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| M 000 | Initial Comments | M 000 | | |

MS Complaint #22824

An abbreviated/partial extended survey of MS Complaint #22824 was initiated 9/20/23 and concluded 9/28/23. During the survey, the State Agency (SA) determined the facility was not in compliance with the Minimum Standard for Institutions for the Aged or Infirm, State licensure requirements. MS Complaint #22824 was determined to have occurred with Immediate Jeopardy (IJ) identified on 9/26/23 and determined to begin on 9/15/23.

The State Agency notified the facility's Administrator of the Immediate Jeopardy on 9/26/23.

Interview, record review, incident reports, written staff statements, and policy and procedure review revealed the IJ was determined to exist on 9/15/23 when Resident #1 was abandoned by the facility's Transportation Assistant (TA) in the facility vehicle after returning to the facility from dialysis at approximately 3:45 PM. Resident #1 was left alone and unattended on the facility transport van for approximately 16 hours and 15 minutes which resulted in Resident #1 missing significant medications, meals, hydration, and post dialysis site care/assessments. At approximately 7:50 AM on 9/16/2023, the facility staff located Resident #1 and removed her from the facility transport van returning her to her room in the facility. Registered Nurse (RN) #1 completed an assessment revealing the resident's temperature 100.3, blood pressure 175/79, pulse 97, Oxygen Saturation 100%. The facility did not obtain blood glucose monitoring at the time of the assessment. The local weather temperature for 9/15/23 at approximately 3:45 pm

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| M 000 | Continued From page 1<br>through 9/16/23 at 8:40 AM, when the facility located Resident #1, ranged from 89 degrees Fahrenheit to 77 degrees Fahrenheit.<br><br>The state licensure requirements that constituted the Immediate Jeopardy (IJ) were as follows:<br><br>Rule 45.17.2- M500- Resident Rights- Level IV<br><br>Rule 45.21.8-M640-Accidents- Level IV<br><br>The facility submitted an acceptable Removal Plan on 9/28/23, in which they alleged all corrective actions to remove the IJ were completed on 9/27/23 and the IJ was removed on 9/28/23.<br><br>The SA validated the Removal Plan on 9/28/23 and determined the IJ was removed on 9/28/23, prior to exit. Therefore, the scope and severity (S/S) for Rule 45.17.2-M500; Resident Rights and Rule 45.21.8; M640; Accidents were lowered from a Level IV to a Level II while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with state licensure requirements.<br><br>The facility was licensed for 74 beds and the facility census was 63 on 9/20/23. | M 000 | | |
| M 500 | 45.17.2 Residents' Rights<br><br>Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility:<br><br>1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of | M 500 | | 10/24/23 |

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| M 500 | Continued From page 2 | M 500 | | |

admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents;

2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;

3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;

4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in

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writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;

5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his

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personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);

13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);

14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);

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| M 500 | Continued From page 5<br>15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and<br><br>16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights.<br><br>This Statute is not met as evidenced by:<br>Level IV<br><br>Based on facility policy review, record review and interviews the facility failed to ensure a resident's right to be free from neglect for one (1) of four (4) sampled residents, Resident #1. On 9/15/23 at approximately 3:45 PM, after returning to the facility from a dialysis appointment the facility abandoned Resident #1 on the facility's transport van. Resident #1 was left alone and unattended on the facility transport van for approximately 16 hours and 15 minutes which resulted in Resident #1 missing medications, meals, hydration, and care and assessments. At approximately 7:50 AM on 9/16/2023, the facility staff located Resident #1 still strapped in the facility transport van.<br><br>The State Agency (SA) conducted an onsite investigation from 9/20/23 through 9/28/23. The situation was determined to be Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 9/15/23 when Resident #1 was abandoned on the facility transport van.<br><br>The facility's neglect to provide ordered care and | M 500 | The Resident was transferred to the hospital on 9/16/2023 at 8:40 am for evaluation. On 9/27/2023 the Resident was assessed by the Licensed Clinical Social Worker (LCSW) for psychosocial well-being.<br><br>All residents have the potential to be affected by this deficient practice.<br><br>All staff members were in-serviced on 9/20/2023 by the Director of Nursing on Abuse, Neglect, Exploitation, and Resident Rights. On 9/16/2023 an extra van driver was added to have two drivers completing transportation at all times. On 9/20/2023 the Administrator implemented a daily check off list for each transportation aide to complete after each transport.<br><br>The Social Service Worker will interview five (5) residents weekly x four (4) weeks starting on 09/28/2023 ending 10/26/2023 then monthly x three (3) months starting | |

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| M 500 | Continued From page 6<br>services placed Resident #1 and other residents who use the facility transport van for transfers in a situation that could likely lead to serious injury, impairment or death.<br><br>The IJ and SQC existed at:<br><br>Rule 45.17.2- Resident Rights- M500 -Scope and Severity "Level IV".<br><br>The SA notified the facility's Administrator of the IJ and SQC on 9/26/23.<br><br>The facility submitted an acceptable Removal Plan on 9/28/23, in which they alleged all corrective actions to remove the IJ was completed on 9/27/23 and the IJ and SQC was removed on 9/28/23.<br><br>The SA validated the Removal Plan on 9/28/23 and determined the IJ and SQC was removed on 9/28/23, prior to exit. Therefore, the scope and severity of Rule 45.17.2- Resident Rights- M500 was lowered from a Scope and Severity of "Level IV" to a "Level II" while the facility develops a plan of correction to monitor the effectiveness of systemic changes to ensure the facility sustains compliance with regulatory requirements.<br><br>Findings include:<br><br>A review of the facility policy titled "Abuse, Neglect, Exploitation and Misappropriation Prevention Program," update 10/2022, revealed, "Policy Statement: Residents have the right to be free from abuse, neglect ... Policy Interpretation and Implementation ...1. Protect residents from ...neglect by anyone including ...a. facility staff ..."<br><br>A record review of the facility-reported | M 500 | on 11/01/2023 ending 1/08/2024 for any reports of abuse, neglect, or exploitation, and resident rights document findings and take corrective action as needed. The Social Service Worker will report finding from weekly and monthly audits to the Quality Assurance and Performance Improvement Committee at the monthly meeting starting on 10/24/2023 ending on 01/11/2024, for review, revision, and resolution of plan as needed. | |

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investigation, dated 9/19/2023, revealed, "Incident: During shift report on 9/16/2023 at approximately 7:00 am (AM), the night shift informed the oncoming shift that the resident did not return from dialysis on 9/15/2023." At approximately 7:50 AM on 9/16/2023, the facility staff located Resident #1 still strapped in the facility transport van.

On 9/20/23 at 9:30 AM, the SA observed Resident #1 sitting hunched over in the wheelchair with poor posture. The shunt/graft was covered by clothing. Resident was unable to stand. The SA observed a lift sling beneath the resident. The resident was soft-spoken and became short of breath during a conversation. During an interview, Resident #1 stated she was "in bad shape," had "been sitting here since yesterday," and was "hurting, hungry, and thirsty." The SA questioned the resident about the incident with the van. Resident #1 had no memory of the incident. The Resident stated that she is always hungry, thirsty, and in pain.

