smoking Evaluation completed.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41726 Based on record reviews, observation and staff interviews, the facility failed to flush a resident's feeding tube between the administration of medications as ordered by the physician for 1 of 1 resident reviewed for feeding tube (Resident #84). Findings included: Resident #84 was admitted to the facility on [DATE] with diagnoses which included gastrostomy and cerebral infarction. A review of Resident #84's physician order dated 11/05/2021 revealed to flush feeding tube with 30 milliliters (MLs) of water between each medication. A review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #84 had severe cognitive impairment. The MDS also revealed Resident #84 was coded to have consumed 51% or more of his nutrition via feeding tube. A review of Resident #84's care plan last revised on 03/01/2022 revealed resident had an enteral feeding tube to meet his nutritional needs due to dysphagia with an intervention that included checking patency and placement of tube daily and before administering feedings and medications. An observation of Nurse #7 on 03/14/2022 at 10:32 am revealed she administered 4 of Resident #84's scheduled medications, apixaban 5mg, levetiracetam 500mg, lisinopril 20mg and paroxetine 10mg, without flushing in between each medication. An interview with Nurse #7 on 03/14/2022 at 11:06 am revealed she knew Resident #84's orders were to flush 30 MLs of water in between each medication but she didn't want to overload him with fluid. Nurse #7 stated she should have followed the physician order. An interview with the Director of Nursing on 03/18/22 at 12:13 PM revealed the physician orders should have been followed by flushing 30 MLs of water between each medication.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on observations, record review and staff interviews, the facility that was located in a county with a high COVID-19 transmission level failed to implement their infection control policy and procedures and the Center for Disease Control and Prevention Guidance for COVID-19 when (1) Nurse #3 failed to wear a N-95 mask, gown and eye protective wear when performing tracheostomy suctioning and care and failed to perform hand hygiene after removing gloves for 1 of 1 resident (Resident #79) reviewed for respiratory care and (2) when COVID-19 screening was not performed for Physician Assistant #1 prior to entering the resident care area. This occurred during a COVID-19 pandemic. Findings included: 1. The Center for Disease Control and Prevention Infection Control Guidance dated February 2, 2022 stated if SARS-CoV-2 infection was not suspected in a patient presenting for care, the healthcare personnel (HCP) should follow standard precautions, and if working in facilities located in counties with a substantial or high COVID -19 transmission level, the HCP should also use a NIOSH approved N-95 or equivalent or higher level respirators should be used for all aerosol-generating procedures, and eye protection should be worn during all patient care encounters. The Center for Disease Control and Prevention Recommendations for Application of Standard Precautions for the Care of all Patients in all Healthcare Settings dated 2007 recommended use of gown, gloves, mask and eye protection during procedures when secretions were anticipated. The facility's Tracheostomy Care policy dated revised 7/15/2021 stated supplies included personal protective equipment (PPE) as indicated and gloves. The policy also stated cleansing the hands after removing gloves. On 3/15/2022 at 3:48p.m., Nurse #3 was observed providing Resident #79's suctioning and tracheostomy care wearing a surgical face mask, his personal eyeglasses and sterile gloves. Nurse #3 was observed conducting tracheostomy suctioning at three different intervals due to Resident #79 experiencing coughing episodes after suctioning was performed and removing sterile gloves four different times while performing suctioning and tracheostomy care on Resident #79 and not performing hand sanitation before applying a new pair of sterile gloves. On 3/15/2022 at 4:13 p.m. in an interview with Nurse #3, he stated he had received education on the use of personal protective equipment and when performing aerosol procedures on Resident #79, a gown, gloves, eye protective wear and N-95 mask were required. He stated he did not wear a gown, eye protective wear or N-95 mask because Resident #79 did not leave the room and had tested negative for COVID-19. Nurse #3 also stated hand sanitation was required when changing gloves and he did not perform hand sanitation when removing his gloves every time. On 3/15/2022 at 4:30 p.m. in an interview with the Director of Nursing/Interim Infection Preventionist, she stated hand sanitation or hand washing was required between changing gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/16/2022 at 6:06 a.m. in an interview with the Director of Nursing/Interim Infection Preventionist, she stated Nurse #3 should had worn full PPE (gown, gloves, N-95 mask and eyewear protection) when providing tracheostomy care and suctioning. 41516 2. A review of the facility ' s COVID-19 Prevention Program updated July 2021 stated all employees, visiting healthcare personnel and visitors must be screened prior to entry into the facility. On 3/14/22 at 9:20 a.m., Physician Assistant #1 (PA) was observed entering the facility without wearing a face mask or eye protective wear, walking past the screening area in the lobby and down the resident care hallway passing resident rooms #11, #12, #13, #14, and #15. On 3/14/2022 at 11:23 a.m., an interview was conducted with the PA #1. He stated he knew he was supposed to enter the facility with a face mask on and was to perform a COVID-19 screening prior to entering the hallway into the resident care areas. He stated he didn ' t perform the COVID-19 screening because there were a lot of people standing in the lobby, and he didn ' t know what was going on. He stated he put his face mask on when he arrived at nurse ' s station #2 which was located across from resident room [ROOM NUMBER]. On 3/18/2022 at 10:36 a.m., an interview was conducted with the Director of Nursing. She stated everyone, including healthcare workers, who entered the facility were expected to complete a COVID-19 screening.