STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE NW LENOIR, NC 28645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced on-site complaint investigation was conducted on 08/18/2021. Additional information was obtained through 09/7/21. The surveyor returned to the facility on 08/27/21 and on 09/07/21 to validate credible allegations of compliance. Therefore, the exit date was changed to 09/07/21. The 1 complaint allegation was substantiated and resulted in deficiencies. Event ID# 7GVK11. Immediate Jeopardy (IJ) was identified at CFR 483.10 at tag F 551 at a scope and severity of J. Immediate Jeopardy (IJ) began on 08/14/2021 and was removed on 08/21/21. The facility was notified on 09/02/21 of additional Immediate Jeopardy identified after management quality review: Immediate Jeopardy (IJ) was identified at CFR 483.10 at tag F 835 at a scope and severity of J. Immediate Jeopardy (IJ) began on 08/13/21 and was removed on 09/04/21.	F 000		
F 551 SS=J	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was	F 551		9/29/21

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

Electronically Signed | 09/22/2021

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valid in the jurisdiction in which it was celebrated.
(i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative.
(ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law.

§483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.

§483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.

§483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law.

§483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.

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F 551	Continued From page 2 (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Legal Guardian (LG), resident, staff, and the Nurse Practitioner (NP), the facility failed to follow instructions from the LG and allowed Resident #1 to leave the facility with an unauthorized person. Resident #1 was later diagnosed with aspiration pneumonia. This situation affected 1 of 3 residents reviewed for accidents. Immediate Jeopardy began when Resident #1 was signed out of the facility on 8/14/21 without consent from the LG. Immediate Jeopardy was removed on 8/21/21 when the facility provided and implemented an acceptable credible allegation for removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with a potential for minimal harm that is not IJ) to complete education and ensure monitoring systems put into place were effective. The findings included: Resident #1 was admitted to the facility on 6/07/21 with the following diagnoses pneumonia, dysphagia, bipolar disorder, schizophrenia, schizoaffective disorder, and dementia.	F 551	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. F551 1. Resident #1continues to reside at the center. Resident # 1□s electronic medical record, hard paper chart under the Demographics tab, and the Leave of Absence sign out/ sign in book were updated by the ED/SS director to indicate that Resident #1 has a Legal Guardian, and that resident is not to make medical, financial or leave of absence decisions without the notification to and consent from the Legal Guardian. Resident #1 was assessed and treated by the Nurse Practitioner on 8-18-21 with follow up on 8 -20-21 to include a chest x- ray and antibiotics, which have been completed as ordered. Resident #1□s plan of care has	

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F 551	Continued From page 3 Review of the court document issued by the State of North Carolina titled; "Letters of Appointment Guardian of the Person" named Resident #1 as being an incompetent person and appointed guardianship to the local Department of Social Services (DSS) on 5/20/21. Review of Resident #1's physician orders revealed the following: -A diet order for nothing by mouth (NPO) written on 6/7/21. -Enteral feed (intake of nutrition via gastrointestinal tract) five times a day give tube feeding bolus via syringe written on 6/7/21. Review of the Minimum Data Set (MDS) dated 6/17/21 assessed Resident #1 cognition as being moderately impaired for making daily decisions. He required extensive assistance with eating and received 51% or greater of his calories and 501 milliliters or greater of fluids through a feeding tube. The care plan revised on 6/23/21 identified Resident #1 required tube feedings related to dysphagia, infection, and pneumonia. The goal was for Resident #1 to remain free of side effects or complications related to tube feedings through the review date. Interventions in place included listen to lung sounds as needed and monitor, document, and report as needed any signs or symptoms of aspiration. Review of the facility sign-out records revealed on 8/14/21 at 10:45 AM Resident #1 was signed out of the facility with Friend #1 who was not authorized by the LG.	F 551	been reviewed and updated by the Interdisciplinary Team, accordingly, as of 09/20/21. 2. Executive Director (ED)/Social Services (SS) Director identified 9 residents with legal guardians on 8-18-21, as those residents who are unable to make decisions for themselves regarding leaves of absence from the center. Current residents have been reviewed by the ED/SS Director on 8-18-21 to ensure that they have not been out on leave of absence without permission from their legal guardians. Also, current residents who have been out on Leave of Absence (LOA) in the past 5 days (since 8-14-21) were assessed by the Director of Nursing (DON)/Assistant Director of Nursing (ADON) on 8-18-21 to ensure no changes in condition, as a result. Residents on specialized diets were reviewed by the ED/DON/ADON on 8-18-21 to ensure consumption of approved diet, as ordered by the MD while out on LOA in the past 5 days (since 8-14-21). There were no additional changes in condition noted for other identified current residents, who had gone out on LOA from 8-14-21 through 8-18-21, requiring immediate notification to the MD by the Licensed Nurse for additional orders. 3. On 8-18-21, Regional Vice President of Operations (RVPO) educated Executive Director on legal guardians and residents□ rights, as pertained to legal guardians. On 8-20-21 Executive Director educated the department managers, to	

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F 551	Continued From page 4 During an interview on 8/18/21 at 2:31 PM the LG revealed she came to the facility for a visit with Resident #1 on 8/13/21. The LG had a conversation with Resident #1 and the Social Worker (SW) stating she made it clear to both Resident #1 was not to leave the facility with anyone except DSS personnel and could not attend the festival on 8/14/21. The LG discussed her concerns related to Resident #1's history of unsafe decisions that compromised his health. On 8/16/21 the LG received information Resident #1 left the facility with an unauthorized person and had been seen by a Family Member (FM) and the Chief of Police unsupervised and eating and drinking at the festival on 8/14/21. On 8/16/21 the LG called the facility and spoke with the Administrator telling her Resident #1 left the facility with a friend without the LG's knowledge and had been seen eating and drinking at the festival. The LG revealed the Administrator was not aware Resident #1 had left the facility on 8/14/21. An interview was conducted on 8/18/21 at 10:59 AM with Resident #1. Resident #1 revealed on 8/14/21 he left the facility with Friend #1 to attend a festival. He left with Friend #1 that morning and returned the same day after it was dark. Resident #1 knew he had an appointed LG but denied she came to see him on 8/13/21. Resident #1 also denied his LG told him he couldn't leave the facility with an unauthorized person or could not attend the festival on 8/14/21. During the interview Resident #1 asked for some water to drink several times before he shared, he wasn't allowed to eat or drink by mouth and had a feeding tube. Resident #1 denied he ate or drank anything when at the festival and stated the people that said he did were not telling the truth.	F 551	include the Social Services Director, along with the nursing and ancillary staff members (including the receptionist), that Residents with Legal Guardians are unable to make decisions for themselves regarding medical and financial to include leaves of absence from the center. The resident□s legal guardian will be notified for such medical, financial, and Leave of Absence requests. The approval for a Leave of Absence for a resident with a legal guardian will be witnessed by 2 staff members and noted in the resident□s medical record. Disapproval by the resident□s legal guardian for a requested leave of absence will also be witnessed by 2 staff members and documented in the resident□s medical record. Additionally, the ED/SS Director has placed a notification in the electronic medical record, hard paper chart under the Demographics tab, as well as in the LOA sign out/sign in book (located at the receptionist□s desk) to indicate that identified residents with a legal guardian are not to make medical, financial or leave of absence decisions without the notification to and consent from their legal guardians. Residents/Responsible Party, when going out on LOA, will be educated by the Licensed Nurse regarding their prescribed diets, to include specialized and therapeutic diets, along with their dietary restrictions to validate an understanding of what the resident can or cannot consume while out on LOA. Licensed Nurses were educated on the above, to include documentation of the discussion in the medical record, upon	