On 9/20/23 at 9:48 AM, an interview with Resident #1's daughter revealed her mother was left in her wheelchair overnight in the facility van because the Transportation Aide (TA) forgot to remove her. Resident #1's daughter also stated she was aware that her mother did not receive her nighttime medications, dinner, or any type of care for bedtime. During the interview, Resident #1's daughter confirmed the facility did not realize her mother was missing until the next day. Resident #1's daughter stated her mother always complains of being hungry, thirsty, and hurting.

On 9/20/23 at 3:40 PM, an interview with Certified Nurse Assistant (CNA) #3 revealed that she worked on 9/15/23 until 7:00 PM. She was

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assigned to Resident #1. CNA #3 stated that Resident #1 usually returned to the facility around 4:30 PM. She would eat her lunch and then at 5:00 PM would eat her supper tray. CNA #3 stated she informed Licensed Practical Nurse (LPN) #1, who was coming on 9/15/23 at 7:00 PM, that the resident "wasn't back yet."

A record review of the Transportation Aide (TA)'s written statement revealed, on 9/16/23, "...Arrived at (Proper Name of Facility) I noticed a elderly women falling so I jumped out of van to assist her .... the lady told me she was too weak then then pulled off. I went back inside (Proper Name of Facility) to finish up normal routine and left for the day. Around 7:15 AM I got a call asking about Resident #1 and I asked the nurse to check the bus ...I would like to add that I arrived at (Proper Name of Facility) at or about 3:30 PM with Resident #1 ..."

On 9/20/23 at 4:05 PM, an interview with the TA revealed on 9/15/23 at approximately 3:30 PM, she arrived from dialysis back to the facility with Resident #1 secured in the transport van. She parked and noticed a visitor who was in distress in the parking lot. She stated that she immediately jumped out of the parked van, closed the door, and assisted the visitor. Following the incident with the visitor, she stated that she clocked out and left the facility. The following day, 9/16/23, at approximately 7:20 AM, she received a phone call from the facility questioning where Resident #1 was. She realized that she had not removed Resident #1 from the van, and the resident remained unattended for approximately 16 hours.

A record review of the License Practical Nurse (LPN) #1's written statement revealed, "... 9/15/23

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I received report that patient had not returned from dialysis. After completed pm (PM) med (medication) pass resident had still not returned. At around 10 or so I tried to call (Professional Name Dialysis) with no answer. Reported told day nurse that she had not returned from dialysis ..."

On 9/20/23 at 5:15 PM, an interview with LPN #1 revealed that she worked 9/15/23 from 7:00 PM until 9/16/23 at 7:00 AM. She said that at approximately 10:00 PM, she had one resident who had not received their medications, Resident #1. She stated, "I realized (Resident #1) was the only resident that did not receive her hours' sleep medications." She stated, "I called (the) dialysis unit and got no answer on 9/15/23 at 10:00 PM." LPN #1 revealed she received an admission on 9/15/23 at 10:00 PM and performed no further searches for Resident #1. The LPN confirmed on 9/16/23, she informed the day shift nurse and Registered Nurse (RN) #1 of the missing resident. LPN #1 confirmed that on 9/15/23 and 9/16/23 in the AM, Resident #1's shunt/ access site dressing was not observed for bleeding following dialysis. She also stated she did not give her medications, accucheck, or insulin.

During an interview on 9/21/23 at 2:28 PM, an interview with CNA #2 revealed that she had worked on 9/15/23 and 9/16/23 and was assigned to the unit on the 7:00 AM to 7:00 PM (7A-7P shift). She assisted RN #1 and other staff finding Resident #1 and removing her from the van. We observed Resident #1 seated in her wheelchair on the van, "sweaty" with "throw-up and drool on her mouth and clothes" and that "her skin was hot, hot." Then we were instructed by RN #1 to bring her to her room, give her a bath, and assist with a meal.

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| M 500 | Continued From page 10<br><br>On 9/22/23 at 4:42 PM, an interview with the Administrator revealed that he was made aware on 9/16/23 at approximately 7:50 AM of the incident in which Resident #1 was last observed by facility staff strapped in her wheelchair on the facility van on 9/15/23 at approximately 3:30 PM and was located by facility staff strapped in her wheelchair on the facility van on 9/16/23 at approximately 7:45 AM. The Administrator confirmed that Resident #1 was left on the facility van following her dialysis treatment and did not receive any medications, food or fluids, care or services, or monitoring for sixteen (16) hours and fifteen (15) minutes.<br><br>During an interview on 9/26/23 at 10:20 AM, with the Medical Director (MD) revealed that there was potential for "serious complications" for Resident #1, ", especially with her comorbidities".<br><br>On 9/26/23 at 1:35 PM, an interview with the Director of Nursing (DON) revealed that on 9/15/23 at approximately 3:30 PM, the TA left Resident #1 in the facility van and was found on 9/16/23 at approximately 7:45 AM. The DON stated that the resident not receiving medications, supervision, or monitoring for over sixteen (16) hours could have resulted in serious injury or impairment. She stated that the failure of the facility to ensure the resident received the morning dose of insulin and monitoring of the blood glucose for Resident #1 on the morning of 9/16/23 could have resulted in the resident experiencing signs and symptoms of hyperglycemia. She said that failure to ensure the administration of respiratory medications on the evening of 9/15/23 for Resident #1 could have resulted in signs and symptoms of Chronic Obstructive Pulmonary Disease (COPD), which could have hurt the resident's breathing or | M 500 | | |

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exacerbated the resident's disease process. The DON stated that the failure of the facility to provide the scheduled dose of blood pressure medication on the evening of 9/15/23 could have resulted in "serious negative cardiac results." During the interview with the DON, she stated that the facility's failure to provide adequate and appropriate monitoring for Resident #1 from approximately 3:30 PM on 9/15/23 until 7:45 AM on 9/16/23 could have resulted in the "serious injury or impairment" of Resident #1. The DON confirmed that failure to monitor the resident dialysis graph/shunt site could have resulted in bleeding at the site, which could have resulted in the resident losing blood or hemorrhaging. She stated that monitoring the site following a dialysis appointment was "very important" for the resident's safety. The DON stated that failure to appropriately monitor Resident #1 for signs/symptoms of hyperglycemia (high blood glucose levels) for over sixteen (16) hours could cause negative results for Resident #1 and cause serious injury or impairment. The DON confirmed that the Resident did not receive supervision, appropriate monitoring, or any Activities of Daily Living (ADL) care during the sixteen (16) plus hours when she was not in the facility.

