STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675229	A. Building B. Wing	07/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Manor Nursing and Rehabilitation	99 Rigby Owen Rd Conroe, TX 77304

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26454 Based on observation, interview, and record review, the facility failed to immediately consult with the resident's physician and notify, consistent with his or her authority, the resident representative when there was a significant change for 1 of 18 residents (Resident #7) reviewed for notification of changes. The facility failed to consult Resident #7's physician when she developed a blister/boil on her chest near her dialysis port. The facility failed to notify Resident #7's responsible party for three days when she was transferred to the hospital with symptoms of infection on 07/11/2022. These failures could place residents who experience a change in condition at risk of delay in treatment, responsible not being informed in care decisions, and further harm or injury. Findings include: Record review of Resident #7's face sheet revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. She was diagnosed with stage 4 (severe) chronic kidney disease, cognitive communication deficit (an impairment in organization/thought organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and necrotizing fasciitis (a serious bacterial infection that destroys tissue under the skin). Record review of Resident #7's MDS dated [DATE] revealed she had a BIMS score of 15 (cognitively intact); she required extensive physical assistance from at least one staff member for bed mobility, locomotion, personal hygiene, and transfers (at least two staff); she was totally dependent on staff for dressing and toilet use; she was always incontinent of bowel and bladder; and she had moisture associated skin damage (incontinence-associated dermatitis, perspiration, drainage). Record review of Resident #7's care plan, updated on 07/05/2022 revealed, Skin (Goal: Prevent/heal pressure sores and skin breakdown, Approach: . Report to charge nurse any redness or skin breakdown immediately) ., Infection Alert (Goal: Resolve Infection, Approach . Monitor for s/sx of infection, Monitor wound/lesion status and progress) ., General . (Approach . I prefer to take my bath/shower on [MWF] My preferred time to bath/shower is [6a - 6p] . Oral care: Twice a day 6:00 a.m. - 2:00 p.m., 2:00 p.m. - 10:00 p. m .) . (continued on next page)

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

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #7's progress notes for July 2022 revealed: On 07/06/2022 at 1:41 p.m., LVN H wrote, Sent message to NP to see what we needed to do for blister on resident's chest. Waiting on a call back. Called resident's family member who states that he is going to dialysis with her Friday . On 07/11/2022 at 11:00 p.m., LVN E wrote, This nurse answered call light, resident with complaint of not feeling right, + body chills, body aches, temperature is 102.8, blood pressure 147/65, pulse 98, respirations 20, slight shortness of breath and nurse raised head of bed, O2 saturation 86%, O2 placed on resident 2L and O2 improved to 92%. Resident states that dialysis may have given her an antibiotic during dialysis today but was not 100% sure. No information returned from dialysis with patient concerning this matter. Resident stated that it had to do with her blister. Resident showed this nurse an area in the center of her chest 2 inches to the left of her port (dialysis port) that was enlarged approximately 3x2 cm with irregular reddened borders, discolored areas throughout with darkened brown and mild greenish, no drainage or smell noted at this time. A thin clear scab layer present. Fluid filled in several areas throughout. Resident with complaints of tenderness and discomfort to area with touch. PRN Tylenol given at this time, and NP notified. New orders received: Rocephin 1 gram IM now x1, stat chest x-ray 2 views, and labs, Doxycycline 100mg by mouth twice per day for 7 days On 07/11/2022 at 11:20 a.m., LVN E wrote, Nurse at bedside with resident updating on plan of care, preparing antibiotic IM injection and resident explained that she is feeling very much off and she feels scared requesting to go ahead and go to hospital. NP was called back and informed of resident request. New order to send resident to ER to evaluate and treat was given. And transport was called at this time. On 07/12/2022 at 1:04 p.m., RN I wrote, Called hospital and spoke with RN. Resident remains in ER. Nursing waiting for a bed to come available. RN informed this nurse that they have completed a swab to test for virus. Resident currently has an Infectious Disease (infectious disease doctor) on her case to find out the location of infection and type. Noted that resident would remain in hospital for at least 48 hours for test results. Informed NP. On 07/13/2022 at 8:30 a.m., LVN J wrote, Resident's family called to see if patient was going to dialysis. He was unaware that she was in the hospital. Resident's family member was made aware of her situation and that she is at hospital receiving dialysis treatments and an antibiotic regimen. Observation and interview with Resident #7 on 07/08/2022 at 3:18 p.m. revealed she was alert, oriented, and could self-propel herself in a wheelchair. In an interview with a representative from Resident #7's dialysis center on 07/19/2022 at 12:45 p.m., she stated Resident #7 was currently in the hospital (as of 07/11/2022). She said on 07/06/2022, Resident #7 disconnected her dialysis line and started to bleed. She said the dialysis center's team stopped the bleeding, but while they were cleaning Resident #7 up, the team noticed a large boil in the center of her chest. She said one of the dialysis center staff called the facility and informed them (the facility staff notified was not identified) about the boil because if it burst, it could cause an infection. The representative said Resident #7 was in the hospital because the boil burst and was infected. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	In an interview with the Interim Administrator and Interim DON on 07/19/2022 at 2:45 p.m. the Interim Administrator and Interim DON stated neither of them were made aware of Resident #7's boil. In an interview with Resident #7's NP on 07/19/2022 at 3:15 p.m., she said she never received any text or other notification regarding Resident #7 on 07/06/2022. She said on 07/11/2022, she received a text message from facility staff at 10:23 p.m. The NP said she ordered an antibiotic injection for Resident #7 because she had symptoms of infection. She said she was only going to treat the infection in-house because she knew Resident #7 would have to pay out-of-pocket at the hospital. She said she called the nurse back and told her Resident #7 may need to go to the hospital because she was recently agitated at dialysis. The NP said previously, Resident #7 was agitated when she had an infection and went to hospital. The NP said Resident #7 tried to pull her lines out at dialysis, so they had to get a family member to go sit with her. She said had the facility initially notified her about Resident #7's boil, she would have given an order based on what the boil looked like. She said at the very least, she would have ordered something topical for the boil. The NP said she called the dialysis center, and they said the boil burst on location. In a telephone interview with Resident #7's RP on 7/20/22 at 11:53 a.m., he said recently, someone had to go with Resident #7 to dialysis to babysit her because she started taking the dialysis lines out while the machine was pumping her blood and there was blood everywhere. He said Resident #7 did some crazy things and she did the same thing (pulled her lines out during dialysis) at the hospital last Wednesday (07/13/2022). He said he did not know if Resident #7 was still in the hospital. He said the facility did not call him to let him know Resident #7 was in the hospital. He said when he called the facility on 07/13/2022 to make sure he still had to go sit with Resident #7 for dialysis, a facility staff member (unidentified) told him Resident # #7 had been in the hospital since Monday, 07/11/2022. He said Resident #7 was diagnosed with an infection that started in her chest. He said he looked at the sore Resident #7 had on her chest. He said if he had not called the facility, he would not have known Resident #7 was in the hospital. Record review of the facility's policy, Change in a Resident's Condition or Status revised 02/2021 revealed, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medial/mental condition and/or status . Policy Interpretation and Implementation. 1. The nurse will notify the resident's attending physician or physician on call when there has been a (an): . d. significant change in the resident's physical/emotional/mental condition; . g. need to transfer the resident to a hospital/treatment center . 2. A significant change of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions . 4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: . b. there is a significant change in the resident's physical, mental, or psychosocial status . e. it is necessary to transfer the resident to a hospital/treatment center . 5. Except in medical emergencies, notifications will be made within twenty-four hours of a change occurring in the resident's medical/mental condition or status .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32677 Based on observation and interview, the facility failed to ensure residents who were on the isolation and Covid -19 Unit who were unable to carry out activities of daily living (ADLs) received the necessary services to maintain good personal hygiene, for 9 of 9 residents in the isolation and Covid unit (Resident#1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, Resident #8, and Resident #9) reviewed for ADLs as evidenced by: The facility failed to provide Resident's #1, #2, #3, #4, #5, #6, #7, #8 and #9 who were all dependent on staff for showers/baths and oral care for ADL's while on the isolation and Covid positive unit. This failure could place residents in isolation that required assistance with ADLs at risk of depression, lower moral, dental cavities, infections, skin breakdown, and a decline in their quality of life. Findings include: Resident #1 Record review of Resident #1's face sheet revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. She was diagnosed with dementia (the loss of cognitive functioning [thinking, remembering, and reasoning] to such an extent that it interferes with a person's daily life and activities) with behavioral disturbances, muscle wasting and atrophy, and reduced mobility. Record review of Resident #1's MDS dated [DATE] revealed she had a BIMS score of 8 (mild cognitive impairment); wandering behaviors were not exhibited; she required extensive physical assistance from at least two staff for bed mobility, transfers, dressing, toilet use, and personal hygiene; she was totally dependent on staff for bathing and locomotion; she was wheelchair bound; and she was always incontinent of bowel and bladder. Record review of Resident #1's Comprehensive care Plan dated 6/15/22 revealed the resident she was diagnosed with dementia and resided in the secure unit. The goal was that Resident #1 will wander about unit without occurrence of any injury. Resident #1's Dental Care plan was identified with the goal to maintain oral hygiene/status and the approach was her dentures, assess oral cavity, evaluate need for dental exam, dentures were to be marked for personal identification, and oral care twice a day. -The resident had an ADL deficit and the approach was requiring assistance with ambulation/transfers, toileting and eating with one staff assisting and she needed dressing/grooming assistance with 2 staff assisting her. Resident also needed assistance with bathing and hygiene, Approach was identified as preferring to take her bath/shower on Monday, Wednesday, and Friday's from 6p.m. to 6 a.m. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review Of Resident #1's progress notes dated07/05/2022 at 5:21 p.m., written by LVN H indicated Nurse called RP and let them know that there are new cases of COVID-19 and that resident that was positive is in COVID-19 unit and this resident will be moved to COVID-19 unit (Resident #1's roommate, Resident #6, tested positive for COVID-19, so Resident #1 was moved to the warm zone on the 100 Hall). Observation and interview with Resident #1 and TCN A on 7/8/22 at 4:09 p.m., revealed Resident #1 turned sideways in the bed hanging out of the bed upon walking up to the room TCNA A rushed to assist Resident #1 to put her legs back in the bed. TCNA A said the facility informed her of Resident #1's accident where she fell and had to get staples in the back of her head yesterday, 7/7/22. There were spots of blood on Resident #1's pillow. Resident #1 had dried blood and 5 staples on her head and hair. Resident #1's hair was matted with blood. Resident #1 said she had not had a shower or a bed bath since she had been in isolation, and no one did oral care. Resident #1 said she did not have teeth, but no one cleaned her mouth. TCNA A said she did not get any help. She said she came from working in the kitchen and into the training program for a CNA. The TCNA said Resident #1 had not received a bed bath or oral care. Resident #2 Resident #2 - Record review of Resident #2's face sheet revealed she was an [AGE] year-old female who was admitted to the facility on [DATE]. She was diagnosed with Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), COVID-19 acute respiratory disease, abnormalities of gait, lack of coordination, and abnormal posture. Record review of Resident #2's MDS dated [DATE] revealed she had a BIMS score of 2 (severe cognitive impairment); wandering behaviors did not exist; she required supervision for set-up only with bed mobility, transfers, walking in room and corridor, locomotion on and off the unit, eating, and toilet use; she required limited physical assistance from one staff for dressing, personal hygiene, and bathing; she ambulated with the assistance of a walker; she is occasionally incontinent of bladder and frequently incontinent of bowel; she did not have a history of falls Record review of Resident #2's care plan, updated on 07/13/2022, revealed she resided in the facility's secured unit due to elopement risk; Resident #2 required dental care, goal was to maintain oral hygiene/status and the approach was to assess oral cavity, evaluated need for dental exam and to provide oral care twice a day; Problem (ADL Funciona/Rehabilitation Potential) with goal set as resident will achieve maximum functional mobility and approach was ambulation/transfers amount of assist, bathing/hygiene amount oof assist, consult PT, OT, ST as needed, dressing/grooming amount of assist: limited, eating amount of assist: limited, resident care as per facility protocol. Record review of Resident #2's progress notes dated 06/29/2022 at 4:30 p.m., written by RN I indicated Called and notified RP that during COVID-19 testing this morning, patient tested positive and would be moving to the COVID-19 hall . Interview on 7/8/22 at 4 p.m. with Resident #2 and TCNA A Resident #2 said she had not had a shower or a bed bath and no one did oral care since she had been in the Covid Unit. Resident #2 said that she wanted a bath, and no one brushed her teeth. The TCNA A said the resident had not had a bed bath or oral care since she had been in the isolation unit. TCNA said none of the residents in isolation have received a bed bath or oral care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #3 Record review of Resident #3's face sheet revealed she was a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. She was diagnosed with cerebrovascular disease (Stroke), dysphagia (difficulty swallowing), cognitive communication deficit (an impairment in organization), post viral fatigue syndrome lack of energy), abnormality of gait (difficulty walking), poly osteoarthritis(joint disease involving at least 5 joints.), Alzheimer's disease (neurodegenerative disease affecting the brain), and vascular dementia with behavioral disturbance (changes to memory, thinking and behavior),. Record review of Resident #3's MDS dated [DATE] revealed she had a BIMS score of 3 (severe cognitive impairment); she required supervision for one person assist for locomotion on and off unit, and eating set-up only with bed mobility, transfers, dressing, toilet use, and personal hygiene she required limited physical assistance from one staff; she was totally dependent on staff for bathing with 2 person assist; she is always incontinent of bladder and bowel; she had a history of falls. Record review of Resident #3's Care Plan dated 6/22/22 revealed she was at risk of skin breakdown due to impaired mobility, incontinence and diabetes mellitus. Resident #3 was revealed have to prefer her bath/shower and oral care (Approach) on Monday, Wednesday, and Friday from 6 a.m. to 6 p.m. and oral care was to be twice a day on 6 a.m. to 6 p.m. and 6 p.m. to 6 a.m. Resident #3 needed assisting with bathing/dressing/grooming, transferring, toileting and bed mobility with one person assisting her (Approach). Observation and Interview on 7/8/22 at 4:18 p.m. with Resident #3 and TCNA A revealed Resident #3 sitting up in her wheelchair. Resident #3 was asked several questions, but she did not answer this surveyor. TCNA A said Resident #3 has not had a bed bath or shower and that she had been in isolation since before last Wednesday, June 29th, 2022. TCNA A said the residents do not receive a bath or shower in isolation and she was not supposed to work with the residents alone because she was in training. Resident #4 Record review of Resident #4's face sheet revealed she was a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. She was diagnosed with end stage renal disease (kidney stopped functioning appropriately), dependent on renal dialysis (a procedure to remove waste from the blood, and excess fluid), wedge compression fracture of third lumbar vertebra, dysphagia (difficulty in swallowing), personal history of Covid-19, abnormality of gait (difficulty walking), muscle wasting and atrophy, disturbance of salivary secretion (dry mouth), hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side (stroke). Record review of Resident #4's MDS dated [DATE] revealed she had a BIMS score of 15 (cognitively intact); she required extensive assistance with bed mobility, transfers, dressing from two staff , and personal hygiene she required extensive assistance from one staff; she was totally dependent on staff for bathing with 2 person assist; she is always incontinent of bladder and bowel. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's Care Plan dated 6/10/22 revealed she required assistance with her dentures and the approach was she preferred bath/showers on Monday, Wednesday and Friday from 6 a.m. to 6 p.m. and oral care twice a day 6 a.m. to 6 p.m. and 6 p.m. to 6 a.m. She has contractures at the bilateral hip flexors and is at risk for skin break down, increased pain from affected areas and injuries so the approach was Resident #4 required repositioning every 2 hours, the areas needed to be kept clean and dry and provide range of motion. Interview on 7/8/22 at 3:53 p.m. with Resident #4 she said today was her 3rd day back in isolation because she went into isolation on 7/5/22. Resident #4 said she came from the hospital and all the residents have to stay 10 days in isolation before being allowed to go to their rooms. She said she had not had a shower, or a bed bath and the facility staff did not brush her teeth. Resident #4 said she did want to receive a bath and it bothered her to not have one. She said the staff change her briefs and give her medication. Resident #5 Record review of Resident #5's face sheet revealed she was an [AGE] year-old female who was admitted to the facility on [DATE]. She was diagnosed with Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), muscle wasting and atrophy, cognitive communication deficit (an impairment in organization/thought organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and dementia with behavioral disturbances (the loss of cognitive functioning [thinking, remembering, and reasoning] to such an extent that it interferes with a person's daily life and activities. Record review of Resident #5's MDS dated [DATE] revealed she had a BIMS score of 3 (severe cognitive impairment); she required extensive physical from at least one staff member for bed mobility, dressing, and personal hygiene; she required limited physical assistance from at least one staff member for transfers, toilet use, and bathing; she was independently ambulatory; and she was occasionally incontinent of bowel and bladder. Record review of Resident #5's care plan updated 07/13/2022 revealed problem with ADL functional/rehabilitation and the approach was for personal hygiene AM Care: Resident will brush teeth, wash face and comb hair with supervision assistance. Every shift, shift 1- 6 a.m. to 6 p.m., shift 2 6 p.m. to 6 a.m. Assist with repositioning routinely and with residents request for use of pillows for comfort/support, assist with transfers as needed. Encourage resident to use call light to give frequent reminders to request assistance for safety, dressing: one assist, offer choices of clothing, and encourage resident to participate as able, encourage independence, praise when attempts are made, grooming/hygiene: one assist, give shower, shave, oral, hair, nail care per schedule and as resident requests General problem revealed approach Resident #5 preferred to take her bath/shower on Tuesday, Thursday and Saturday from 6 p.m. to 6a.m. once a day. Record review of Resident #5's progress noted dated 07/02/2022 at 7:06 a.m., written by LVN J indicated Resident tested positive for COVID-19 infection. Resident has a cough and a runny nose. She is already on isolation due to previous exposure. Will continue to monitor. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with Resident #5 on 07/20/2022 at 11:30 a.m. in the locked memory care unit revealed she was in bed. Resident #5 was alert but was somewhat confused. Resident #5 said she did not have a shower or bed bath while in isolation and that she washed herself. She said the staff did not brush teeth daily and that she wanted to brush her teeth, but someone kept taking her toothbrush. Resident #5 said she took her finger and washed teeth. She said the facility gave her a rag to wash and she washed herself when she could find a towel, but she did not have soap. Resident #5 said there was not always any staff in isolation. Resident #5 said she did not like it, period for not receiving a bath and she felt unclean. Resident #6 Record review of Resident #6's face sheet revealed she was an [AGE] year-old female who was admitted to the facility on [DATE]. She was diagnosed with dementia without behavioral disturbances (the loss of cognitive functioning [thinking, remembering, and reasoning] to such an extent that it interferes with a person's daily life and activities), muscle wasting and atrophy, and cognitive communication deficit (an impairment in organization/thought organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). Record review of Resident #6's MDS dated [DATE] revealed she had a BIMS score of 4 (severe cognitive impairment); she required limited assistance from at least one staff member for bed mobility, dressing, toilet use, and personal hygiene; she was totally dependent on staff for bathing; she was independently ambulatory with a cane; she was occasionally incontinent of bladder and frequently incontinent of bowel. Record review of Resident #6's care plan, updated on 07/07/2022 revealed problem for dental care and the approach was to monitor oral status as needed, oral care twice a day; problem: ADL functional/rehabilitation potential and the approach was ambulatory/transfers amount of assist: one person assist. Encourage/remind resident to ask for assistance for safety. Keep call light within reach, bathing/hygiene amount of assist: 1, dressing/grooming amount of assist: 1, eating amount of assist: set up help and toileting amount of assist: 1. General (problem) and approach revealed resident preferred to take her bath/showered, and nail care on Monday, Wednesday and Friday from 6 a.m. to 6 p.m., Oral care twice a day from 6 a.m. to 2 p.m. and from 2 p.m. to 10 p.m. Record review of Resident #6's progress note dated 07/05/2022 at 5:17 p.m., written by LVN H indicated Nurse called RP and let them know that there are new cases of COVID-19 and that resident is positive and will be moved to COVID-19 unit. Record review of Resident #6's progress note dated 07/16/2022 at 5:17 a.m., written by LVN E indicated Resident has completed COVID-19 quarantine, pending room change. Resident #7 Record review of Resident #7's face sheet revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. She was diagnosed with stage 4 (severe) chronic kidney disease, COVID-19 acute respiratory disease, cognitive communication deficit (an impairment in organization/thought organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), reduced mobility, and necrotizing fasciitis (a serious bacterial infection that destroys tissue under the skin). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #7's MDS dated [DATE] revealed she had a BIMS of 15 (cognitively intact); she required extensive physical assistance from at least one staff member for bed mobility, locomotion, personal hygiene, and transfers (at least two staff; she was totally dependent on staff for dressing and toilet use; she was always incontinent of bowel and bladder; and she had moisture associated skin damage (incontinence-associated dermatitis, perspiration, drainage). Record review of Resident #7's care plan, updated on 07/05/2022 revealed, General . (Approach . I prefer to take my bath/shower on [MWF] My preferred time to bath/shower is [6a - 6p] . Oral care: Twice a day 6:00 a. m. - 2:00 p.m., 2:00 p.m. - 10:00 p.m .) . Interview on 7/8/22 at 3:18 p.m. with Resident #7 she said she did not get bed baths in isolation and no one provided oral care. Interview on 7/19/22 at 11:54 a.m. with Ombudsman she said the resident's hair had to be shaved from her head recently because it was so mated, and the facility had not provided care to Resident #7's hair. Interview on 7/19/22 at 12:45 p.m. with local Dialysis Social worker she said does not know when Resident #7's hair was shaved. Resident #7's family member started coming to sit with her at dialysis on 7/8/22 and he said they had an issue with the facility brushing Resident #7's hair and he had shaved it because it was matted. The Social worker said the facility was sending Resident #7 to dialysis in a shower cap. The Social Worker said they did speak with the facility for not combing Resident #7's hair and after that they started sending her in a shower cap. The social worker said Resident #7 was in the hospital now because on 7/6/22 she disconnected her line and started to blead and the team got it stopped. When they were cleaning her up, they noticed a large boil in the center of her chest. The Dialysis center called the DON and told her about the boil and that they needed to look at it. If the boil burst, it could cause infection and that is what happened. Resident #7 was now in the hospital for the infection now. Telephone interview on 7/20/22 11:53 a.m. with Resident #7's family member said Resident #7 was in the hospital prior to coming to the facility and Resident #7's hair was all knotted up where she had been laying since November. Recently he decided to cut her hair to take all the knots out of her hair. The family member said he did not know if they were not showering the residents. He made the decision to get her hair cut and they cut all the knots out. He was tired of seeing the knots in her hair. He cut her hair in the middle of June 2022. The family member said he asked the facility, but they kept telling him that he needed to sign a release saying it was okay for them to cut her hair. He said the facility was not even washing her hair. He asked them many times to comb her hair and groom it. They said no they could not touch her hair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 7/19/22 at 2:30 p.m. with CNA M she said she had been working at the facility for one year, she was Certified and working the day shift. CNA M said she worked the COVID unit. She said she worked the warm unit. She said when she worked the warm unit, she was also assigned to another hall. CNA M said there was always supposed to be two people working in the isolation hall. She said they never left residents alone that she knew of and that there was always at least one person that she knew of. CNA M said Resident #7's hair was matted, the facility staff washed Resident #7's hair, and that was the first time ever giving her a shower, she did not know how long her hair had been like that. CNA M said she did wash Resident #7's hair but did not try to comb it. She said only the back of Resident #7's hair was matted. CNA M said Resident #7 did not get her hair cut that she knew of. She said she did not know if she ever asked anybody to comb it out. Resident #8 Record review of Resident #8's Face Sheet dated 7/8/22 revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included chronic obstructive pulmonary disease, post Covid-19 condition, muscle weakness, history of tracheostomy, thrombocytopenia, type 2 diabetes mellitus with hyperglycemia and hypertension. Record review of Resident #8's MDS dated [DATE] revealed she had a BIMS of 15 (cognitively intact); she required supervision set up for eating; activity did not occur for transfer, walk in room, walk in corridor, and locomotion on and off unit; total dependent for bed mobility, dressing and toilet use; extensive physical assistance from at least one staff member for personal hygiene; she was always incontinent of bowel and bladder; and she had cutaneous abscess of groin, muscle weakness (generalized), and bursitis of left shoulder. Record review of Resident #8's care plan, updated on 07/04/2022 revealed, Impaired Physical mobility route muscle weakness and she needed assistance with bathing/dressing/grooming, transfers, toileting, and bed mobility with one staff assisting; she needed assistance with set up for eating. Resident #8 needed assistance with ambulation/transfers, bathing/hygiene, dressing/grooming, and toileting amount of assist with 1 staff assisting. She preferred to take bath/shower on Tuesday, Thursday, and Saturday from 6 p.m. to 6 a. m. and oral care twice a day 6 a.m. to 2 p.m. and 2 p.m. to 10 p.m. Record review of Resident #8's Progress notes dated 6/23/22 at 5:52 p.m. by LVN G revealed, Resident moved to quarantine hall after testing positive this AM. Resident is having fatigue but showing no other signs and symptoms of Covid-19. Interview with Resident #8 on 7/8/22 at 11:20 a.m. she said she had been on isolation and the facility does not take the residents out of the hallway to get a bath. She said the shower is on the 500 Hall and residents on isolation and Covid does not even get bed baths and she was on isolation for 10 days. Resident said she went into isolation on Thursday, 6/23/22. Resident #8 said she felt really bad that she had not had a bath and she could not wait to get back to her room to get a shower. On Saturday, 7/2/22 they found she was negative, and she came back to room on Saturday and the first thing she did was to have the facility to give her a shower. Resident #9 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #9's Face Sheet dated 7/19/22 revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included acute respiratory failure with hypoxia (.not enough oxygen in the blood), mild cognitive impairment, anxiety disorder, paroxysmal atrial fibrillation(rapid heart rate), paranoid schizophrenia (delusions and hallucinations of the mind), major depression, hypertension (high blood pressure), dysphagia, muscle wasting and atrophy, and history of tracheostomy (procedure in the neck creating surgical airway). Record review of Resident #9's MDS dated [DATE] revealed she had a BIMS of 15 (cognitively intact); she required supervision set up for bed mobility, transfer, dressing, eating, toilet use and personal hygiene; she was independent for walk in room, walk in corridor, locomotion on and off unit; bathing did not occur; she was occasionally incontinent of bladder and frequently incontinent of bowel. Record review of Resident #9's Care Plan dated 7/18/22 revealed dental care and the approach was to brush twice daily and ADL function's approach for bathing/dressing/grooming with one-person physical assist, oral care twice a day 6 a.m. to 2 p.m. and 2 p.m. to 10 p.m., nail care once a day on Monday, Wednesday and Friday from 6 p.m. to 6 a.m. Record review of Resident #9's progress notes dated 6/27/22 at 8:13 a.m. written by LVN G Called and left message with Responsible party that while doing routine Covid testing this morning, patient tested positive and would be moving to the Covid hall . Interview with Resident #9 on 7/8/22 at 3:02 p.m. she said she was on isolation for 10 days and she did not receive showers or bed baths on isolation. Resident #9 said she did not ask for a bath, but none of the residents get a bed bath or shower while on isolation. Resident #9 said she washed herself with a wash rag, but the Staff did not give her soap. She said she brought her towel from her room before they moved her to isolation. Resident #9 said she did not think any of the other residents brought towels and she knew her roommate did not bring a towel. She said all the residents had to sit dirty and she did not like sitting that way. Resident #9 said she just came back to her room last night on 7/7/22 and she made sure to get a shower last night. Interview with LVN A on 7/8/22 at 3:40 p.m., she said she was working the Covid unit, and she did not observe any of the residents receiving bed baths. LVN A said there were 6 residents back in the isolation and Covid unit now. LVN A said Resident #1, Resident #3 and Resident #4 were in the warm zone and Resident #2, Resident #5 and Resident #6 were in the hot zone. Interview with TCNA A on 7/8/22 at 4:25 p.m., she said the last 3 residents were Resident #2, Resident #5 and Resident #6 and none of them had a shower or bed bath and that she was not even supposed to work with the residents alone. Interview with LVN A on 7/8/22 at 4:32 p.m. she said she worked as the nurse in the Covid area on 7/7/22 and today and the CNA who worked yesterday 7/7/22 was CNA B. CNA B was also stationed to be in both the Covid unit and the main facility as well. LVN A said she was also working everywhere. LVN A said there were times where there was no staff in the Covid unit. LVN A said it was always like that. LVN A said she was told that a TCNA was not supposed to be by themselves when they are in training. LVN A said she had worked at the facility for a year, and it had always been that way and the residents do not receive showers/bed baths while on isolation. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/19/2022 at 7:42 p.m. in a telephone interview with LVN E she said she worked the 6p.m. to 6a.m shift on the Covid unit. She said at night she worked as the nurse for the warm zone and 200 halls, and she had one aide that was on same assignment. LVN E said she was the only nurse sometimes and there was only one aide. LVN E said the residents were not getting their bed baths and she recalled urging aides to do bed baths. LVN E said she recalled Resident #7's hair being tangled pretty good. She said the staff had to encourage her for self-care. Observation on 7/8/22 at 3:48 p.m. revealed there was no shower on the Covid/isolation hall. Observation in the sampled residents rooms did not reveal any soap or toothpaste in their rooms. Observation did not reveal any residents receiving bed baths or showers. Record review of Facility's policy on, Activities of Daily Living (ADLs), Supporting dated March 2018 revealed, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene .Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: Hygiene (bathing, dressing, grooming, and oral care) .