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F 551	Continued From page 5 During an interview on 8/20/21 at 8:15 AM Friend #1 confirmed he was the person who signed out and took Resident #1 to the festival on 8/14/21. Resident #1 had called and asked if he would take him to the festival and he was aware Resident #1 was deemed incompetent and assigned a court appointed LG but had no knowledge he wasn't allowed to take Resident #1 out of the facility. On 8/14/21 Friend #1 picked up Resident #1 and was assisted by a male staff member with signing out while a female staff got Resident #1 ready to leave. Friend #1 revealed he was not given any medications or means to hydrate Resident #1 during the time they spent together. Friend #1 denied Resident #1 was left alone at any time they were together but a person at the festival did give Resident #1 a bottle of water which he did take a sip of. Friend #1 revealed he was able to get the bottle of water away from Resident #1 before he drank anymore and denied Resident #1 had anything else to eat or drink. Resident #1 and Friend #1 left the facility around 10:30 AM and returned the same day around 9:00 PM. Friend #1 stated he was told by facility staff not to let Resident #1 have anything to eat or drink by mouth and indicated he was already aware of this. Attempts to identify and interview the male staff who assisted signing Resident #1 out of the facility were unsuccessful. An interview was conducted on 8/18/21 at 3:04 PM with the FM of Resident #1. The FM revealed he attended the same festival on 8/14/21 and saw Resident #1 there. The FM revealed Resident #1 was walking from a building that served beer, soda, and food and was holding a cup containing	F 551	Resident□s Leave of Absence. ED/DON/ADON educated current licensed nursing staff on 08/18/2021 that residents will be assessed upon return from LOA for an acute change in condition. Resident□s physician will be immediately notified of an acute change in condition, as a result of the nursing assessment, for further orders. Staff members not educated by 8/20/2021 will be educated upon the next scheduled shift. The Executive Director will be responsible for tracking staff that have completed the education. On 8/20/21 the Executive Director provided education to the Assistant Director of Nursing that she would be responsible for training the staff that are not educated by 8/20/21. The facility social worker will be responsible for notifying staff and placing this information in the electronic medical record, hard paper chart under the Demographics tab, as well as in the LOA sign out/sign in book for new admissions with a legal guardian after 8/18/21. The facility social worker was notified of this responsibility on 08/18/2021. The staff were provided education on 8/20/21 by executive director to look to at the medical record/ resident sign out notebook to validate if the residents have a court appointed guardian before allowing them to leave the facility. 4. Quality Improvement monitoring of residents with legal guardians will be conducted by the ED/DON 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then 1 time weekly for 4 weeks, and then 1 time monthly for 3	

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F 551	Continued From page 6 a liquid in one hand and what appeared to be bread in the other and appeared to be alone. The FM did not interact with Resident #1 but did observe him for approximately 5 minutes and stated he did not see Resident #1 eat or drink. The FM did notify Resident #1's LG but did not contact the facility. An interview was conducted on 8/23/21 at 2:31 PM with the Chief of Police (COP). The COP revealed he received information from others that Resident #1 was with Friend #1 and was drinking at the festival on 8/14/21. The COP revealed when he saw Resident #1, he was standing outside a local restaurant and appeared to be alone and did not have any food or drinks nor did the COP see him consume any. The COP couldn't recall the names of the persons who informed him Resident #1 was drinking at the festival. An interview was conducted with Director of Nursing (DON) on 8/18/21 at 12:17 PM. The DON revealed Resident #1 asked about going to a festival and during their Department Head (DH) meeting on 8/13/21 they discussed concerns related to safety and him having a feeding tube and a diet order for NPO. A decision was made to let Resident #1 attend the festival and leave the facility on 8/14/21 and the SW was to contact the LG. During the DON's shift on 8/14/21 she was informed someone was at the facility to pick up Resident #1 and the last information she heard it was okay, so she approved he could leave the facility. The DON revealed she was not aware Resident #1's LG visited on 8/13/21 and instructed the SW he could not leave the facility with an unauthorized person or attend the festival and she was not made aware of this information	F 551	months. to ensure the following: a) Identified residents have notifications in the electronic medical record, hard paper chart under the Demographics tab, and the Leave of Absence sign out/ sign in book to indicate that they are unable to make decisions for themselves regarding medical and financial decisions to include leaves of absence. b). The resident□s Legal Gurardian is notified of such requests; and, the approval/disapproval by the Legal Guardian is witnessed by 2 staff members and noted in the medical record. c) The Resident/Responsible Party is educated by Licensed Nurse regarding prescribed diets, to include specialized and therapeutic diets, along with dietary restrictions to validate an understanding of what the resident can and cannot consume while out on LOA; and, this discussion is documented in the medical record. d) Resident is assessed by the nurse upon return from LOA for an acute change in condition with notification to the physician, as indicated. Results of Quality Improvement monitoring will be reported to the Quality Improvement Committee monthly for 6 months continued compliance and/or revision. The Executive Director is responsible for implementing this plan. 5)As of 09/29/2021 the corrective actions will be completed.	

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until 8/16/21 when the Administrator told her about the phone call from the LG.

An interview was conducted on 8/18/21 at 11:18 AM with the SW. The SW explained on 8/13/21 she was told to speak with Resident #1's LG about his request to go to a festival. Resident #1's LG told the SW and Resident #1 he could not leave the facility unless with another DSS worker. The SW revealed she also stated this information during their DH meeting on 8/13/21 but did not recall who attended but did tell the Assistant Director of Nursing (ADON).

An interview was conducted on 8/18/21 at 11:57 AM with the ADON. The ADON revealed she was not told face to face by the SW Resident #1 was not to leave the facility. The ADON revealed she understood when a resident had a LG, they cannot leave the facility without first notifying the LG. The ADON revealed she knew notes were posted on 8/13/21 telling staff not to let Resident #1 leave the facility.