The Emergency Department Nurse Practitioner (EDNP) from the local hospital confirmed in an interview on 9/27/23 at 4:15 PM, that she assessed and treated Resident #1 at the local hospital ED on 9/16/23 and that she had diagnosed Resident #1 with Heat Exposure, Neglect, and Abandonment. The EDNP confirmed her blood pressure was elevated and considered hospitalization. However, while blood tests revealed Creatine Phosphokinase (CPK) levels elevated to approximately ten (10) times the normal levels, this finding did not reach the

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threshold for hospitalization. The EDNP explained that Resident #1's elevated CPK levels were indicative of the resident being in one position for an extended period of time which led to the breakdown of muscle tissue due to muscle damage. The EDNP stated that while Resident #1 "did not have devastating results, her health was compromised". The EDNP stated that Resident #1 "was in an extremely dangerous situation" and noted conditions that contributed to this situation included having missed routinely scheduled doses of hypertension medications, food, and fluids for twenty-four (24) hours and exposure to hot, humid conditions for over sixteen (16) hours. The EDNP stated that Resident #1 had not received any psychosocial assessment during her time at the emergency department (ED). She stated that the ED's dedicated Case Worker was not on duty on 9/16/23 and that the Case Worker on duty had communicated with the facility related to giving a report to the staff and communication with the family of Resident #1 to confirm their approval to return Resident #1 to the facility. She stated that psychosocial assessments were normally under the canopy of a certified psychiatric provider. She stated that she had not completed a thorough psychosocial assessment. She said that she had only documented observations on the ED Progress/Discharge notes.

Record review of the hospital emergency department (ED) report signed by Acute Care-NP; Emergency Medicine (EDNP) revealed that on 9/16/23. The "PHYSICIAN ATTESTATION NOTE" signed by the EDNP stated that Resident #1 was assessed and received treatment at the ED "after being left in the transport vehicle overnight." Record review of the local hospital Emergency Department (ED) notes dated 9/16/23 revealed

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that Resident #1 was assessed and treated by ED Nurse Practitioner (EDNP) on 9/16/23 for "Heat Exposure ...Rhabdomyolysis ...Adult Neglect or Abandonment ...Elevated Blood Pressure Reading".

Record review of the Progress Note dated 9/27/23, Resident #1 was seen for counseling by a contracted Licensed Certified Social Worker (LCSW) on 9/27/23 with "Chief complaint" listed as "A recent Incident. Resident was left overnight in the facility transport LCSW asked to assess resident 2* (secondary) to this event." The progress note review revealed "Resident Quote; "I thought I was doomed" ...Resident reports current emotional status or behavior as: Tired and concerned that the incident (being left in the transport van overnight) not be repeated and another resident suffer as she had. Today resident discussed: The Incident of being left in the transport van. Resident shared that she was anxious, hurting, and afraid. She explained that she got through the night by crying and being worried and didn't sleep at all. When asked if it was the most frightened, she had ever been in her life, resident stated it was not but "close" ...she feels she was "denied the help I was supposed to get and added she is resentful and angry about the incident ..."

On 9/28/23 at 11:10 AM, a telephone interview with the facility's contracted Licensed Certified Social Worker (LCSW) revealed that regarding the cognitive level of Resident #1, the resident was able to express her feelings and needs verbally. She was sure Resident #1 remembered being in the facility van overnight on 9/15/23 because Resident #1 "was able to describe being in the wheelchair and the van, and the pain and fear she felt." The LCSW stated that the incident

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was "definitely detrimental in the way she was frightened and talked about not being provided with care." The LCSW reported that Resident #1 stated, "I was denied the care I needed" during their conversation on 9/27/23. The LCSW reported that effects from the incident "may appear over time" and said, "That will be found out in days to come."

A record review of the "Order Summary Report" as of 9/25/23 revealed Resident #1 missed the following physician orders for blood pressure at 7-10 P: Amlodipine, Metoprolol Tartrate Tablet, Clonidine HCL and Hydralazine HCL Tablet.

A record review of the "Order Summary Report" as of 9/25/23 revealed Resident #1 missed the following physician order to monitors access site Right Upper Arm for thrill & bruit, two times a day and observe dressing to right arm two times a day.

A record review of the "Order Summary Report" as of 9/25/23 revealed Resident #1 missed her diabetic medication and accucheck on 9/16/23 of Insulin Detemir Solution 100 UNIT/ML (milliliter) and accucheck is less than 60 mg/dl (deciliter) or greater than 400 mg/dl.

A record review of the "Order Summary Report" as of 9/25/23 revealed an order for Proventil HFA (bronchitis).
Record review of Resident #1's "Medication Administration Record (MAR)" for 9/1/23 - 9/30/23 revealed on 9/15/23, the following medications were coded as 3 (absent from home) and not administered for blood pressure Amlodipine, Metoprolol Tartrate Tablet, Clonidine HCL and Hydralazine HCL Tablet.

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| M 500 | Continued From page 15<br><br>Record review of Resident #1's "Medication Administration Record (MAR)" for 9/1/23 - 9/30/23 revealed on 9/16/23, the following medications were coded as 3 (absent from home) and not administered: Insulin Detemir Solution, Accu check, and Proventil for bronchitis.<br><br>In a record review "Documentation Survey" revealed, the facility failed to perform ADL (Activities of Daily Living) on Resident #1 for 16 hours and 15 minutes, on 9/15/23 through 9/16/23.<br><br>Record review revealed Resident #1 had no progress reports from 9/7/23 till 9/16/23 at 9:40 AM.<br><br>Record review of Resident #1's "Progress Notes" revealed, 9/16/23 09:40 (9:40 AM) Note Text, "Arrived to facility at approx. (approximately) 8:40 AM in regards to resident being left on facility transport van overnight ... MD (Medical Doctor) notified of incident and findings...Orders received to send to ER (Emergency Room). At approx. (approximately) 0920 (9:20 AM) Report was called to (Formal Name/local hospital) ER, Admin (Administrator) aware of incident and also at facility at this time. RP (Responsible Party) arrived to facility at approx. 0930 (9:30 AM) and Admin informed RP of incident and status of resident. Resident left facility at via stretcher at this time."<br><br>Record review of the "Admission Record" revealed the facility admitted Resident #1 on 12/20/22 with diagnoses including Type 2 Diabetes Mellitus without complications, Hypertensive, Insulin-Dependent, Dependence on Renal Dialysis, chronic diastolic (congestive) heart failure, Type 2 Diabetes Mellitus, and | M 500 | | |

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Hypertensive Heart and Chronic Kidney Disease with Heart Failure and with Stage 5 Chronic kidney disease.

Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/7/23 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 07 indicating Resident #1 had severe cognitive impairment. Section G revealed for resident transfer, that the resident was an extensive assist with two people. Section H revealed the resident was always incontinent of bowel and bladder. Section J revealed Resident #1 experienced pain frequently. Section M revealed the resident was at risk for pressure ulcers/injuries.

The facility provided the following removal plan on 9/28/23.

On 9/26/2023 1:15 pm the State Agency notified the Administrator that the facility neglected to provide care and services for Resident #1 from approximately 3:45 pm on 9/15/2023 until approximately 7:45 am on 9/16/2023, failed to notify the Physician timely of a change in condition after resident was left in the transport van, alone and unattended by a staff member which resulted in Resident #1 missing medications, meals, hydration and post dialysis site care/assessments.