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 26454 Based on observation, interview, and record review, the facility failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment for 4 of 18 residents (Resident #1, Resident #2, Resident #5, and Resident #6) reviewed for sufficient staff. 1. The facility failed to assign dedicated staff for the COVID-19 unit and frequently left Resident #1, Resident #2, Resident #5, and Resident #6, who were all cognitively impaired with histories of falls, wandering, and exit seeking behaviors unattended for indeterminate amounts of time when designated staff provided care to residents in other parts of the building. 2. The facility failed to have staff available to supervise the COVID-19 unit when Resident #1 sustained a head injury and required five staples after a fall. 3. The facility designated temporary CNA's who were not adequately trained to care for cognitively impaired residents to work the COVID-19 unit. 4. The facility failed to have sufficient staff to ensure cognitively impaired residents who were COVID-19 positive and COVID-19 negative isolated separately. An Immediate Jeopardy (IJ) situation was identified on 07/14/2022 at 12:56 p.m. While the IJ was removed on 07/20/2022 at 10:00 a.m., the facility remained out of compliance at a scope of pattern with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place quarantined residents at risk of serious injury from falls, resident to resident incidents, and exposure to COVID-19 infection. Findings include: Resident #1 (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's face sheet revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. She was diagnosed with dementia (the loss of cognitive functioning [thinking, remembering, and reasoning] to such an extent that it interferes with a person's daily life and activities) with behavioral disturbances, diabetes (too much sugar in the blood), muscle wasting and atrophy, reduced mobility, depression (a group of conditions associated with the elevation or lowering of a person's mood), insomnia (a sleep disorder in which you have trouble falling and/or staying asleep), generalized anxiety disorder (severe, ongoing anxiety that interferes with daily activities), delirium due to known abnormal physiological condition (serious disturbance in mental abilities that result in confused thinking and reduced awareness of surroundings), repeated falls, altered mental status (a change in mental function that stems from illnesses, disorders and injuries affecting your brain), and cognitive communication deficit (an impairment in organization/thought organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). Record review of Resident #1's MDS dated [DATE] revealed she had a BIMS score of 8 (mild cognitive impairment); wandering behaviors were not exhibited; she required extensive physical assistance from at least two staff for bed mobility, transfers, dressing, toilet use, and personal hygiene; she was totally dependent on staff for bathing and locomotion; she was wheelchair bound; she was always incontinent of bowel and bladder; and she experienced one fall with injury since admission. Record review of Resident #1's care plan, updated on 07/10/2022, revealed she resided in the facility's secured unit (Goal: Safety will be maintained, and resident will wander about unit without occurrence of any injury over review period. Approach/Intervention . Keep environment free of possible hazards, Monitor to assure resident's safety .); she was prescribed psychotropic drugs; and she had actual falls on 06/25/2022 and 07/07/2022 (with injury to head) (Goal: Resident will remain free of injuries and falls. Approach/Intervention . Continue frequent redirection to reduce falls, fall mat in place . Instruct resident on safety measures .) Record Review of Resident #1's, Event Report, dated 07/10/2022 revealed LVN C wrote, . Event Date: 07/07/2022, 5:55 p.m . What was resident doing just prior to fall? In wheelchair self-propelling in the hallway. Was Fall Witnessed? No . Does resident exhibit or complain of pain related to the fall? Yes (location) Head . Location of Injury: Back of Head. Note any injury to the head, extremities, or trunk: Laceration . Immediate measures taken: First Aid, Direct Pressure to Wound . Laceration with uncontrolled bleeding . Notes: 07/07/2022, 5:48 p.m. I was at the nurses station and heard yelling coming from the quarantine hall. I approached the 100 Hall and opened the door find this resident on the floor with her wheelchair in front of her. Resident was in sitting position and bleeding from her head onto her shirt. I asked resident what happened, and she stated she stood up and did not remember what happened after that. I Immediately called the CNA and other nurse on the floor for help. Resident laid down and I placed a towel on her head to stop the bleeding coming from the back of her head. Resident was able to tell me her date of birth and was responding to questions I asked her . Nurse stayed with resident and applied pressure to bleeding spot until EMS arrived. Hospice notified of 911 call . Record review of Resident #1's, Morse Fall Scale dated 07/13/2022 revealed the Regional Nurse Consultant wrote, . Description: Fall Assessment . History of Falling: Yes . Gait: Impaired, Mental Status: Overestimates/Forgets Limitation . Level: High Risk for Falls . (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation and interview with Resident #1 and TCNA A on 07/08/2022 at 4:09 p.m. in the COVID-19 unit (warm zone) revealed Resident #1 was in her bed turned sideways with her feet hanging off the bed. TCNA A rushed to assist Resident #1 and placed her feet back into bed. Resident #1 was alert and oriented at that time. TCNA A said Resident #1 should be on one on one at this time because she moved constantly. TCNA A said she tried to rush whenever she had to provide other residents with incontinent care because of Resident #1's behaviors (wandering behaviors and standing from her wheelchair). TCNA A said Resident #1 had a fall on the previous day (07/07/2002) and had to get staples in the back of her head. Resident #1's five staples were observed at that time. TCNA A said she was the only staff member assigned to the warm and hot zones at that time (07/08/2022). TCNA A said she did not get any help and she had not been trained to provide ADL's, incontinent care, or care for cognitively impaired residents when she transferred from the dietary department to work the floor as a temporary CNA. TCNA A said Resident #1 resided in the secured memory care unit and had always been up and down (stood up from her wheelchair). TCNA A said Resident #1 needed to be monitored at all times. Record review of Resident #1's Progress Notes for July 2022 revealed: On 07/05/2022 at 5:21 p.m., LVN H wrote, Nurse called RP and let them know that there are new cases of COVID-19 and that resident that was positive is in COVID-19 unit and this resident will be moved to COVID-19 unit (Resident #1's roommate, Resident #6, tested positive for COVID-19, so Resident #1 was moved to the warm zone on the 100 Hall). On 07/06/2022 at 1:30 p.m., RN I wrote, Day 2/10 resident on Warm area of COVID-19 hall due to COVID-19 exposure. Asymptomatic. Resident continues to self-propel ad lib (as much and as often as desired) in hallway. Redirection for resident to remain in Warm area, unsuccessful. Resident continues to propel self up and down hallway. Resident has wandering behavior at all times. Nurse able to get resident to sit quietly in room to eat all meals successfully. DON and Administrator aware. Will continue to monitor for any changes of condition. On 07/07/2022 at 4:17 a.m., LVN E wrote, Day 2/3 quarantine due to COVID-19 exposure. Resident on warm unit with continual need for monitoring due to increased wandering behaviors at baseline. Resident remains asymptomatic. Fluids encouraged. On 07/07/2022 at 11:35 a.m., LVN D wrote, Resident arrived back at facility via stretcher with EMT x2 personnel. Head laceration to posterior part of head addressed with 5 staples in place intact. Resident has no complaints of pain or discomfort and shows no s/sx of pain during assessment. Medication reconciliation sent to NP . Laceration was 44cm in size when measured in ED . Staples to be removed in 7 days per D/C orders from hospital . On 07/08/2022 at 9:15 a.m., LVN C wrote, Day 1/3 return from ER from fall causing laceration to posterior head with 5 staples in place. Resident states she has pain in her head. Scheduled Tylenol given for pain relief. Resident does not understand to call for help before getting out of bed alone or to use the call bell. Resident became angry and started swatting her hand when trying to redirect back into bed. PRN medication administered at this time for agitation. Resident is in her bed with call bell within reach but also has CNA at bedside to help prevent falls/ assistance to bed/wheelchair. On 07/16/2022 at 5:10 a.m., LVN E wrote, Quarantine completed, rapid test negative. Resident moved back to her room. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation of Resident #1 on 07/13/2022 at 2:30 p.m. revealed she was in her wheelchair at the end of the 100 Hall, which was designated as the facility's hot zone (for COVID-19 positive residents). After approximately two minutes, an unknown staff member was observed pushing Resident #1's wheelchair out of the hot zone, into the warm zone (the warm zone was located behind the fire doors towards the front of the 100 Hall. The hot zone was located at the end of the 100 Hall. The two zones were separated by blue tape on the floor). Resident #2 Record review of Resident #2's face sheet revealed she was an [AGE] year-old female who was admitted to the facility on [DATE]. She was diagnosed with Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), COVID-19 acute respiratory disease, generalized anxiety disorder (severe, ongoing anxiety that interferes with daily activities), delirium due to known abnormal physiological condition (serious disturbance in mental abilities that result in confused thinking and reduced awareness of surroundings), major depressive disorder (a group of conditions associated with the elevation or lowering of a person's mood), anxiety disorder (severe, ongoing anxiety that interferes with daily activities), Trigeminal neuralgia (chronic pain condition affecting the trigeminal nerve in the face), abnormalities of gait, lack of coordination, and abnormal posture. Record review of Resident #2's MDS dated [DATE] revealed she had a BIMS score of 2 (severe cognitive impairment); wandering behaviors did not exist; she required supervision for set-up only with bed mobility, transfers, walking in room and corridor, locomotion on and off the unit, eating, and toilet use; she required limited physical assistance from one staff for dressing, personal hygiene, and bathing; she ambulated with the assistance of a walker; she is occasionally incontinent of bladder and frequently incontinent of bowel; she did not have a history of falls Record review of Resident #2's care plan, updated on 07/13/2022, revealed she resided in the facility's secured unit due to elopement risk; she was at risk for falls/safety/elopement and was aggressive to peers. Record review of Resident #2's progress notes for June 2022 and July 2022 revealed: On 06/29/2022 at 4:30 p.m., RN I wrote, Called and notified RP that during COVID-19 testing this morning, patient tested positive and would be moving to the COVID-19 hall . On 07/04/2022 at 10:36 p.m., LVN D wrote, Day 6/10 COVID-19 + in quarantine . Resident having to constantly be redirected on staying on COVID-19 unit as per morning shift, residents were allowed out of the unit if they wore a mask. This resident was given several different masks and she continued to remove it while in common areas. Nurse informed resident if she does not wear a mask that she has to stay behind the closed doors of the COVID-19 unit. Resident got upset and yelled at this nurse stating, leave me alone! Nurse explained to resident that she is sick and does not need to get the rest of the residents sick, she was still upset. Nurse directed resident onto COVID-19 unit and to her room several times . On 07/06/2022 at 11:24 p.m., LVN E wrote, Day 8/10 COVID-19 + quarantine. Resident alert and oriented x 1-2 with memory impairment noted. Wander behaviors present throughout shift . (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation and interview with Resident #2 and TCNA A on 07/08/2022 at 4:00 p.m. revealed she was walking back and forth on the 100 Hall, from warm zone to hot zone. TCNA A said Resident #2 wandered back and forth from warm zone to hot zone all day. Resident #2 was not wearing a mask, but she did have one in her hand. Resident #2 said she was going to get into trouble because she was not wearing her shoes (she was only wearing socks). TCNA A said Resident #2 was from the secured unit and she was COVID-19 positive. TCNA A attempted to redirect Resident #2 back to the hot zone by interlocking their arms. TCNA A walked Resident #2 across the blue tape on the floor into the hot zone. Resident #5 Record review of Resident #5's face sheet revealed she was an [AGE] year-old female who was admitted to the facility on [DATE]. She was diagnosed with Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), COVID-19 acute respiratory disease, dementia with behavioral disturbance (the loss of cognitive functioning [thinking, remembering, and reasoning] to such an extent that it interferes with a person's daily life and activities), altered mental status (a change in mental function that stems from illnesses, disorders and injuries affecting your brain), muscle wasting and atrophy, cognitive communication deficit (an impairment in organization/thought organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), history of falls, psychotic disorder with delusions (A mental disorder characterized by a disconnection from reality), dementia with behavioral disturbances (the loss of cognitive functioning [thinking, remembering, and reasoning] to such an extent that it interferes with a person's daily life and activities), anxiety disorder (severe, ongoing anxiety that interferes with daily activities), major depression (a group of conditions associated with the elevation or lowering of a person's mood), and insomnia (a sleep disorder in which you have trouble falling and/or staying asleep). Record review of Resident #5's MDS dated [DATE] revealed she had a BIMS score of 3 (severe cognitive impairment); wandering behaviors were not exhibited; she required extensive physical assistance from at least one staff member for bed mobility, dressing, and personal hygiene; she required limited physical assistance from at least one staff member for transfers, toilet use, and bathing; she was independently ambulatory; and she was occasionally incontinent of bowel and bladder. Record review of Resident #5's care plan updated 07/13/2022 revealed she was at risk for injury/elopement due to impaired cognition, impaired safety awareness, and tendency to wander (Goal: I will not wander into an unsafe environment over the next 90 days. Approach/Interventions: Provie escort/guidance when leaving secured unit, Redirect as needed, resident requires queuing and reminders for hygiene .); she resided in the facility's secured unit; she was prescribed psychotropic medication; she was at risk for falls due to impaired safety awareness and impaired mobility and she had a history of falls prior to admission (Goal: Resident will be free of falls. Approach/Interventions: Keep bed in low position with brakes locked, Give frequent education on how to use and encourage her to use before ambulating/transferring for safety .) Record review of Resident #5's progress notes for June 2022 and July 2022 revealed: (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 06/29/2022 at 4:09 p.m., LVN C wrote, Resident moved to quarantine hall for exposure to a COVID-19 + resident (Resident #'s roommate, Resident #2 tested positive for COVID-19 on 09/29/2022). Resident is asymptomatic at this time. Resident will not stay in her room after multiple times trying to explain to her that it is necessary to prevent the spread of COVID-19. She states she does not want to stay in that room. I was able to redirect her to her room. She is in her room at this time with call bell within reach. On 07/02/2022 at 10:35 a.m., LVN C wrote, Other nurse informed me that resident was tested last night for COVID-19 and tested positive. Previous day shift nurse notified DON. Resident refuses to stay in room. She states this is not her room. She wanders and redirection is successful after multiple attempts . On 07/05/2022 at 5:20 p.m., RN I wrote, Day 5/10 of resident testing positive for COVID-19. Resident remains on COVID-19 hall/quarantine. Continued redirection needed to keep resident on Hot Side. Resident cursing at this nurse at various times, redirection successful x 3 attempts . Will continue to monitor resident for any respiratory changes and wandering out of quarantine/Hot location. On 07/06/2022 at 1:16 p.m., RN I wrote, Day 6/10 on COVID-19 positive test. Remains asymptomatic. Resident required to have continued redirection on staying in quarantine and remaining on designated hall. Successful with multiple attempts . Interview with Resident #5 on 07/20/2022 at 11:30 a.m. she said she recalled being on the COVID-19 hall. She said there was not always a staff member present on the hall Resident #6 Record review of Resident #6's face sheet revealed she was an [AGE] year-old female who was admitted to the facility on [DATE]. She was diagnosed with dementia without behavioral disturbances (the loss of cognitive functioning [thinking, remembering, and reasoning] to such an extent that it interferes with a person's daily life and activities), muscle wasting and atrophy, cognitive communication deficit (an impairment in organization/thought organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), anxiety disorder (severe, ongoing anxiety that interferes with daily activities), depression (a group of conditions associated with the elevation or lowering of a person's mood), COVID-19 acute respiratory disease, mood disorder, restlessness, and agitation. Record review of Resident #6's MDS dated [DATE] revealed she had a BIMS score of 4 (severe cognitive impairment); wandering behavior was not exhibited; she required limited assistance from at least one staff member for bed mobility, dressing, toilet use, and personal hygiene; she was totally dependent on staff for bathing; she was independently ambulatory with a cane; she was occasionally incontinent of bladder and frequently incontinent of bowel; and she was prescribed antipsychotic medication. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #6's care plan, updated on 07/07/2022 revealed she was at risk for falls, injury, and/or elopement due to impaired cognition with impaired safety awareness, impaired memories, impaired daily decision making, and a history of exit seeking (Goal: Resident will remain free of injuries and falls. Approach/Interventions: Keep bed in low position as resident will allow . Keep cane within reach . Resident will have guidance/escort when exiting the secured unit); and she resided in the facility's secured unit. Record review of Resident #6's progress notes for July 2022 revealed: On 0706/2022 at 1:27 p.m., RN I wrote, Day 2/10 of resident on COVID-19 hall due to positive COVID-19 test. Resident asymptomatic. Continued redirection required to keep resident quarantined to designated Hot area. Successful at times after multiple attempts . Observation and interview with Resident #6 on 07/20/2022 at 3:30 p.m. in the locked memory care unit revealed she was in bed. Resident #6 said she could not recall her birthdate, but she knew it was in the summer (her birthdate was in February). In an interview with LVN C on 07/08/2022 at 3:40 p.m., she said she worked the COVID-19 unit and there were 6 residents currently (as of 07/08/2022) on the unit. She said Resident #1, Resident #3 and Resident #4 were in the warm zone and Resident #2, Resident #5 and Resident #6 were in the hot zone. In a follow up interview with LVN C on 07/08/2022 at 4:32 p.m., she said there were times when there were no staff in the COVID-19 unit (warm zone or hot zone) because the staff designated to work the COVID-19 unit were also designated to work other halls in the facility. LVN C said it was always like that (when no staff were in the COVID-19 unit, but she could not say how often this happened). LVN C said this was the first time residents from the secured memory care unit were placed in the COVID-19 unit and so far, they had been on isolation 8 days. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with LVN C on 07/13/2022 at 12:45 p.m., she stated Resident #1 wandered and went from wheelchair to walking all day. She said Resident #1 was the only wheelchair bound resident in the COVID-19 unit at that time (07/13/2022). She said the rest of the residents from the secured unit (Resident #2, Resident #5 and Resident #6) walked independently. She said there were also two other residents in the warm zone at that time (07/13/2022). LVN C said it was not ok to leave dementia (confused) residents alone for any period of time, but she was designated to work two halls. She said the hardest thing was to watch Resident #1 because she was a wanderer and she needed constant redirection from going down to the hot zone. She said on 07/07/2022, during shift change around 5:49 p.m., she was outside of the COVID-19 unit by the nurse's station when she heard someone yell. She looked through the windows of the fire doors outside the COVID-19 unit and saw Resident #1 sitting on her buttocks. LVN C said when she entered the COVID-19 unit, she saw blood dripping from the back of Resident #1's head. She said Resident #1's wheelchair and a food cart was near where she fell . She said there were no CNA's or nurses inside the COVID-19 unit when Resident #1 fell . She said two CNAs went home early and there was only one left for the other halls, excluding the memory care unit. She said she called 911 at 5:51 p.m. Resident #1 had a laceration in the back of her head and returned to the facility that same night (07/07/2022) with five staples. She said Resident #1 knew she fell and told LVN C she was trying to walk around. She said this was the first time a resident fell in the COVID-19 unit while no staff was in the unit. She said she did not know how long the residents were left alone on 07/07/2022. She said the only CNA they had that day, TCNA B, was busy doing something else. In a telephone interview with TCNA B on 07/13/2022 at 1:40 p.m., she stated she often worked the COVID-19 unit alone. She said she was present on 07/07/2022 when Resident #1 fell . She said her co-worker had to go home early, so she was the only CNA on the floor. She said she had to run between the COVID-19 unit and other halls (there were two other occupied halls, excluding the secured memory care unit, who had their own staff). She said Resident #1 was confused, but she could have a conversation and knew she needed to sit down because she would fall. She said Resident #1 stood up a lot and wandered. She said Resident #1 was placed in the warm zone but frequently wandered into the hot zone. She said if any staff was in the COVID-19 unit, they brought her back to the warm zone, but if not, Resident #1 went into the hot zone. She said sometimes, there was nobody (no staff) in there (the COVID-19 unit) at all. She stated she had not been trained to care for dementia residents. In a telephone interview with LVN E on 07/19/2022 at 7:42 p.m., she stated she usually worked the 6:00 p.m. - 6:00 a.m. shift. She said she had worked as the night shift designated COVID-19 unit nurse, but she was also designated to work the 200 Hall at the same time. LVN E said one CNA also had the same assignment on the night shift (COVID-19 unit and 200 Hall). She said things got tricky (difficult) when wanderers from the secured unit got placed in the COVID-19 unit. She said the residents from the secured unit required constant redirection to keep the COVID-19 positive residents in the hot zone and the quarantined residents in the warm zone. She said once the confused residents moved into the COVID-19 unit, she tried to navigate working that unit and the other hall to keep everyone safe. She said she had to leave the residents in the COVID-19 unit alone if she had an admission (new resident admission) or if other residents on the other hall had needs. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with the Interim Administrator 07/13/2022 at 10:15 a.m., she stated there were no dedicated staff to work the COVID-19 unit (warm and hot zones). She said staff were designated to work the COVID-19 unit in addition to working their other assigned halls. She said there was not a continuous staff member in the hot/warm zone at all times. She said she was aware that some residents in the COVID-19 unit required redirection because they wandered. She stated TCNA A was out on vacation. An unsuccessful attempt was made to contact TCNA A by phone on 07/13/2022 at 11:41 a.m. The phone number was disconnected. Record review of TCNA A's employee record revealed she was hired on 04/08/2021 as a dietary aide. Further review indicated on 03/08/2022, TCNA A submitted a 2-week notice to transfer from the dietary department to work the floor as a CNA. Record review of TCNA A's employee training record revealed the following : 01/28/2022 - Temporary Nurse Aide 8 Hour Training 02/07/2022 - Sensory Changes and Communication 02/10/2022 - Fire Safety, Resident Abuse, Hand Washing, HIPAA and You 02/11/2022 - A Review of F-TAGs for Residents Right and Grievances, Texas House [NAME] 300: Understanding Patient Rights Under the Law, Bloodborne Pathogens 02/22/2022 - Workplace Violence 02/28/2022 - Sexual Harassment 05/03/2022 - COVID-19 Training for Frontline Nursing Home Staff Record review of the facility's policy, Staffing revised July 2021 revealed, Our center provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the center assessment. Policy Interpretation 1. Licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services. 2. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care . Record review of the facility's policy, Secure Unit, revised 05/13/14 revealed, The Secure Unit is designed to provide a holistic approach of care for the residents with dementia, those with exit-seeking behaviors, hoarders and those that require less stimulation that the General Population . Staffing on the Secure Unit: Staffing requirements on the Secure Unit are determined by the DON and Administrator. Regardless of census, if the community requires additional staff due to increases in incidents/accidents the unit will be staffed based on acuity to ensure resident safety . The Secure Unit should not be left unattended, a staff member is required to be present on the Unit at all times . (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	This was determined to be an Immediate Jeopardy (IJ). The Interim DON/Regional Nurse Consultant was notified on 07/14/2022 at 12:56 p.m. an IJ situation was identified due to the above findings, and IJ template was provided. The facility's Plan of Removal was accepted on 07/18/2022 at 2:16 p.m. and indicated: Plan of Removal is for Sufficient staffing Please accept this Plan of Removal as a credible allegation of compliance for immediate jeopardy initiated on July 14th, 2022. 1. Action: 2 CNA's for each shift will be assigned to the Covid Unit which consist of warm and hot zones and will be trained by Nursing Administration to properly monitor and re-direct wandering residents that are cognitively impaired with behaviors. Licensed staff members assigned to the Covid Unit will not leave the unit which consist of warm and hot zones unless relieved by another staff member. 2 wandering residents were transferred off the Covid unit 07/16/2022, allowing 1 CNA on warm zone and 1 CNA on hot zone to timely provide adl care. a. Temporary Nurse Aides are assigned to COVID unit which consist of warm and hot zones have been trained and have demonstrated competencies related to PPE and handwashing on 7/18/2022. b. Temporary Nurse Aide skills competency checklist has been sent to AHCA Temporary Nurse Aide Training program. Resident # 1 and Resident # 2 are being monitored. Staff will not be allowed to work until appropriate training has been received. This will include part-time and or agency personnel. Interim Director of Nursing or designee will continue effective of training and report any concerns to Interim Administrator. No additional residents residing on COVID unit which consist of warm and hot zones have any noted injuries. All shifts appropriately staffed. c. Center audit completed related to temporary nurse aides hired under CMS waiver related to COVID pandemic. Currently, 6 temporary nurse aides employed by center. Training completed after 80 work hours post hire. 1 has completed testing and 5 temporary nurse aides awaiting for authorization to test from AHCA temporary nurse aide training program. d. There will be 2 qualified, trained staff on the COVID unit which consist of a warm and hot zone to meet and provide ADL care and to redirect wandering residents Training Completion date: Beginning July 14th, 2022 and ending July 16th, 2022. Staff out on leave, PRN, or Agency staff will be trained prior to the beginning of next scheduled shift. Interim Director of Nursing or designee will continue effectiveness of training and report any concerns to Interim Administrator daily for the next 2 weeks. Responsible: RNM/ Interim Administrator Residents residing on COVID unit which consist of warm and hot zones assessed by regional nurse manager on July 15th, 2022. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. Action: Nursing Administration to conduct education with nursing personnel and anyone accessing the COVID unit on the following: 1. Caring for residents that are cognitively impairment with behaviors 2. Falls Preventions and 3. COVID response related to wandering residents with behaviors that require quarantine in warm and isolation hot zones. Completion Timeline: Beginning July 14th, 2022 and ending July 16th, 2022. Responsible: RNM/ Interim Administrator 3. Action: Adhoc QAPI meeting with medical director/nurse practitioner and IDT at 3pm on July 15th. The purpose of the Ad hoc QPAI was to inform the Medical Director of the IJ Situation, latest version of Covid response plan review, Falls Prevention and Behaviors Policies and Plan of Removal. Responsible: Interim Administrator, Director of Nursing/ RNM Monitoring of the plan of removal: The surveyor confirmed the facility implemented their plan of removal sufficiently from 7/18/22-7/20/22 to remove the IJ by: Record Review of, In-Servic [TRUNCATED]