An interview was conducted on 8/18/21 at 5:08 PM with the SW. The SW revealed she was present during the DH meeting on 8/13/21 and asked to notify the LG Resident #1 wanted to attend a festival on 8/14/21. The SW revealed before she was able to contact Resident #1's LG the LG came to facility for a visit on 8/13/21. The SW explained she and the LG and Resident #1 were standing together when she heard the LG tell Resident #1 several times not to leave the facility and he could not go to the festival on 8/14/21. The SW stated she wrote a note in Resident #1's chart and made a sign to put in a book kept on the medication cart for nurses to access related to resident information and taped

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a note at the nurse station for nurses to see stating Resident #1 could not leave the facility with anyone other than DSS personnel or facility staff.

An interview was conducted on 8/19/21 at 11:18 AM with Med Aide (MA) #1 scheduled to work on 8/13/21 from 6:45 AM to 11:15 PM. MA #1 stated she did receive a note Resident #1 was only allowed to go out of the facility with his LG on 8/13/21 and stated the note was kept in the 24-hour nurse book at the nurse station. MA #1 also stated she did tell the oncoming nurse but could not recall who that was.

During an interview on 8/19/21 at 10:47 AM Nurse #1 revealed she was responsible for the care of Resident #1 on 8/14/21 the day Friend #1 took him out of the facility. Nurse #1 revealed she was not told Resident #1 was deemed incompetent to make his own decisions nor aware he was appointed a LG. Nurse #1 revealed she did have access to Resident #1's medical record but didn't review before letting him leave the facility with someone she assumed was a family member nor did she notify the LG. Nurse #1 was aware Resident #1 was not allowed to have anything by mouth and if he ate or drank would be at risk for aspiration, but she didn't recall informing Friend #1 that information. Nurse #1 explained she should've reviewed Resident #1's medical records and notified his LG to ensure he was safe to leave the facility. Nurse #1 stated she was not told by anyone nor did she see any type of note Resident #1 was not to leave the facility with no one other than his LG.

During an interview on 8/20/21 at 10:48 AM Nurse #2 explained he was responsible for the

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care of Resident #1 on 8/14/21 when he returned to the facility around 9 PM. Nurse #2 did not speak to Friend #1 nor question Resident #1 about ingesting food or fluids. Nurse #2 revealed he wasn't told by anyone Resident #1 was not allowed to leave the facility except with his LG nor did Nurse #2 see any notes stating that information. Nurse #2 stated 8/19/21 was the first time he was notified Resident #1 could not leave the facility with anyone other than his LG and asked to sign a paper stating Resident #1 had to have 2 facility staff or 1 facility staff and a DSS Guardian with him if he left the facility.

An interview was conducted on 8/19/21 at 12:09 PM with Nurse #5 who was the oncoming nurse scheduled on 8/13/21 from 10:45 PM to 7:00 AM on 8/14/21. Nurse #5 was aware Resident #1 was strictly NPO with nutrition and medications administered via feeding tube and revealed Resident #1 was known to be non-compliant with being NPO and would sneak drinks of water. Nurse #5 stated she didn't know anything about Resident #1 being deemed incompetent or having a LG but was aware she could look that information up in Resident #1's medical record. Nurse #5 revealed she didn't know anything about Resident #1's LG giving instructions he could not leave the facility with an unauthorized person or attend the festival and stated she did not receive any information in report on 8/13/21 he could only leave the facility with DSS personnel.

An interview was conducted on 8/18/21 at 4:38 PM with the DON. The DON revealed she was aware Resident #1 was deemed incompetent and assigned a LG. The DON revealed the LG should've been notified before Resident #1 left

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the facility and stated it was an oversight on her part. The DON revealed on 8/16/21 the Administrator made her aware Resident #1 was suspected of eating and drinking when at the festival which put him at risk for aspiration. The DON stated she performed an assessment for signs of aspiration and found nothing abnormal, so she did not inform the Nurse Practitioner (NP) on 8/16/21 and did not document her assessment.

An interview was conducted on 8/18/21 at 4:52 PM with the Administrator. The Administrator revealed she became aware Resident #1 left facility with an unauthorized person when his LG called on 8/16/21 stating a FM saw Resident #1 eating and drinking at the festival. The Administrator told the LG she would investigate. The Administrator spoke with Resident #1 who confirmed had been out of building with a friend. The Administrator spoke with the SW who confirmed Resident #1's LG said he could not attend the festival during a visit on 8/13/21. The Administrator did not talk with Friend #1 who took Resident #1 to the festival. When the Administrator found out on 8/16/21, she asked the DON to assess Resident #1 but did not inform the NP. The Administrator revealed during their DH morning meeting on 8/13/21 it was agreed Resident #1 could attend the festival and stated the SW was to contact his LG. The Administrator did not tell Resident #1 he could go to the festival and was aware he was deemed incompetent by a court of law with an appointed LG. It was the Administrator's expectation the LG would've been notified before Resident #1 left the facility with someone other than the LG.

On 8/18/21 at 11:44 AM a review of the note

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written by the SW revealed it was taped at the nurse's station and read in part, "Attention Nursing Resident #1 cannot leave this building with anyone but his DSS guardian, or one of our staff members. He cannot make or receive any calls from Friend #1 per his Guardian." The note was signed by the SW and posted at the nurse's station with directions not to remove. There was no date on the note.

An interview was conducted with the NP on 8/18/21 at 1:19 PM. The NP was aware Resident #1 was deemed incompetent and appointed a LG. The NP explained Resident #1 was NPO due to his diagnosis of severe dysphagia and stated he would not be trustworthy to make good decisions about not eating or drinking and if he did eat or drink it would put him at risk for aspiration pneumonia which could lead to his death. The NP was not aware Resident #1 left the facility without the LG's knowledge nor made aware by facility on 8/16/21 he was suspected of eating and drinking. The NP stated if the facility was aware Resident #1 was suspected of eating and drinking, she should have been notified and would expect nurse staff to listen to his lung sounds and obtain a full set of vital signs for at least 2 days and ask that the nurse put Resident #1 on her list of residents to see on her next visit for her own assessment.

An interview was conducted with the NP on 8/20/21 at 10:00 AM. The NP assessed Resident #1 on 8/18/21 and revealed he was mildly tachycardiac (heart rate greater than 100) with minimal chest congestion and she ordered a chest x-ray. The NP received the chest x-ray results on 8/20/21 and explained the results showed bilateral pleural effusions (buildup of fluid

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in the space between the lungs and chest wall) meaning pneumonia was present in the lower lobes likely due to aspiration. The NP revealed physician orders were provided for an antibiotic and diuretic for the treatment of pneumonia.