On 9/15/2023 the Transportation Assistant (TA) left Resident #1 in the facility vehicle after returning to the facility from dialysis at approximately 3:45 pm. The facility staff located Resident #1 and removed her from the facility vehicle at approximately 7:50 am on 9/16/2023, assisted Resident #1 back in the facility, transferred Resident #1 to bed, Registered Nurse

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| M 500 | Continued From page 17<br><br>(RN) #1 completed an assessment revealing a temperature 100.3, blood pressure 175/79, pulse 97, Oxygen Saturation 100%. The nurse did not obtain blood sugar at this time. The physician was notified of the incident at approximately 8:40 am on 9/16/2023 by the Director of Nursing. The Resident Representative was notified of the incident at approximately 9:15 am on 9/16/2023 by the Administrator.<br><br>1. 9/16/2023 8:40 am the DON (Director of Nurses) arrived at the facility, assessed Resident #1 and noted that resident was at baseline.<br><br>2. On 9/16/2023 the Medical Director was notified at 8:40 am and received an order to send to the emergency room for evaluation.<br><br>3. 9/16/2023 9:15 am the Administrator notified the State Department of Health of the incident.<br><br>4. 9/16/2023 9:40 am Resident #1 was transferred to the hospital and returned to the facility at 2:30 pm.<br><br>5. 9/16/2023 10:00 am the DON conducted a 100% head count of all residents in the facility and audited records of all residents that were out of the facility to ensure adequate documentation with no negative findings.<br><br>6. On 9/16/2023 at 10:10 am the investigation revealed that when the TA arrived at the facility on 9/15/2023 with Resident #1 she noticed a visitor almost fall, got out of the vehicle to assist then went in the facility not realizing that the Resident #1 was still on the van. LPN #1 received in report on 9/15/2023 at 7:00 pm that Resident #1 did not return from dialysis and did not follow up to determine where the resident was located. | M 500 | | |

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| M 500 | Continued From page 18<br><br>7. On 9/16/2023 at 10:45am an emergency Quality Assurance and Performance Improvement (QAPI) Committee meeting was held regarding the incident involving Resident #1 that occurred on 9/15/2023. In attendance were the Administrator, DON, Infection Preventionist (IP), Regional Director of Operations, Regional Nurse Consultant, Medical Records Nurse, Minimum Data Set (MDS) Nurse, RN Supervisor, Medical Director, and Dietary Manager.<br><br>QAPI minutes included:<br>Review of the incident, investigation and missing resident policy.<br>Review of immediate actions taken.<br>Recommendations to prevent reoccurrence were to complete in-service for all staff regarding missing residents prior to working, in-service for nurses to include if the reason why a resident is not in the facility is not documented in the record to notify the supervisor immediately, initiate a log for 2 people to document that the facility vehicle is checked at the end of each day and after each transport, conduct a missing person drill on each shift, initiate 2 staff members to ride on the facility vehicle for all resident transports and educate all transportation drivers of new procedures.<br><br>8. On 9/16/2023 11:30 the DON began in-service for all staff regarding missing residents and all nurses to include if the reason a resident is not in the facility is not documented in the progress note to notify the supervisor immediately, no staff was allowed to work until receiving in-service.<br><br>9. 9/18/2023 11:30 am the Director of Nursing created a log to be placed on the facility vehicle and in-serviced all transportation drivers regarding signing in and out with a witness after | M 500 | | |

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every transport and at the end of each day to verify that no residents are on the transport van.

10. 9/16/2023 11:58 am the Administrator conducted a missing resident drill for all staff on day shift.

11. 9/17/2023 6:30 am the Administrator conducted a missing resident drill for all staff on night shift. The missing resident drill consisted of a resident being hidden in the Administrator's office and was identified by a staff member who did a sweep of the office areas and the staff member immediately reported to the Administrator that the resident was found. No changes to policy and procedure needed.

12. On 9/18/2023 at 11 am the Administrator notified the Attorney General's office of the incident.

13. 9/19/2023 at 10 am the DON in-serviced all staff on abuse and neglect policies.

14. 9/19/2023 at 6:30 pm the MDS Nurse audited 100 % of the records for all residents receiving dialysis to include care plans with no adverse findings. On 9/26/2023 at 8 pm the MDS nurse audit the care plans of 100% of residents receiving routine transportation services, dialysis, and diabetic care with no adverse findings.

15. On 9/20/2023 at 2:40 PM the Administrator notified the local police department of the incident involving Resident #1.

16. 9/26/2023 2:34 pm an emergency QAPI meeting was held regarding the incident involving Resident #1 being left on the van on 9/15/2023. Those in attendance were Administrator, DON,

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| M 500 | Continued From page 20<br>IP, Social Service Director, Medical Records, Business Office Manager, Customer Relations Specialist, RN Supervisor, MDS Nurse and Medical Director.<br><br>-The Committee reviewed the incident, the Immediate Jeopardies cited by the state agency on 9/26/2023, and the policies regarding abuse and neglect, supervision of residents, dialysis care, diabetic care, timely notification of the physician, accidents, staffing and care plans. The following recommendations were discussed.<br><br>The root cause analysis revealed that the TA was distracted and as a result left Resident #1 on the facility vehicle. It also revealed that the nurse failed to follow proper procedure to investigate why Resident #1 did not return from dialysis that resulted in the resident not being located in a timely manner which resulted in the resident not receiving proper dialysis care, diabetic care and medications.<br><br>There were no recommendations to make changes to any policies by the QAPI Team and all interventions that were put into place were effective.<br><br>The MDS Nurse will conduct another audit of the care plans for 100% of residents receiving dialysis and diabetic care.<br><br>The MDS Nurse will conduct an audit of the care plans for 100% of residents receiving routine transportation services.<br><br>The Social Service Director will evaluate Resident #1 for signs of psychosocial harm due to the incident that occurred on 9/15/2023. | M 500 | | |

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| M 500 | Continued From page 21<br><br>The facility assessment was reviewed and updated regarding staffing according to the acuity of the residents. The Committee determined at this time the staffing required for the night shift is 4 Certified Nursing Assistants and 2 Nurses. If these requirements are not met the nurse will contact the DON and Administrator and they will make arrangements to cover staffing needs by contacting all employees, department heads and sister facilities as needed to fill gaps.<br><br>DON will provide in-service for all staff regarding abuse/neglect, accidents, and supervision of residents. DON will provide in-service for all nursing staff regarding staffing, care plans, diabetic care, dialysis care and timely notification of the physician. All staff will receive in-service prior to returning to work.<br><br>17. 9/26/2023 3:00 pm the Social Service Director spoke with Resident #1 concerning her psychosocial needs and noted no signs of psychosocial harm related to the incident that occurred on 9/15/2023.<br><br>18. 9/26/2023 5:00 pm the DON began in-servicing all staff regarding accidents, supervision of residents and abuse/neglect. All staff will receive in-service prior to returning to work.<br><br>19. 9/26/2023 5:00 pm the DON began in-servicing all nursing staff regarding diabetic care, dialysis care, staffing, notifying the physician in a timely manner and care plans. All staff will receive in-service prior to returning to work.<br><br>20. On 9/27/2023 at 5:00 pm the Licensed Clinical Social Worker (LCSW) assessed | M 500 | | |

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Resident #1 concerning her psychological needs and concerns regarding the incident on 9/15/2023 the LCSW concluded, "bothered but not overly traumatized by the event as evidenced by her willingness to stay, having stated faith in caregivers/staff here, continue to monitor Resident."