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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** 26454 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 4 of 18 residents (Resident #1, Resident #2, Resident #5, and Resident #6) reviewed for infection control. The facility failed to develop and implement an effective system to ensure Resident #1 (in quarantine for COVID-19 exposure), Resident #2 (in isolation for COVID-19), Resident #5 (in isolation for COVID-19), and Resident #6 (in isolation for COVID-19), who were all cognitively impaired with histories of wandering and exit-seeking behaviors, were adequately isolated in the warm and hot zones respectively. Staff failed to remove PPE while exiting the warm zone of the facility. These failures could place residents at risk of exposure to infection. Findings include: Resident #1 Record review of Resident #1's face sheet revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. She was diagnosed with dementia (the loss of cognitive functioning [thinking, remembering, and reasoning] to such an extent that it interferes with a person's daily life and activities) with behavioral disturbances, diabetes (too much sugar in the blood), muscle wasting and atrophy, reduced mobility, delirium due to known abnormal physiological condition (serious disturbance in mental abilities that result in confused thinking and reduced awareness of surroundings), repeated falls, altered mental status (a change in mental function that stems from illnesses, disorders and injuries affecting your brain), and cognitive communication deficit (an impairment in organization/thought organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). Record review of Resident #1's MDS dated [DATE] revealed she had a BIMS score of 8 (mild cognitive impairment); wandering behaviors were not exhibited; she required extensive physical assistance from at least two staff for bed mobility, transfers, dressing, toilet use, and personal hygiene; she was totally dependent on staff for bathing and locomotion; she was wheelchair bound; and she was always incontinent of bowel and bladder. Record review of Resident #1's care plan, updated on 07/10/2022, revealed she resided in the facility's secured unit (Goal: Safety will be maintained, and resident will wander about unit without occurrence of any injury over review period. Approach/Intervention . Keep environment free of possible hazards, Monitor to assure resident's safety .) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's progress notes dated 07/06/2022 at 1:30 p.m., written by RN I indicated Day 2/10 resident on Warm area of COVID-19 hall due to COVID-19 exposure. Asymptomatic. Resident continues to self-propel ad lib in hallway. Redirection for resident to remain in Warm area, unsuccessful. Resident continues to propel self up and down hallway. Resident has wandering behavior at all times. Nurse able to get resident to sit quietly in room to eat all meals successfully. DON and Administrator aware. Will continue to monitor for any changes of condition. Record review of Resident #1's progress notes dated 07/07/2022 at 4:17 a.m., written by LVN E indicated Day 2/3 quarantine due to COVID-19 exposure. Resident on warm unit with continual need for monitoring due to increased wandering behaviors at baseline. Resident remains asymptomatic. Fluids encouraged. Observation of Resident #1 on 07/13/2022 at 2:30 p.m. revealed she was in her wheelchair at the end of the 100 Hall, which was designated as the facility's hot zone (for COVID-19 positive residents). After approximately two minutes, an unknown staff member walked from the warm zone and pushed Resident #1's wheelchair out of the hot zone, into the warm zone (the warm zone was located behind the fire doors towards the front of the 100 Hall. The hot zone was located at the end of the 100 Hall. The two zones were separated by blue tape on the floor). The unknown staff member remained in the warm zone and did not change their PPE or leave out of the back door of the hot zone. Resident #2 Record review of Resident #2's face sheet revealed she was an [AGE] year-old female who was admitted to the facility on [DATE]. She was diagnosed with Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), COVID-19 acute respiratory disease, generalized anxiety disorder (severe, ongoing anxiety that interferes with daily activities), delirium due to known abnormal physiological condition (serious disturbance in mental abilities that result in confused thinking and reduced awareness of surroundings), major depressive disorder (a group of conditions associated with the elevation or lowering of a person's mood), anxiety disorder (severe, ongoing anxiety that interferes with daily activities), Trigeminal neuralgia (chronic pain condition affecting the trigeminal nerve in the face), abnormalities of gait, lack of coordination, and abnormal posture. Record review of Resident #2's MDS dated [DATE] revealed she had a BIMS score of 2 (severe cognitive impairment); wandering behaviors did not exist; she required supervision for set-up only with bed mobility, transfers, walking in room and corridor, locomotion on and off the unit, eating, and toilet use; she required limited physical assistance from one staff for dressing, personal hygiene, and bathing; she ambulated with the assistance of a walker; she is occasionally incontinent of bladder and frequently incontinent of bowel; she did not have a history of falls Record review of Resident #2's care plan, updated on 07/13/2022, revealed she resided in the facility's secured unit due to elopement risk; she was at risk for falls/safety/elopement and was aggressive to peers (Goal: Resident will remain free of injuries and falls. Approach/Interventions: Redirect patient, de-escalation technique, remove from stimulus, frequent monitoring .) Record review of Resident #2's progress notes for June 2022 and July 2022 revealed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/29/2022 at 4:30 p.m., RN I wrote, Called and notified RP that during COVID-19 testing this morning, patient tested positive and would be moving to the COVID-19 hall . On 07/04/2022 at 10:36 p.m., LVN D wrote, Day 6/10 COVID-19 + in quarantine . Resident having to constantly be redirected on staying on COVID-19 unit as per morning shift, residents were allowed out of the unit if they wore a mask. This resident was given several different masks and she continued to remove it while in common areas. Nurse informed resident if she does not wear a mask that she has to stay behind the closed doors of the COVID-19 unit. Resident got upset and yelled at this nurse stating, leave me alone! Nurse explained to resident that she is sick and does not need to get the rest of the residents sick, she was still upset. Nurse directed resident onto COVID-19 unit and to her room several times . On 07/06/2022 at 11:24 p.m., LVN E wrote, Day 8/10 COVID-19 + quarantine. Resident alert and oriented x 1-2 with memory impairment noted. Wander behavior present throughout shift . Observation and interview with Resident #2 and TCNA on 07/08/2022 at 4:00 p.m. revealed Resident #2 was walking back and forth on the 100 Hall, from warm zone to hot zone. TCNA A said Resident #2 wandered back and forth from warm zone to hot zone all day. Resident #2 was not wearing a mask, but she did have one in her hand. Resident #2 said she was going to get into trouble because she was not wearing her shoes (she was only wearing socks). TCNA A said Resident #2 was from the secured unit and she was COVID-19 positive. TCNA A attempted to redirect Resident #2 back to the hot zone by interlocking their arms. TCNA A walked Resident #2 across the blue tape on the floor into the hot zone. TCNA A was observed going back and forth into the warm and hot zones, including resident rooms. TCNA A interacted with COVID-19 positive and negative residents wearing the same PPE. Resident #5 Record review of Resident #5's face sheet revealed she was an [AGE] year-old female who was admitted to the facility on [DATE]. She was diagnosed with abnormalities of gait and mobility, Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), COVID-19 acute respiratory disease, dementia with behavioral disturbance (the loss of cognitive functioning [thinking, remembering, and reasoning] to such an extent that it interferes with a person's daily life and activities), altered mental status (a change in mental function that stems from illnesses, disorders and injuries affecting your brain), muscle wasting and atrophy, cognitive communication deficit (an impairment in organization/thought organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), history of falls, psychotic disorder with delusions (A mental disorder characterized by a disconnection from reality), anxiety disorder (severe, ongoing anxiety that interferes with daily activities), major depression (a group of conditions associated with the elevation or lowering of a person's mood), and insomnia (a sleep disorder in which you have trouble falling and/or staying asleep). Record review of Resident #5's MDS dated [DATE] revealed she had a BIMS score of 3 (severe cognitive impairment); wandering behaviors were not exhibited; she required extensive physical assistance from at least one staff member for bed mobility, dressing, and personal hygiene; she required limited physical assistance from at least one staff member for transfers, toilet use, and bathing; she was independently ambulatory; and she was occasionally incontinent of bowel and bladder. (continued on next page)

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	675229	A. Building B. Wing	07/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Manor Nursing and Rehabilitation	99 Rigby Owen Rd Conroe, TX 77304