Review of Resident #1's physician orders revealed the following:
-Levofloxacin (antibiotic medication used to treat bacterial infections) 750 milligram (mg) give 1 tablet via peg tube one time only for pneumonia for day 1 to start on 8/20/21.
-Furosemide (diuretic medication used to remove excess fluid from the body) 40 mg give 1 tablet via peg tube in the afternoon for pleural effusions for 3 days to start on 8/20/21.

During a follow-up interview on 8/20/21 at 3:57 PM the NP could not say Resident #1 aspirated on 8/14/21 but stated there was a delay in notification he was suspected of ingesting food or fluids on 8/14/21. If notified on 8/16/21 the NP revealed she would have assessed Resident #1 at that time, and it was possible the delay in notification and treatment could have a negative outcome and Resident #1 could have become septic from having pneumonia.

The Administrator was informed of immediate jeopardy on 8/20/21 at 9:28 PM.

The facility provided the following acceptable immediate jeopardy removal plan with the correction date of 08/21/21.

Identify those recipients who have suffered, or likely to suffer, a serious adverse outcome as a result of the non-compliance.

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The Executive Director (ED) and Social Services (SS) Director identified 9 residents with legal guardians on 8-18-21 as those residents who are unable to make decisions for themselves regarding leaves of absence from the center. Current residents have been reviewed by the ED/SS Director on 8-18-21 to ensure that they have not been out on leave of absence without permission from their legal guardians. Also, current residents who have been out on Leave of Absence (LOA) in the past 5 days (since 8-14-21) were assessed by the Director of Nursing (DON)/Assistant Director of Nursing (ADON) on 8-18-21 to ensure no changes in condition, as a result. Residents on specialized diets were reviewed by the ED/DON/ADON on 8-18-21 to ensure consumption of approved diet, as ordered by the MD while out on LOA in the past 5 days (since 8-14-21). There were no additional changes in condition noted for other identified current residents, who had gone out on LOA from 8-14-21 through 8-18-21, requiring immediate notification to the MD by the Licensed Nurse for additional orders.

Brief Summary of the allegation:
Resident #1 was admitted to the facility on 6/7/21 with following diagnosis: pneumonia, dysphagia, bipolar disorder, schizophrenia, and dementia. Resident #1 court appointed guardian met with social worker at the facility on 8/13/21 to discuss that the resident had court appointed guardian and was not to not leave the facility with anyone other the DSS personnel. Family friend who accompanied him to a local festival signed Resident #1 out of the facility on 8/14/21 at 10:45 am. Resident #1 returned from the festival at approximately 9:00 pm on 8/14/21. Nurse #2 did not observe resident to have any signs of

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dehydration or sunburn. Nurse #2 checked resident's stomach for residual contents and there were none. Nurse #2 administrated a bolus tube feeding, per physician orders at approximately 9:30 pm on 8/14/21. On 8/16/21 the court, appointed guardian called the facility and informed the administrator Resident#1 had left the facility on 8/14/21 with a friend without her knowledge or consent with someone other than DSS personnel. The Legal Guardian revealed that multiple people at the festival had told her that the resident had been seen eating and drinking and appeared to be unsupervised. On 8/18/21, the Nurse Practitioner assessed resident, found resident to have mild tachycardia with minimal chest congestion, and ordered a chest x ray. The Nurse Practitioner received the results of the chest x rays on 8/20/21 and determined that Resident #1 had bilateral pleural effusions in lungs. Resident #1 was then started on antibiotics.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be completed.

On 8-18-21, Regional Vice President of Operations (RVPO) educated Executive Director (ED) on legal guardians and residents' rights, as pertained to legal guardians. On 8-20-21 Executive Director educated the department managers, to include the Social Services Director, along with the nursing and ancillary staff members (including the receptionist), that Residents with Legal Guardians are unable to make decisions for themselves regarding medical and financial to include leaves of absence from the center. The resident's Legal Guardian will be

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notified for such medical, financial, and Leave of Absence requests. The approval for a Leave of Absence for a resident with a Legal Guardian will be witnessed by 2 staff members and noted in the resident's medical record. Disapproval by the resident's Legal Guardian for a requested leave of absence will also be witnessed by 2 staff members and documented in the resident's medical record. Additionally, the ED/SS Director has placed a notification in the electronic medical record, hard paper chart under the "Demographics" tab, as well as in the LOA sign out/sign in book (located at the receptionist's desk) to indicate that identified residents with a Legal Guardian are not to make medical, financial or leave of absence decisions without the notification to and consent from their Legal Guardians. Residents/Responsible Party, when going out on LOA, will be educated by the Licensed Nurse regarding their prescribed diets, to include specialized and therapeutic diets, along with their dietary restrictions to validate an understanding of what the resident can or cannot consume while out on LOA. Licensed Nurses were educated on the above, to include documentation of the discussion in the medical record, upon Resident's Leave of Absence. ED/DON/ Assistant Director of Nursing (ADON) educated current licensed nursing staff on 08/18/2021 that residents will be assessed upon return from LOA for an acute change in condition. Resident's physician will be immediately notified of an acute change in condition, as a result of the nursing assessment, for further orders. Staff members not educated by 8/20/2021 will be educated upon the next scheduled shift. The Executive Director will be responsible for tracking staff that have completed the education. On 8/20/21 the Executive Director provided

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education to the Assistant Director of Nursing that she would be responsible for training the staff that are not educated by 8/20/21. The facility Social Worker will be responsible for notifying staff and placing this information in the electronic medical record, hard paper chart under the "Demographics" tab, as well as in the LOA sign out/sign in book for new admissions with a legal guardian after 8/18/21. The facility Social Worker was notified of this responsibility on 08/18/2021. The staff were provided education on 8/20/21 by Executive Director to look to at the medical record/ resident sign out notebook to validate if the residents have a court appointed guardian before allowing them to leave the facility.

On 8-20-21, an ad-hoc Quality Assurance Performance Improvement Committee meeting was held with the Executive Director, Medical Director, DON/ADON, and Social Services Director to review and adopt the plan of action to abate the Immediate jeopardy.

The facility alleged immediate jeopardy removal effective date 8/21/21.