The facility alleges removal of the immediacy on 9/28/2023.

The SA validated the Removal Plan on 9/28/23 and determined the IJ was removed on 9/28/23 prior to exit.

The SA validated through interview and record review that the DON stated she arrived on 9/16/2023 8:40 am and assessed Resident #1.

The SA validated through interviews and record reviews that on 9/16/2023 the Medical Director was notified at 8:40 am and gave an order to send to the emergency room for evaluation.

The SA validated through interviews and record reviews that on 9/16/2023 9:15 am the Administrator notified the State Department of Health of the incident.

The SA validated through interviews and record reviews that on 9/16/2023 9:40 am Resident #1 was transferred to the hospital and returned to the facility at 2:30 pm.

The SA validated through interviews and documentation reviews that on 9/16/2023 10:00 am the DON conducted a 100% head count of all residents in the facility and audited records of all residents that were out of the facility to ensure adequate documentation with no negative

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findings.

The SA validated through interviews and record reviews that on 9/16/2023 at 10:10 am the facility initiated an investigation that revealed when the TA arrived at the facility on 9/15/2023 with Resident #1 she noticed a visitor almost fall, got out of the vehicle to assist then went in the facility not realizing that the Resident #1 was still on the van. The SA validated that the facility investigation also revealed LPN #1 did not follow up to determine where the resident was located when told in report on 9/15/2023 at 7:00 pm that Resident #1 did not return from dialysis.

The SA validated through interviews, observations, and record reviews that on 9/16/2023 at 10:45am an emergency Quality Assurance and Performance Improvement (QAPI) Committee meeting was held regarding the incident involving Resident #1 that occurred on 9/15/2023. In attendance were the Administrator, DON, Infection Preventionist (IP), Regional Director of Operations, Regional Nurse Consultant, Medical Records Nurse, Minimum Data Set (MDS) Nurse, RN Supervisor, Medical Director, and Dietary Manager.

The SA validated through staff interviews and record reviews that on 9/16/2023 11:30 the DON began in-service for all staff regarding missing residents and all nurses to include if the reason a resident is not in the facility is not documented in the progress note to notify the supervisor immediately, no staff was allowed to work until receiving in-service.

The SA validated through observation, interviews, and record reviews that on 9/18/2023 11:30 am the Director of Nursing created a log to be placed

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| M 500 | Continued From page 24<br>on the facility vehicle and in-serviced all transportation drivers regarding signing in and out with a witness after every transport and at the end of each day to verify that no residents are on the transport van.<br><br>The SA validated through interviews and documentation reviews that on 9/16/2023 11:58 am the Administrator conducted a missing resident drill for all staff on day shift.<br><br>The SA validated through interviews and documentation reviews that on 9/17/2023 6:30 am the Administrator conducted a missing resident drill for all staff on night shift.<br><br>The SA validated through interview that on 9/18/2023 at 11 am the Administrator notified the Attorney General's office of the incident.<br><br>The SA validated through interviews and staff sign in sheets that on 9/19/2023 at 10 am the DON in-serviced all staff on abuse and neglect policies.<br><br>The SA validated through interview and record review that on 9/19/2023 at 6:30 pm the MDS Nurse audited 100 % of the records for all residents receiving dialysis to include care plans with no adverse findings. On 9/26/2023 at 8 pm the MDS nurse audit the care plans of 100% of residents receiving routine transportation services, dialysis, and diabetic care with no adverse findings.<br><br>The SA validated through interview that on 9/20/2023 at 2:40 PM the Administrator notified the local police department of the incident involving Resident #1. | M 500 | | |

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| M 500 | Continued From page 25<br><br>The SA validated through interviews and record reviews that on 9/26/2023 2:34 pm an emergency QAPI meeting was held regarding the incident involving Resident #1 being left on the van on 9/15/2023. Those in attendance were Administrator, DON, IP, Social Service Director, Medical Records, Business Office Manager, Customer Relations Specialist, RN Supervisor, MDS Nurse and Medical Director.<br><br>The SA validated through interview and record review that on 9/26/2023 3:00 pm the Social Service Director spoke with resident #1 concerning her psychosocial needs.<br><br>The SA validated through interviews and staff sign in sheets that on 9/26/2023 5:00 pm the DON began in-servicing all staff regarding accidents, supervision of residents and abuse/neglect. All staff will receive in-service prior to returning to work.<br><br>The SA validated through interviews and record reviews that on 9/26/2023 5:00 pm the DON began in-servicing all nursing staff regarding diabetic care, dialysis care, staffing, notifying the physician in a timely manner and care plans. All staff will receive in-service prior to returning to work.<br><br>The SA validated through interview and documentation review that on 9/27/2023 at 5:00 pm the Licensed Clinical Social Worker (LCSW) assessed Resident #1 concerning her psychological needs and concerns regarding the incident on 9/15/2023 the LCSW concluded, "bothered but not overly traumatized by the event as evidenced by her willingness to stay, having stated faith in caregivers/staff here, continue to monitor Resident." | M 500 | | |

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| M 640 | 45.21.8 Accidents<br><br>Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies.<br><br>This Statute is not met as evidenced by:<br>Level IV<br><br>Based on policy review, record review, and interviews, the facility failed to provide supervision for a resident who was left alone, abandoned, strapped in her wheelchair without monitoring on the facility transport van following a dialysis treatment for approximately 16 hours and 15 minutes for one (1) of four (4) Residents reviewed. Resident #1. The facility failed to remove the resident from the facility van following transportation from her hemodialysis treatment, abandoning the resident restrained by seat belts in a wheelchair in the facility transport van, without supervision or monitoring. The staff was unaware of Resident #1's location from approximately 3:30 PM on 9/15/23 through 7:45 AM on 9/16/23.<br><br>The State Agency (SA) conducted an onsite investigation from 9/20/23 through 9/28/23. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 9/15/23 when Resident #1 was abandoned on the facility transport van.<br><br>The facility's failure to supervise Resident #1 placed this resident, and other resident, in a situation that was likely to cause serious harm, | M 640 | The Resident was given morning medication, fed breakfast, given liquids, and cleaned before being sent to the hospital on 9/16/2023 for further evaluation. On 9/19/2023 the Director of Nursing provided the transportation aide with 1 on 1 in-service training to ensure after each transport van is checked to ensure no resident is left behind.<br><br>All Residents have the potential to be affected by this deficient practice.<br><br>All transportation completed a van check in-service before being allowed to transport any resident. On 9/16/2023 an extra transportation was added to ensure double check is completed on each transport. A daily check list was implemented on 9/16/2023 by the Administrator to have both transportation aides sign at completion of day.<br><br>The Administrator will audit transportation log weekly x four (4) weeks starting on 09/28/2023 ending 11/07/2023 then monthly x three (3) months starting on 11/01/2023 ending 1/01/2024, document and take corrective action when needed. | 10/24/23 |