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's care plan updated 07/13/2022 revealed she was at risk for injury/elopement due to impaired cognition, impaired safety awareness, and tendency to wander (Goal: I will not wander into an unsafe environment over the next 90 days. Approach/Interventions: Provide escort/guidance when leaving secured unit, Redirect as needed, resident requires queuing and reminders for hygiene .); she resided in the facility's secured unit; she was prescribed psychotropic medication; she was at risk for falls due to impaired safety awareness and impaired mobility and she had a history of falls prior to admission. Record review of Resident #5's progress notes for June 2022 and July 2022 revealed: On 06/29/2022 at 4:09 p.m., LVN C wrote, Resident moved to quarantine hall for exposure to a COVID-19 + resident (Resident #'s roommate, Resident #2 tested positive for COVID-19 on 09/29/2022). Resident is asymptomatic at this time. Resident will not stay in her room after multiple times trying to explain to her that it is necessary to prevent the spread of COVID-19. She states she does not want to stay in that room. I was able to redirect her to her room. She is in her room at this time with call bell within reach. On 07/02/2022 at 10:35 a.m., LVN C wrote, Other nurse informed me that resident was tested last night for COVID-19 and tested positive. Previous day shift nurse notified DON. Resident refuses to stay in room. She states this is not her room. She wanders and redirection is successful after multiple attempts . On 07/05/2022 at 5:20 p.m., RN I wrote, Day 5/10 of resident testing positive for COVID-19. Resident remains on COVID-19 hall/quarantine. Continued redirection needed to keep resident on Hot Side. Resident cursing at this nurse at various times, redirection successful x 3 attempts . Will continue to monitor resident for any respiratory changes and wandering out of quarantine/Hot location. On 07/06/2022 at 1:16 p.m., RN I wrote, Day 6/10 on COVID-19 positive test. Remains asymptomatic. Resident required to have continued redirection on staying in quarantine and remaining on designated hall. Successful with multiple attempts . Resident #6 Record review of Resident #6's face sheet revealed she was an [AGE] year-old female who was admitted to the facility on [DATE]. She was diagnosed with dementia without behavioral disturbances (the loss of cognitive functioning [thinking, remembering, and reasoning] to such an extent that it interferes with a person's daily life and activities), COVID-19 acute respiratory disease, mood disorder, restlessness, and agitation. Record review of Resident #6's MDS dated [DATE] revealed she had a BIMS score of 4 (severe cognitive impairment); wandering behavior was not exhibited; she required limited assistance from at least one staff member for bed mobility, dressing, toilet use, and personal hygiene; she was totally dependent on staff for bathing; she was independently ambulatory with a cane; she was occasionally incontinent of bladder and frequently incontinent of bowel; and she was prescribed antipsychotic medication. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #6's care plan, updated on 07/07/2022 revealed she was at risk for falls, injury, and/or elopement due to impaired cognition with impaired safety awareness, impaired memories, impaired daily decision making, and a history of exit seeking (Goal: Resident will remain free of injuries and falls. Approach/Interventions: Keep bed in low position as resident will allow . Keep cane within reach . Resident will have guidance/escort when exiting the secured unit); and she resided in the facility's secured unit. Record review of Resident #6's progress notes dated 0706/2022 at 1:27 p.m., written by RN I indicated, Day 2/10 of resident on COVID-19 hall due to positive COVID-19 test. Resident asymptomatic. Continued redirection required to keep resident quarantined to designated Hot area. Successful at times after multiple attempts . In an interview with LVN C on 07/08/2022 at 3:40 p.m., she said she worked the COVID-19 unit and there were 6 residents currently (as of 07/08/2022) on the unit. She said Resident #1, Resident #3 and Resident #4 were in the warm zone and Resident #2, Resident #5 and Resident #6 were in the hot zone. In a follow up interview with LVN C on 07/08/2022 at 4:32 p.m., she said there were times when there were no staff in the COVID-19 unit (warm zone or hot zone) because the staff designated to work the COVID-19 unit were also designated to work other halls in the facility. LVN C said it was always like that (when no staff were in the COVID-19 unit, but she could not say how often this happened). LVN C said this was the first time residents from the secured memory care unit were placed in the COVID-19 unit and so far, they had been on isolation 8 days. In an interview with LVN C on 07/13/2022 at 12:45 p.m., she stated Resident #1 wandered and went from wheelchair to walking all day. She said Resident #1 was the only wheelchair bound resident in the COVID-19 unit at that time (07/13/2022). She said the rest of the residents from the secured unit (Resident #2, Resident #5 and Resident #6) walked independently. She said there were also two other residents in the warm zone at that time (07/13/2022). LVN C said it was not ok to leave dementia (confused) residents alone for any period of time, but she was designated to work two halls. She said the hardest thing was to watch Resident #1 because she was a wanderer and she needed constant redirection from going down to the hot zone. In a telephone interview with TCNA B on 07/13/2022 at 1:40 p.m., she stated she often worked the COVID-19 unit alone. She said she had to run between the COVID-19 unit and other halls (there were two other occupied halls, excluding the secured memory care unit, who had their own staff). She said Resident #1 was confused, but she could have a conversation and knew she needed to sit down because she would fall. She said Resident #1 stood up a lot and wandered. She said Resident #1 was placed in the warm zone but frequently wandered into the hot zone. She said if any staff was in the COVID-19 unit, they brought her back to the warm zone, but if not, Resident #1 went into the hot zone. She said sometimes, there was nobody (no staff) in there (the COVID-19 unit) at all. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a telephone interview with LVN E on 07/19/2022 at 7:42 p.m., she stated she usually worked the 6:00 p.m. - 6:00 a.m. shift. She said she had worked as the night shift designated COVID-19 unit nurse, but she was also designated to work the 200 Hall at the same time. LVN E said one CNA also had the same assignment on the night shift (COVID-19 unit and 200 Hall). She said things got tricky (difficult) when wanderers from the secured unit got placed in the COVID-19 unit. She said the residents from the secured unit required constant redirection to keep the COVID-19 positive residents in the hot zone and the quarantined residents in the warm zone. She said once the confused residents moved into the COVID-19 unit, she tried to navigate working that unit and the other hall to keep everyone safe. She said she had to leave the residents in the COVID-19 unit alone if she had an admission (new resident admission) or if other residents on the other hall had needs. In an interview with the Interim Administrator 07/13/2022 at 10:15 a.m., she stated there were no dedicated staff to work the COVID-19 unit (warm and hot zones). She said staff were designated to work the COVID-19 unit in addition to working their other assigned halls. She said if a staff member had to leave the warm zone to redirect a resident in the hot zone, they should have followed protocol, which was to remove their PPE and leave out the back door. That staff would have to go around to the facility's front door to be screened and put on new PPE to go back to the warm unit. She said there was not a continuous staff member in the hot/warm zone at all times. She said she was aware that some residents in the COVID-19 unit required redirection because they wandered. She stated TCNA A was out on vacation. In an interview with the Interim DON on 07/13/2022 at 10:30 a.m., she stated any staff member who went into the facility's hot zone for any reason, should doff (remove) their PPE and exit from the back door (located in the back of the hot zone on the 100 Hall). She said even if staff had to return to the warm zone (located at the front of the 100 Hall) after redirecting residents in the hot zone, they should exit the back door and return to the front entrance of the facility to be screened and then donn (put on) new PPE. An unsuccessful attempt was made to contact TCNA A by phone on 07/13/2022 at 11:41 a.m. The phone number was disconnected. Record review of the facility' policy, COVID-19 Response for Nursing Facilities, dated 06/27/2022 revealed, . Isolation - Once a case of COVID-10 is identified in the NF, immediate action must be taken to isolate the resident who is positive for COVID-19 away from other residents . If a resident requires a higher level of care or the NF cannot fully implement all recommended precautions, the resident should be transferred to another facility capable of implementation . Create a plan for cohorting residents with symptoms of respiratory infection and COVID-19, including dedicating staff to work only affected units, if possible . Staff leaving and entering isolation room . Put on proper PPE . Directly before exiting the isolation room, remove all PPE except respirator [and face shield or goggles] . Record review of the facility' policy, Infection Prevention and Control Program, revised March 2022 revealed, An infection prevention and control program is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections . 10. Outbreak Management: a. Outbreak management is a process that consists of: . (2) managing the affected residents; (3) preventing the spread to other residents . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of, In-Service Training Report, dated 07/14/2022 revealed all facility staff were educated by the Interim DON on, Staffing in the COVID Unit with Wandering/Dementia Residents. The document read in part, COVID unit must have 2 staff at all times; 1 for hot zone; 1 for warm zone - when there are dementia residents that wander . Record review of In-Service Training Report, dated 07/14/2022 revealed all facility staff were educated by the Interim DON on, Infection Control; Dementia Residents and Wandering. The Document read in part, . to include PPE, proper Donning/Doffing . Record review of undated, Helping Residents with Dementia Prevent the Spread of COVID-19 in LTC Communities revealed, Strategies used to prevent the spread of COVID-19 are especially difficult for residents with dementia living in long-term care communities . Refraining from touching their faces . Practicing hand hygiene . Wearing a mask . Refraining from placing things in their mouth . Keeping residents in safe areas . Maintaining social distancing: Increase one-on-one structured programming throughout the day . Record review of, In-Service Training Report, dated 07/14/2022 revealed all facility staff were educated by the Interim DON on, Fall & Fall Risk, Managing. The in-service topics included, fall prevention, potential interventions, and fall risk factors. Record review of, Falls and Fall Risks, Managing, revised July 2019 revealed, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling . Fall Risk Factors . 2. c. delirium and other cognitive impairment .