The facility's credible allegation for immediate jeopardy removal with the correction date 8/21/21 was validated on 8/27/21.
The Administrator revealed an initial in-service was provided to her by the Regional Vice President of Operations via phone on 8/18/21 to ensure LG's were called before the resident could leave and that training was provided to nursing staff, Department Heads, Business Management Office, and Receptionist. Review of the education provided by the interim DON for staff included the following information: Residents with an

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appointed Legal Guardian (LG) are unable to make decisions for themselves regarding leaves of absence and the LG will be notified; approval and/or disapproval will be witnessed by 2 staff and documented in their medical record; special diet education will be provided upon leave completed on 8/20/21. The interim DON confirmed her, and the DON provided training to staff that was completed on 8/20/21. The training was related to the facility's process for approval of leave for a resident deemed incompetent with an appointed LG. An interview with the SW revealed she was aware it was her responsibility to notify and maintain residents with an appointed LG with a permanent note in their hard chart and in the sign in/out logbook triggering facility staff to contact the LG before the resident could leave the facility. Interviews conducted with nurses revealed they were responsible for checking the residents medical record for guardianship and provide notification to the LG before a resident could leave and to provided education related to a resident's diet and upon return assess for a change of condition and notify the physician if concerns were noted and to document all the above. Interviews with Nursing staff, Department Heads, Business Management Office staff, and Receptionist revealed they were able to define what it meant for resident to be deemed incompetent and the role of their LG and knew the facility's process for when a resident with an appointed LG wanted to leave the facility. The sign in/out logbook was reviewed and found no other resident with an appointed LG were signed out during 08/2021. A Quality Assurance and Performance Improvement (QAPI) dated 8/20/21 identified a resident with court appointed LG left facility without approval. The goal was to review residents currently residing with LG. The QAPI

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F 551	Continued From page 18 signatures included the Administrator, the interim DON, and the Medical Director. The medical records of the 9 residents with an appointed LG were reviewed and revealed the following: - Physician orders were transcribed to their Medication Administration Record with directions the resident was not to leave the facility with anyone without permission from the guardian and triggered administering staff to initial each shift. Diet orders were in place with instructions for texture and consistency of fluids. - The sign in/out logbook kept at the reception desk identified the 9 residents using a permanent note with directions to check with their LG before leaving the building with anyone and provided the LG's contact information. - The hard chart for the 9 residents with an appointed LG contained a permanent note with directions to check with their LG before leaving the building with anyone and provided the LG's contact information.	F 551		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F 580		9/29/21

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F 580	Continued From page 19 a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, interviews with staff and the Nurse Practitioner (NP), the facility failed to notify the NP when a resident (Resident #1) with a diet order to receive nothing by mouth was	F 580	F580 1. Resident #1continues to reside at the center. Resident #1 was assessed and	

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F 580	Continued From page 20 suspected to consume food and fluids which resulted in delay in the identification and treatment for pneumonia for 1 of 3 residents reviewed for accidents. The findings included: Resident #1 was admitted to the facility on 6/7/21 with the following diagnoses: pneumonia, dysphagia, bipolar disorder, schizophrenia, schizoaffective disorder, and dementia. Review of Resident #1's physician orders revealed the following: -A diet order for nothing by mouth (NPO) written on 6/7/21. -Enteral feed (intake of nutrition via gastrointestinal tract) five times a day give tube feeding bolus via syringe written on 6/7/21. Review of the Minimum Data Set (MDS) dated 6/17/21 assessed Resident #1 cognition as being moderately impaired for making daily decisions. He required extensive assistance with eating and received 51% or greater of total calories and 501 milliliters or greater of fluids through a feeding tube. The care plan revised on 6/23/21 identified Resident #1 required tube feeding related to dysphagia, infection, and pneumonia. The goal was for Resident #1 to remain free of side effects or complications related to tube feeding through the review date. Interventions in place included listen to lung sounds as needed and monitor, document, and report as needed any signs or symptoms of aspiration.	F 580	treated by the Nurse Practitioner on 8-18-21 with follow up on 8-20-21 to include a chest x- ray and antibiotics, which have been completed as ordered. Resident #1□s plan of care has been reviewed and updated by the Interdisciplinary Team, accordingly, as of 09/20/21. 2. Current residents who have been out on Leave of Absence (LOA) in the past 5 days (since 8-14-21) were assessed by the Director of Nursing (DON)/Assistant Director of Nursing (ADON) on 8-18-21 to ensure no changes in condition, as a result. Residents on specialized diets were reviewed by the ED/DON/ADON on 8-18-21 to ensure consumption of approved diet, as ordered by the MD while out on LOA in the past 5 days (since 8-14-21). There were no additional changes in condition noted for other identified current residents, who had gone out on LOA from 8-14-21 through 8-18-21, requiring immediate notification to the MD by the Licensed Nurse for additional orders. 3. ED/DON/ADON educated current licensed nursing staff on 08/18/2021 that residents will be assessed upon return from LOA for an acute change in condition. Resident□s physician will be immediately notified of an acute change in condition, as a result of the nursing assessment, for further orders. Licensed Nursing Staff members not educated by 8/20/2021 will be educated upon the next scheduled shift. The Executive Director will be responsible for tracking staff that have completed the education. On	

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F 580	Continued From page 21 Review of the facility sign in/out record for Resident #1 showed on 8/14/21 at 10:45 he was signed out. Review of Resident #1's physician orders revealed the following: -Chest x-ray 2 views one time only written on 8/19/21. -Levofloxacin (antibiotic medication used to treat bacterial infections) 750 milligram (mg) give 1 tablet via peg tube one time only for pneumonia for day 1 to start on 8/20/21. -Furosemide (diuretic medication used to remove excess fluid from the body) 40 mg give 1 tablet via peg tube in the afternoon for pleural effusions (buildup of fluid in the space between the lungs and chest wall) for 3 days to start on 8/20/21. An interview was conducted on 8/20/21 at 5:04 PM with the Director of Nursing (DON). The DON explained the Administrator was notified by Resident #1's Legal Guardian on 8/16/21 he was suspected of consuming food and fluids while at a festival. After being notified of this the Administrator asked the DON to assess Resident #1. The DON stated she assessed Resident #1 for signs and symptoms of aspiration such as wheezing, difficulty in breathing, and congestion from 8/16/21 through 8/19/21. The DON revealed her assessments found nothing abnormal therefore she did not notify the Nurse Practitioner (NP) on 8/16/21 when the facility became aware. During an interview on 8/20/21 at 10:00 AM the NP revealed she became aware Resident #1 was suspected of consuming food or fluids when the surveyor told her on 8/18/21. The NP completed an assessment for signs and symptoms of	F 580	8/20/21, the Executive Director provided education to the Assistant Director of Nursing that she would be responsible for training the staff that are not educated by 8/20/21. This education will also be provided to all new employees as part of new hire orientation, contract staff and agency staff, this education will be provided prior to starting work. 4. Quality Improvement monitoring of notification of residents□ acute changes of condition will be conducted by the ED/DON 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then 1 time weekly for 4 weeks, and then 1 time monthly for 3 months. to ensure the following: a) Resident is assessed by a licensed nurse upon return from LOA for an acute change in condition b) Resident□s physician is immediately notified of an acute change in condition, as a result of the nursing assessment, for further orders. Results of Quality Improvement monitoring will be reported to the Quality Improvement Committee monthly for 6 months continued compliance and/or revision. The Executive Director is responsible for implementing this plan. 5) As of 09/29/2021 the corrective actions will be completed.	