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| M 640 | Continued From page 27<br>injury, impairment, or death.<br><br>The situation was determined to be an Immediate Jeopardy (IJ) that began on 9/15/23, when the facility abandoned Resident #1 on the facility van for approximately sixteen (16) hours and fifteen (15) minutes following hemodialysis. The resident received no treatment, supervision, monitoring or care during this time.<br><br>The IJ and SQC existed at:<br><br>Rule 45.21.8 Accidents- M640- Scope and Severity "Level IV"<br><br>The State Agency (SA) notified the facility Administrator of the IJ and SQC on 9/26/23 at 1:15 PM. The facility provided an acceptable Removal Plan on 9/27/23, in which the facility alleged all corrective actions were completed on 9/27/23 to remove the IJ on 9/28/23.<br><br>The facility submitted an acceptable Removal Plan on 9/28/23, in which they alleged all corrective actions to remove the IJ and SQC were completed on 9/27/23 and the IJ was removed on 9/28/23.<br><br>The SA validated the Removal Plan on 9/28/23 and determined the IJ was removed on 9/28/23, prior to exit. Therefore, the scope and severity for Rule 45.21.8 Accidents- M640- scope and severity "Level IV" was lowered to a "Level II", while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.<br><br>Findings include: | M 640 | The Administrator will report findings from weekly and monthly audits to the Quality Assurance and Performance Improvement Committee at the monthly meeting starting on 10/24/2023 ending on 01/11/2024, for review, revision, and resolution of plan as needed. | |

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| M 640 | Continued From page 28<br><br>A review of the facility's policy, "Accidents and Incidents" with a revision date of 9/25/23, revealed, "Policy: It is the policy of this facility that the resident environment remains as free of accidents and hazards as possible, and those residents receive supervision and assistance devices to prevent accidents whenever possible..."<br><br>A record review of the Facility Investigation, dated 9/19/2023, revealed, during shift report on 9/16/2023 at approximately 7:00 am (AM), the night shift informed the oncoming shift that the resident did not return from dialysis on 9/15/2023. At approximately 7:50 AM on 9/16/2023, the facility staff located Resident #1 still strapped in the facility transport van.<br><br>A record review of Resident #1's Incident Report revealed, 9/16/23 13:38 (1:38 PM), " ...writer notified of resident being left in facility transport van after dialysis yesterday evening. Resident was located in facility van the AM ..."<br><br>A record review of the Transportation Aide (TA's) written statement revealed, on 9/16/23, " ...Arrived at (Proper Name/facility) I noticed a elderly women falling so I jumped out of van to assist her .... the lady told me she was to weak then pulled off. I went back inside (Proper Name of facility) to finish up normal routine and left for the day. Around 7:15 AM I got a call asking about Resident #1 and I asked the nurse to check the bus ...I would like to add that I arrived at (Proper Name of facility) at or about 3:30 PM with Resident #1 ..."<br><br>An interview with the TA on 9/20/23 at 4:05 PM, revealed that 9/15/23, "After receiving Resident | M 640 | | |

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#1 from dialysis, I drove back to the facility and parked the van, with Resident #1 secured in the van." The TA noticed a visitor who was in distress in the parking lot and assisted the visitor. Following the incident with the visitor, she clocked out and left the facility. The following morning, she received a phone call from the facility questioning where Resident #1 was located. At that moment, she realized she had not transferred the resident from the van to the facility. The resident remained unattended for approximately 16 hours while in the facility van.

A record review of Licensed Practical Nurse (LPN) #1's written statement revealed, " ... On 9/15/23, I received a report that patient had not returned from dialysis. After completed pm (PM) med (medication) pass resident had still not returned. At around 10 or so I tried to call (Professional Name/Dialysis) with no answer. Reported to the oncoming nurse that she had not returned from dialysis ..."

On 9/20/23 at 5:15 PM, an interview with LPN #1 confirmed she was assigned to Resident #1 on 9/15/23 at 7:00 PM until 9/16/23 at 7:00 AM. LPN #1 stated that on 9/15/23 at 10:00 PM, Resident #1 did not receive her medications and was not in the building. She assumed she was at the hospital or still at dialysis. She attempted to contact dialysis unsuccessfully and passed on to the oncoming nurse on 9/16/23 at 7:00 AM that Resident #1 was not in the building.

On 9/20/23 at 10:25 AM, an interview with the Director of Nurses (DON) confirmed that Resident #1 was left in the facility transport van, strapped in her wheelchair from 9/15/23 at approximately 3:30 PM until 9/16/23 at 7:45 AM, when she was located by the facility staff. The

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DON revealed the resident was unattended for approximately 16 hours and 15 minutes.

During an interview on 9/20/23 at 3:40 PM, Certified Nurse Assistant (CNA) #3 revealed that she worked the day shift at the facility on Friday, 9/15/23, until 7:00 PM and confirmed Resident #1 was not in the facility. She reported to the night shift nurse (LPN #1) that Resident #1 was not in the facility. When she arrived at work on 9/16/23 at approximately 7:45 AM, Resident #1 was in the facility van strapped in her wheelchair.

A record review Registered Nurse (RN) #1's written statement revealed, " ...At approximately 7:10, I was notified by night shift nurse and oncoming nurse and Certified Nurse Assistant (CNA) that resident did not return to facility from Dialysis on 9/15/23. Night shift nurse stated, "I do not know where she is, I did not realize she was still gone around 10 pm (PM)." Called TA, she stated, "Oh my gosh, check the van." Resident was seen in the van, shoulders moving up and down indicating she was breathing."

On 9/21/23 at 9:23 AM, an interview with Registered Nurse (RN) #1 confirmed on 9/16/23 that she was informed that Resident #1 was not in the building. She stated she started making phone calls to locate the resident. The TA advised her to look in the facility van, where she was located still strapped in her wheelchair. Resident #1 was strapped in her wheelchair and the facility van for approximately 16 hours and 15 minutes with no supervision.

In an interview on 9/22/23 at 4:42 PM, with the Administrator, confirmed Resident #1 was last observed on the facility van when she was transported from dialysis on 9/15/23 at

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approximately 3:30 PM. The Administrator conveyed that he was informed on 9/16/23 at approximately 7:50 AM of the incident that Resident #1 was left unattended on the facility van following her dialysis treatment for approximately 16 hours and 15 minutes, with no supervision.

In an interview on 9/26/23 at 10:20 AM, with the Medical Director (MD) revealed the potential for "serious complications" for Resident #1 for being unsupervised and left in the facility van for over 16 hours.

In an interview on 9/26/23 at 1:35 PM, with the DON revealed that on 9/15/23 at approximately 3:30 PM, the TA left Resident #1 in the facility van and was found on 9/16/23 at approximately 7:45 AM. The DON stated that the resident not receiving medications, supervision, or monitoring for over sixteen (16) hours could have resulted in serious injury or impairment. The DON confirmed that the Resident did not receive supervision, appropriate monitoring or any Activities of Daily Living (ADL) care, during the sixteen (16) plus hours when she was not in the facility.

On 9/27/23 at 3:13 PM, an interview with RN #4 from the dialysis clinic confirmed Resident #1's dialysis was completed, and she was transported from the dialysis clinic to the facility on 9/15/23 at approximately 3:15 PM, by a facility staff member. She was unsure of who performed the transport.