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F 580	Continued From page 22 aspiration and found Resident #1 to be slightly tachycardic (abnormally high heart rate) with minimal chest congestion and ordered a chest x-ray. On 8/20/21 the NP received Resident #1's chest x-ray results and explained there was bilateral pleural effusions meaning pneumonia in the lower lobes likely due to aspiration and revealed she ordered antibiotic and diuretic medications for treatment of pneumonia. The NP stated she would expect the facility to notify her on 8/16/21 when they became aware Resident #1 was suspected of eating and drinking. A second interview was conducted with the NP on 8/20/21 at 3:57 PM. The NP stated she could not determine Resident #1 aspirated on 8/14/21 but stated there was a delay in the notification when he was suspected of consuming food or fluids and if notified on 8/16/21 when the facility was made aware the NP stated she would have assessed Resident #1 for signs and symptoms of aspiration at that time. The NP also stated it was possible the delay in notification and treatment could have a negative outcome and Resident #1 could've become septic from having pneumonia.	F 580		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		9/29/21

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F 684	Continued From page 23 by: Based on record review, interviews with the staff, a Family Member, the Legal Guardian, and the Nurse Practitioner, the facility failed to provide ongoing assessments for a resident (Resident #1) with a diet order to receive nothing by mouth after it was suspected he consumed food and fluids while at a festival for 1 of 3 residents reviewed for accidents. The findings included: Resident #1 was admitted to the facility on 6/07/21 with the following diagnoses: pneumonia, dysphagia, bipolar disorder, schizophrenia, schizoaffective disorder, and dementia. Review of Resident #1's physician orders revealed the following: -A diet order for nothing by mouth (NPO) written on 6/7/21. -Enteral feed (intake of nutrition via gastrointestinal tract) five times a day give tube feeding bolus via syringe written on 6/7/21. Review of the Minimum Data Set (MDS) dated 6/17/21 assessed Resident #1 cognition as being moderately impaired for making daily decisions. He required extensive assistance with eating and received 51% or greater of his calories and 501 milliliters or greater of fluids through a feeding tube. The care plan revised on 6/23/21 identified Resident #1 required tube feeding related to dysphagia, infection, and pneumonia. The goal was for Resident #1 to remain free of side effects or complications related to tube feeding through the review date. Interventions in place included	F 684	F684 1. Resident #1continues to reside at the center. Resident #1 was assessed and treated by the Nurse Practitioner on 8-18-21 with follow up on 8-20-21 to include a chest x- ray and antibiotics, which have been completed as ordered. Resident #1□s plan of care has been reviewed and updated by the Interdisciplinary Team, accordingly, as of 09/20/21. 2. Current residents who have been out on Leave of Absence (LOA) in the past 5 days (since 8-14-21) were assessed by the Director of Nursing (DON)/Assistant Director of Nursing (ADON) on 8-18-21 to ensure no changes in condition, as a result. Residents on specialized diets were reviewed by the ED/DON/ADON on 8-18-21 to ensure consumption of approved diet, as ordered by the MD while out on LOA in the past 5 days (since 8-14-21). There were no additional changes in condition noted for other identified current residents, who had gone out on LOA from 8-14-21 through 8-18-21, requiring immediate notification to the MD by the Licensed Nurse for additional orders. 3. ED/DON/ADON educated current licensed nursing staff on 08/18/2021 that residents will be assessed upon return from LOA for an acute change in condition. Resident□s physician will be immediately notified of an acute change in condition, as a result of the nursing assessment, for further orders. Licensed	

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F 684	Continued From page 24 listen to lung sounds as needed and monitor, document, and report as needed any signs or symptoms of aspiration. Review of the facility sign out and sign in records for Resident #1 showed he was signed out on 8/14/21 at 10:45 AM. A review of Resident #1's medical record revealed a progress note dated 8/16/21 was made as a late entry created on 8/19/21 by the Director of Nursing (DON). The progress note read in part: "Temperature 97.4; Pulse 85; Respirations 18; and Blood Pressure 130/78. Level of consciousness noted as oriented to person, place, and time. Swallowing problems are not noted and is NPO with feeding tube in place. GI complaints are none and abdomen is soft and bowel sounds are within normal limits. Respiratory status is clear with no shortness of breath noted, lung sounds are clear with no cough noted, and oxygen is not in use." There were no other assessments that included a full set of vital signs or lungs sounds or respiratory status after the late entry note created on 8/16/21 to indicate nurses assessed Resident #1 for aspiration. An interview was conducted on 8/18/21 at 3:04 PM with the Family Member (FM) of Resident #1. The FM revealed he attended a festival on 8/14/21 and saw Resident #1 there. The FM revealed Resident #1 was walking from a building that served beer, soda, and food and was holding a cup containing a liquid in one hand and what appeared to be bread in the other. The FM didn't interact with Resident #1 but did observe him for approximately 5 minutes and revealed he did not see Resident #1 eat or drink.	F 684	Nursing Staff members not educated by 8/20/2021 will be educated upon the next scheduled shift. The Executive Director will be responsible for tracking staff that have completed the education. On 8/20/2, the Executive Director provided education to the Assistant Director of Nursing that she would be responsible for training the staff that are not educated by 8/20/21. This education will also be provided to all new employees as part of new hire orientation, contract staff and agency staff, this education will be provided prior to starting work. 4. Quality Improvement monitoring of notification of residents□ acute changes of condition will be conducted by the ED/DON 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then 1 time weekly for 4 weeks, and then 1 time monthly for 3 months. to ensure the following: a) Resident is assessed by a licensed nurse upon return from LOA for an acute change in condition b) Resident□s physician is immediately notified of an acute change in condition, as a result of the nursing assessment, for further orders. Results of Quality Improvement monitoring will be reported to the Quality Improvement Committee monthly for 6 months continued compliance and/or revision. The Executive Director is responsible for implementing this plan. 5) As of 09/29/2021 the corrective actions will be completed.	

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An interview was conducted on 8/18/21 at 2:31 PM with the Legal Guardian (LG) of Resident #1. The LG revealed Resident #1 was deemed incompetent with a history of drinking alcohol and failed 3 swallow studies and now has a feeding tube. The LG revealed on 8/16/21 she was informed by a FM it was suspected Resident #1 had been eating and drinking when at a festival on 8/14/21. The LG revealed she called the facility on 8/16/21 and informed the Administrator of the suspicions.

During an interview on 8/18/21 at 4:52 PM the Administrator revealed she was made aware Resident #1 was suspected of eating and drinking on 8/16/21 when his LG called her. The Administrator revealed she then asked the DON to complete an assessment of Resident #1.