Record review of the local weather temperature for 9/15/23 at approximately 3:45 pm through 9/16/23 at 8:40 AM, when the facility located Resident #1, ranged from 89 degrees Fahrenheit to 77 degrees Fahrenheit and was obtained at

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| M 640 | Continued From page 32<br>https://www.timeanddate.com.<br><br>Record review of the "Admission Record" revealed the facility admitted Resident #1 on 12/20/22 with diagnoses including Type 2 Diabetes Mellitus without complications, Hypertension, Insulin-Dependent, Dependence on Renal Dialysis, Chronic Diastolic (congestive) Heart Failure, Type 2 Diabetes Mellitus, Hypertensive Heart and Chronic Kidney Disease with Heart Failure and with Stage 5 Chronic kidney disease.<br><br>Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/7/23 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 07 indicating Resident #1 had severe cognitive impairment. Section G revealed for resident transfer that the resident was an extensive assist with two people. Section H revealed the resident was always incontinent of bowel and bladder. Section J revealed Resident #1 experienced pain frequently. Section M revealed that the resident was at risk for pressure ulcers/injuries.<br><br>The facility provided the following Removal Plan on 9/28/23.<br><br>On 9/26/2023 1:15 pm the State Agency notified the Administrator that the facility neglected to provide care and services for Resident #1 from approximately 3:45 pm on 9/15/2023 until approximately 7:45 am on 9/16/2023, failed to notify the Physician timely of a change in condition after resident was left in the transport van, alone and unattended by a staff member which resulted in Resident #1 missing medications, meals, hydration and post dialysis site care/assessments. | M 640 | | |

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| M 640 | Continued From page 33<br><br>On 9/15/2023 the Transportation Assistant (TA) left Resident #1 in the facility vehicle after returning to the facility from dialysis at approximately 3:45 pm. The facility staff located Resident #1 and removed her from the facility vehicle at approximately 7:50 am on 9/16/2023, assisted Resident #1 back in the facility, transferred Resident #1 to bed, Registered Nurse (RN) #1 completed an assessment revealing a temperature 100.3 Fahrenheit, blood pressure 175/79, pulse 97, Oxygen Saturation 100%. The nurse did not obtain blood sugar at this time. The physician was notified of the incident at approximately 8:40 am on 9/16/2023 by the Director of Nursing. The Resident Representative was notified of the incident at approximately 9:15 am on 9/16/2023 by the Administrator.<br><br>1. 9/16/2023 8:40 am the DON (Director of Nurses) arrived at the facility, assessed Resident #1 and noted that resident was at baseline.<br><br>2. On 9/16/2023 the Medical Director was notified at 8:40 am and received an order to send to the emergency room for evaluation.<br><br>3. 9/16/2023 9:15 am the Administrator notified the State Department of Health of the incident.<br><br>4. 9/16/2023 9:40 am Resident #1 was transferred to the hospital and returned to the facility at 2:30 pm.<br><br>5. 9/16/2023 10:00 am the DON conducted a 100% head count of all residents in the facility and audited records of all residents that were out of the facility to ensure adequate documentation with no negative findings. | M 640 | | |

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| M 640 | Continued From page 34<br><br>6. On 9/16/2023 at 10:10 am the investigation revealed that when the TA arrived at the facility on 9/15/2023 with Resident #1 she noticed a visitor almost fall, got out of the vehicle to assist then went in the facility not realizing that the Resident #1 was still on the van. LPN #1 received in report on 9/15/2023 at 7:00 pm that Resident #1 did not return from dialysis and did not follow up to determine where the resident was located.<br><br>7. On 9/16/2023 at 10:45am an emergency Quality Assurance and Performance Improvement (QAPI) Committee meeting was held regarding the incident involving Resident #1 that occurred on 9/15/2023. In attendance were the Administrator, DON, Infection Preventionist (IP), Regional Director of Operations, Regional Nurse Consultant, Medical Records Nurse, Minimum Data Set (MDS) Nurse, RN Supervisor, Medical Director, and Dietary Manager.<br>QAPI minutes included:<br>Review of the incident, investigation and missing resident policy.<br>Review of immediate actions taken.<br>Recommendations to prevent reoccurrence were to complete in-service for all staff regarding missing residents prior to working, in-service for nurses to include if the reason why a resident is not in the facility is not documented in the record to notify the supervisor immediately, initiate a log for 2 people to document that the facility vehicle is checked at the end of each day and after each transport, conduct a missing person drill on each shift, initiate 2 staff members to ride on the facility vehicle for all resident transports and educate all transportation drivers of new procedures.<br><br>8. On 9/16/2023 11:30 the DON began in-service for all staff regarding missing residents and all nurses to include if the reason a resident is not in | M 640 | | |

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| SUNPLEX SUB-ACUTE CENTER | 6520 SUNSCOPE DRIVE OCEAN SPRINGS, MS 39564 |

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the facility is not documented in the progress note to notify the supervisor immediately, no staff was allowed to work until receiving in-service.

9. 9/18/2023 11:30 am the Director of Nursing created a log to be placed on the facility vehicle and in-serviced all transportation drivers regarding signing in and out with a witness after every transport and at the end of each day to verify that no residents are on the transport van.

10. 9/16/2023 11:58 am the Administrator conducted a missing resident drill for all staff on day shift.

11. 9/17/2023 6:30 am the Administrator conducted a missing resident drill for all staff on night shift. The missing resident drill consisted of a resident being hidden in the Administrator's office and was identified by a staff member who did a sweep of the office areas and the staff member immediately reported to the Administrator that the resident was found. No changes to policy and procedure needed.

12. On 9/18/2023 at 11 am the Administrator notified the Attorney General's office of the incident.

13. 9/19/2023 at 10 am the DON in-serviced all staff on abuse and neglect policies.

14. 9/19/2023 at 6:30 pm the MDS Nurse audited 100 % of the records for all residents receiving dialysis to include care plans with no adverse findings. On 9/26/2023 at 8 pm the MDS nurse audit the care plans of 100% of residents receiving routine transportation services, dialysis, and diabetic care with no adverse findings.

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| M 640 | Continued From page 36<br><br>15. On 9/20/2023 at 2:40 PM the Administrator notified the local police department of the incident involving Resident #1.<br><br>16. 9/26/2023 2:34 pm an emergency QAPI meeting was held regarding the incident involving Resident #1 being left on the van on 9/15/2023. Those in attendance were Administrator, DON, IP, Social Service Director, Medical Records, Business Office Manager, Customer Relations Specialist, RN Supervisor, MDS Nurse and Medical Director.<br>-The Committee reviewed the incident, the Immediate Jeopardies cited by the state agency on 9/26/2023, and the policies regarding abuse and neglect, supervision of residents, dialysis care, diabetic care, timely notification of the physician, accidents, staffing and care plans. The following recommendations were discussed.<br><br>The root cause analysis revealed that the TA was distracted and as a result left Resident #1 on the facility vehicle. It also revealed that the nurse failed to follow proper procedure to investigate why Resident #1 did not return from dialysis that resulted in the resident not being located in a timely manner which resulted in the resident not receiving proper dialysis care, diabetic care and medications.<br><br>There were no recommendations to make changes to any policies by the QAPI Team and all interventions that were put into place were effective.<br><br>The MDS Nurse will conduct another audit of the care plans for 100% of residents receiving dialysis and diabetic care.<br><br>The MDS Nurse will conduct an audit of the care | M 640 | | |

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plans for 100% of residents receiving routine transportation services.