During an interview on 8/18/21 at 4:38 PM the DON revealed she assessed Resident #1 for signs of aspiration on 8/16/21 after the Administrator was informed by Resident #1's LG he was suspected of eating and drinking while at a festival on 8/14/21. The DON explained her assessment included a full set of vital signs and she checked for abnormal lung sounds and stated his lung sounds were clear and there were no changes of condition or abnormal vital sign readings.

A second interview was conducted on 8/20/21 at 5:04 PM with the DON. The DON stated; "we kept on eye on Resident #1 to watch for signs and symptoms of aspiration such as wheezing, difficulty of breathing or congestion." The DON was unable to provide information of who she told to monitor Resident #1 for signs of aspiration to

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include lung sounds and vital signs and stated she personally did the assessments every day when she encountered Resident #1 and would check on him. The DON revealed she did not document her assessments.

An interview was conducted on 8/20/21 at 5:38 PM with Nurse #4. Nurse #4 worked on 8/17/21 on first shift and was responsible for the care of Resident #1. Nurse #4 did not recall checking Resident #1's lung sounds but did check his temperature. Nurse #4 stated no one told her it was suspected Resident #1 consumed food or fluids when at a festival nor asked her to monitor for signs of aspiration. Nurse #4 stated she didn't report anything related to assess for aspiration to Resident #1's oncoming nurse.

An interview was conducted on 8/20/21 at 6:50 PM with Nurse #5. Nurse #5 explained she worked on 8/16/21 from 11 PM to 7 AM. Nurse #5 stated she didn't know Resident #1 went out of the facility on 8/14/21 and no one told her she needed to check his lungs sounds for possible aspiration or it was suspected he had consumed food or drank fluids when at the festival.

Attempts made to interview the Nurses who worked from 8 AM to 11 PM on 8/16/21 were unsuccessful.

During an interview on 8/18/21 at 1:19 PM the Nurse Practitioner (NP) revealed she was aware Resident #1 was deemed incompetent with a LG. The NP explained Resident #1 received nothing by mouth due to a diagnosis of severe dysphagia (difficulty with swallowing) and stated he would not be trustworthy to make good decisions about not eating or drinking. The NP revealed if

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F 684	Continued From page 27 Resident #1 did eat or drink it would put him at risk for aspiration pneumonia which could lead to his death. The NP was not aware Resident #1 was suspected of consuming food and drinks when at a festival until 8/18/21 after being told by the surveyor. The NP stated if the facility knew he was suspected of eating and drinking, she should be notified, and she would've had the nurses listen to his lung sounds and obtain full set of vital signs for at least 2 days and request he be added to her list of residents to see on her next visit for her to assess.	F 684		
F 835 SS=J	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Legal Guardian (LG), resident, staff, and the Nurse Practitioner (NP), the administration failed to provide oversight and leadership to Department Heads (DH) and direct care staff to effectively communicate which residents were assigned legal guardianship and ensure a guardian's directive to only leave the facility with authorized persons was followed for 1 of 3 resident (Resident#1) reviewed for accidents. Immediate Jeopardy (IJ) began on 08/13/21 when the facility's administration failed to effectively communicate to DH and direct care staff which residents were assigned a LG and failed to	F 835	F835 1. Resident #1continues to reside at the center. Resident # 1□s electronic medical record, hard paper chart under the Demographics tab, and the Leave of Absence sign out/ sign in book were updated by the ED/SS director to indicate that Resident #1 has a Legal Guardian, and that resident is not to make medical, financial or leave of absence decisions without the notification to and consent from the Legal Guardian. Resident #1 was	9/29/21

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F 835	Continued From page 28 communicate the LG's directives that a resident could not leave the facility with an unauthorized person. The failure of administration to effectively communicate LG directives placed Resident #1 and other residents at risk for harm or serious injury. Immediate Jeopardy was removed on 9/4/21 when the facility provided and implemented an acceptable credible allegation for removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with a potential for minimal harm that is not IJ) to complete education and ensure monitoring systems put into place were effective. The findings included: The citation was crossed referenced with F 551: Based on record review and interviews with the Legal Guardian (LG), resident, staff, and the Nurse Practitioner (NP), the facility failed to follow instructions from the LG and allowed Resident #1 to leave the facility with an unauthorized person. Resident #1 was later diagnosed with aspiration pneumonia. This situation affected 1 of 3 residents reviewed for accidents. The Administrator was informed of immediate jeopardy on 9/2/21 at 6:48 PM. The facility provided the following acceptable IJ removal plan with the correction date of 9/4/21. A brief summary of the allegation: The Social Services Director spoke with the guardian of Resident #1 and was informed that he was not allowed to leave the facility on 8/14/2021 to attend a festival. However, the	F 835	assessed and treated by the Nurse Practitioner on 8-18-21 with follow up on 8 -20-21 to include a chest x- ray and antibiotics, which have been completed as ordered. Resident #1□s plan of care has been reviewed and updated by the Interdisciplinary Team, accordingly, as of 09/20/21. 2. Executive Director (ED)/Social Services (SS) Director identified 9 residents with legal guardians on 8-18-21 as those residents who are unable to make decisions for themselves regarding leaves of absence from the center. Current residents have been reviewed by the ED/SS Director on 8-18-21 to ensure that they have not been out on leave of absence without permission from their legal guardians. Also, current residents who have been out on Leave of Absence (LOA) in the past 5 days (since 8-14-21) were assessed by the Director of Nursing (DON)/Assistant Director of Nursing (ADON) on 8-18-21 to ensure no changes in condition, as a result. Residents on specialized diets were reviewed by the ED/DON/ADON on 8-18-21 to ensure consumption of approved diet, as ordered by the MD while out on LOA in the past 5 days (since 8-14-21). There were no additional changes in condition noted for other identified current residents, who had gone out on LOA from 8-14-21 through 8-18-21, requiring immediate notification to the MD by the Licensed Nurse for additional orders. The 9 residents with a guardian have been validated that the current plan of care is accurate.	

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F 835	Continued From page 29 Social Service Director did communicate to some but not all of the department heads during stand down. The Director of Nursing was unaware of the directive from the guardian and allowed the resident to sign out of the facility and go to the festival on 8/14/2021. Other direct care staff were not aware of the guardian's directives because it had not been communicated to them by any department head. Identify those recipients who have suffered, or likely to suffer, a serious adverse outcome as a result of the non-compliance. Executive Director (ED)/Social Services (SS) Director identified 9 residents with legal guardians on 8-18-21 as those residents who are unable to make decisions for themselves regarding leaves of absence from the center. Current residents have been reviewed by the ED/SS Director on 8-18-21 to ensure that they have not been out on leave of absence without permission from their legal guardians. Also, current residents who have been out on Leave of Absence (LOA) in the past 5 days (since 8-14-21) were assessed by the Director of Nursing (DON)/Assistant Director of Nursing (ADON) on 8-18-21 to ensure no changes in condition, as a result. Residents on specialized diets were reviewed by the ED/DON/ADON on 8-18-21 to ensure consumption of approved diet, as ordered by the MD while out on LOA in the past 5 days (since 8-14-21). There were no additional changes in condition noted for other identified current residents, who had gone out on LOA from 8-14-21 through 8-18-21, requiring immediate notification to the MD by the Licensed Nurse for additional orders. All 9 residents with a guardian have been validated that the current plan of care	F 835	3. The Regional Vice President of Operations (RVPO) educated the ED on 09/02/2021 in regards to effective communication pertaining to the administrative staff being informed during the facility□s daily stand up and stand down meetings on residents with guardians and the directives given by that guardian concerning their resident. If a department head is not in attendance, an email and phone call will be made to that department head by the ED or designee to inform them of the most recent changes to the resident□s plan of care during morning meeting. The department head will notify their staff of residents with guardians and inform them of the guardian□s directive concerning the resident. The DON or designee will use on-shift (internal staffing communication platform) to send a notification to direct care staff, which includes agency staff upon knowledge of the change in plan of care. On the weekend, the Customer Service Liaison (CSL) who is a current department head will ensure that staff are aware of the residents with guardians and directives given by the guardians concerning their residents .When concerns are identified, the CSL/Department Head will notify the ED immediately. The ED will educate the administrative staff on 09/03/2021 in regards to effective communication pertaining to the administrative staff being informed during the facility□s daily stand up and stand	

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F 835	Continued From page 30 is accurate. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be completed. The Regional Vice President of Operations (RVPO) educated the ED on 09/02/2021 in regards to effective communication pertaining to the administrative staff being informed during the facility's daily stand up and stand down meetings on residents with guardians and the directives given by that guardian concerning their resident. If a department head is not in attendance an email and phone call will be made to that department head by the ED to inform them of the most recent changes to the resident's plan of care during morning meeting. The department head will notify their staff of residents with guardians and inform them of the guardian's directive concerning the resident. The DON or designee will use on-shift (internal staffing communication platform) to send a notification to direct care staff which includes agency staff upon knowledge of the change in plan of care. On the weekend the Customer Service Liaison (CSL) who is a current department head will ensure that staff are aware of the residents with guardians and directives given by the guardians concerning their residents. Any concerns identified the CSL/Department Head will notify the ED immediately. The ED will educate the administrative staff on 09/03/2021 in regards to effective communication pertaining to the administrative staff being informed during the facility's daily stand up and stand down meetings on residents with guardians	F 835	down meetings on residents with guardians and the directives given by the guardian concerning their resident. If a department head is not in attendance, an email and phone call will be made to that department head by the ED or designee to inform them of the most recent changes to the resident□s plan of care during morning meeting. The department head will notify their staff of residents with guardians and inform them of the guardian□s directive concerning the resident. The DON or designee will use on-shift (internal staffing communication platform) to send a notification to direct care staff, which includes agency staff upon knowledge of the change in plan of care. On the weekend, the Customer Service Liaison (CSL), who is a current department head, will ensure that staff are aware of the residents with guardians and directives given by the guardians concerning their residents. When concerns are identified, the CSL/Department Head will notify the ED immediately. 4. Quality Improvement monitoring of residents with regard to communication will be conducted by the ED/DON 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then 1 time weekly for 4 weeks, and then 1 time monthly for 3 months. to ensure the following: a) The administrative staff is informed during the facility□s daily stand up and stand down meetings on residents with guardians and the directives given by the guardian concerning their resident. b) When a	

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F 835	Continued From page 31 and the directives given by the guardian concerning their resident. If a department head is not in attendance an email and phone call will be made to that department head by the ED to inform them of the most recent changes to the resident's plan of care during morning meeting. The department head will notify their staff of residents with guardians and inform them of the guardian's directive concerning the resident. The DON or designee will use on-shift (internal staffing communication platform) to send a notification to direct care staff which includes agency staff upon knowledge of the change in plan of care. On the weekend the Customer Service Liaison (CSL) who is a current department head will ensure that staff are aware of the residents with guardians and directives given by the guardians concerning their residents. Any concerns identified the CSL/Department Head will notify the ED immediately. The facility alleged IJ removal effective date 9/4/21. The facility's credible allegation for IJ removal was validated on 9/7/21. Review of the education completed revealed the ED received training on a system put into place to identify residents with a LG and their directives. The ED explained her role was to ensure DH staff were aware of residents with a LG and information pertaining to directives were delivered upon receipt to DH staff during stand up and stand down meetings and/or a follow up email and phone call to ensure all DH staff received the most up to date information. Interviews with DH staff revealed they were able to explain how they were kept up to date with directives and their role in informing the appropriate staff to ensure direct care and agency	F 835	department head is not in attendance, an email and phone call is made to that department head by the ED to inform them of the most recent changes to the resident□s plan of care during morning meeting. c) The department head notifies their staff of residents with guardians to inform them of the guardian□s directive concerning the resident. d) The DON/ designee uses on-shift (internal staffing communication platform) to send a notification to direct care staff, which includes agency staff upon knowledge of the change in plan of care. e) On the weekend, the Customer Service Liaison (CSL), who is a current department head, will ensure that staff are aware of the residents with guardians and directives given by the guardians concerning their residents. f) When concerns are identified, the CSL/Department Head notifies the ED immediately. Results of Quality Improvement monitoring will be reported to the Quality Improvement Committee monthly for 6 months continued compliance and/or revision. The Executive Director is responsible for implementing this plan. 5) As of 09/29/2021 the corrective actions will be completed.	

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staff received the most current up to date information pertaining to a resident ' s specific directives put in place by their LG. Interviews were conducted with newly hired and direct care staff to confirm they were aware where and how to locate legal guardianship information for residents residing at the facility.

During an interview on 9/7/21 at 2:53 PM the ED revealed she received education from the Regional Vice President of Operations pertaining to the process for communicating with DH staff and to discuss residents with changes to their directive during stand up and stand down meetings. If a DH was not present it was also the ED's responsibility to notify them via email and phone call to ensure the most current directive information was received. The ED explained it was the responsibility of each DH to notify their staff and the Director of Nursing would be responsible for the nursing and/or direct care staff including agency staff using an on-shift system to send a text requesting staff see their DH. It was then the DH's responsibility to inform their staff of changes or new directives put in place by a resident's LG. The ED also revealed their ad-hoc meeting confirmed the root cause of LG directives not being followed was a lack of communication between DH, nursing, and agency staff.