The Social Service Director will evaluate Resident #1 for signs of psychosocial harm due to the incident that occurred on 9/15/2023.

The facility assessment was reviewed and updated regarding staffing according to the acuity of the residents. The Committee determined at this time the staffing required for the night shift is 4 Certified Nursing Assistants and 2 Nurses. If these requirements are not met the nurse will contact the DON and Administrator and they will make arrangements to cover staffing needs by contacting all employees, department heads and sister facilities as needed to fill gaps.
DON will provide in-service for all staff regarding abuse/neglect, accidents, and supervision of residents. DON will provide in-service for all nursing staff regarding staffing, care plans, diabetic care, dialysis care and timely notification of the physician. All staff will receive in-service prior to returning to work.

17. 9/26/2023 3:00 pm the Social Service Director spoke with Resident #1 concerning her psychosocial needs and noted no signs of psychosocial harm related to the incident that occurred on 9/15/2023.

18. 9/26/2023 5:00 pm the DON began in-servicing all staff regarding accidents, supervision of residents and abuse/neglect. All staff will receive in-service prior to returning to work.

19. 9/26/2023 5:00 pm the DON began in-servicing all nursing staff regarding diabetic care, dialysis care, staffing, notifying the

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physician in a timely manner and care plans. All staff will receive in-service prior to returning to work.

20. On 9/27/2023 at 5:00 pm the Licensed Clinical Social Worker (LCSW) assessed Resident #1 concerning her psychological needs and concerns regarding the incident on 9/15/2023 the LCSW concluded, "bothered but not overly traumatized by the event as evidenced by her willingness to stay, having stated faith in caregivers/staff here, continue to monitor Resident."

The facility alleges removal of the immediacy on 9/28/2023.

The SA validated the Removal Plan on 9/28/23 and determined the IJ was removed on 9/28/23 prior to exit.

The SA validated through interview and record review that the DON stated she arrived on 9/16/2023 8:40 am and assessed Resident #1.

The SA validated through interviews and record reviews that on 9/16/2023 the Medical Director was notified at 8:40 am and gave an order to send to the emergency room for evaluation.

The SA validated through interviews and record reviews that on 9/16/2023 9:15 am the Administrator notified the State Department of Health of the incident.

The SA validated through interviews and record reviews that on 9/16/2023 9:40 am Resident #1 was transferred to the hospital and returned to the facility at 2:30 pm.

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| M 640 | Continued From page 39<br><br>The SA validated through interviews and documentation reviews that on 9/16/2023 10:00 am the DON conducted a 100% head count of all residents in the facility and audited records of all residents that were out of the facility to ensure adequate documentation with no negative findings.<br><br>The SA validated through interviews and record reviews that on 9/16/2023 at 10:10 am the facility initiated an investigation that revealed when the TA arrived at the facility on 9/15/2023 with Resident #1 she noticed a visitor almost fall, got out of the vehicle to assist then went in the facility not realizing that the Resident #1 was still on the van. The SA validated that the facility investigation also revealed LPN #1 did not follow up to determine where the resident was located when told in report on 9/15/2023 at 7:00 pm that Resident #1 did not return from dialysis.<br><br>The SA validated through interviews, observations, and record reviews that on 9/16/2023 at 10:45am an emergency Quality Assurance and Performance Improvement (QAPI) Committee meeting was held regarding the incident involving Resident #1 that occurred on 9/15/2023. In attendance were the Administrator, DON, Infection Preventionist (IP), Regional Director of Operations, Regional Nurse Consultant, Medical Records Nurse, Minimum Data Set (MDS) Nurse, RN Supervisor, Medical Director, and Dietary Manager.<br><br>The SA validated through staff interviews and record reviews that on 9/16/2023 11:30 the DON began in-service for all staff regarding missing residents and all nurses to include if the reason a resident is not in the facility is not documented in the progress note to notify the supervisor | M 640 | | |

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| M 640 | Continued From page 40<br>immediately, no staff was allowed to work until receiving in-service.<br><br>The SA validated through observation, interviews, and record reviews that on 9/18/2023 11:30 am the Director of Nursing created a log to be placed on the facility vehicle and in-serviced all transportation drivers regarding signing in and out with a witness after every transport and at the end of each day to verify that no residents are on the transport van.<br><br>The SA validated through interviews and documentation reviews that on 9/16/2023 11:58 am the Administrator conducted a missing resident drill for all staff on day shift.<br><br>The SA validated through interviews and documentation reviews that on 9/17/2023 6:30 am the Administrator conducted a missing resident drill for all staff on night shift.<br><br>The SA validated through interview that on 9/18/2023 at 11 am the Administrator notified the Attorney General's office of the incident.<br><br>The SA validated through interviews and staff sign in sheets that on 9/19/2023 at 10 am the DON in-serviced all staff on abuse and neglect policies.<br><br>The SA validated through interview and record review that on 9/19/2023 at 6:30 pm the MDS Nurse audited 100 % of the records for all residents receiving dialysis to include care plans with no adverse findings. On 9/26/2023 at 8 pm the MDS nurse audit the care plans of 100% of residents receiving routine transportation services, dialysis, and diabetic care with no adverse findings. | M 640 | | |

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| M 640 | Continued From page 41<br><br>The SA validated through interview that on 9/20/2023 at 2:40 PM the Administrator notified the local police department of the incident involving Resident #1.<br><br>The SA validated through interviews and record reviews that on 9/26/2023 2:34 pm an emergency QAPI meeting was held regarding the incident involving Resident #1 being left on the van on 9/15/2023. Those in attendance were Administrator, DON, IP, Social Service Director, Medical Records, Business Office Manager, Customer Relations Specialist, RN Supervisor, MDS Nurse and Medical Director.<br><br>The SA validated through interview and record review that on 9/26/2023 3:00 pm the Social Service Director spoke with resident #1 concerning her psychosocial needs.<br><br>The SA validated through interviews and staff sign in sheets that on 9/26/2023 5:00 pm the DON began in-servicing all staff regarding accidents, supervision of residents and abuse/neglect. All staff will receive in-service prior to returning to work.<br><br>The SA validated through interviews and record reviews that on 9/26/2023 5:00 pm the DON began in-servicing all nursing staff regarding diabetic care, dialysis care, staffing, notifying the physician in a timely manner and care plans. All staff will receive in-service prior to returning to work.<br><br>The SA validated through interview and documentation review that on 9/27/2023 at 5:00 pm the Licensed Clinical Social Worker (LCSW) assessed Resident #1 concerning her | M 640 | | |

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| M 640 | Continued From page 42<br>psychological needs and concerns regarding the incident on 9/15/2023 the LCSW concluded, "bothered but not overly traumatized by the event as evidenced by her willingness to stay, having stated faith in caregivers/staff here, continue to monitor Resident." | M 640 | | |