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F 000	INITIAL COMMENTS	F 000		

The State Agency (SA) conducted a complaint investigation (CI) for MS #17831 from 6/17/21 to 6/21/21. The SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA substantiated MS #17831 for freedom from involuntary seclusion and identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 6/18/21, which began on 6/7/21 when Registered Nurse (RN) #5 instructed Certified Nursing Assistant (CNA) #4 to place a linen cart in front of Resident #1's door to prevent him from exiting his room, causing mental anguish and the likelihood of physical harm to Resident #1. The facility failed to suspend RN #5 and allowed her to remain in the facility caring for residents until the end of her shift. This placed Resident #1 and other residents in a situation that was likely to cause serious injury, harm, impairment, or death.

The SA notified the facility of the IJ and SQC on 6/18/21 at 5:30 PM and the IJ templates were provided to the Administrator.

The IJ and SQC existed at:

42 CFR(s): 483.12 (a)(1) Free form Involuntary Seclusion, (F603) Scope and Severity - J
42 CFR (s): 483.12 (c)(2)-(4) Investigate, Prevent, Correct Alleged Violation, (F610) Scope and Severity - J
42 CFR (s): 483.35 (a) (1) (2) Sufficient Nursing Staff (F725) Scope and Severity - J

The facility submitted an acceptable Removal Plan on 6/19/21 in which the facility alleged all corrective actions were completed 6/18/21 and

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

Electronically Signed | 07/14/2021

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F 000	Continued From page 1 the IJ was removed on 6/19/21. The SA validated the Removal Plan on 6/21/21 and determined the IJ was removed on 6/19/21. Therefore, the scope and severity for 42 CFR(s): 483.12 (a)(1) Free from Involuntary Seclusion, (F603), 42 CFR (s): 483.12 (c)(2)-(4) Investigate, Prevent, Correct Alleged Violation, (F610) and 42 CFR (s): 483.35 (a) (1) (2) Sufficient Nursing Staff (F725), were lowered to a scope and severity of "D" while the facility develops and implements a plan of correction and monitors for the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. The facility held a license for 60 beds with a census of 43.	F 000		
F 603 SS=J	Free from Involuntary Seclusion CFR(s): 483.12(a)(1) §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview,	F 603	• The Administrator was notified by	8/1/21

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F 603	Continued From page 2 record review, and facility policy review, the facility failed to ensure a resident was free from involuntary seclusion for one (1) of five (5) residents reviewed for involuntary seclusion. Resident #1 On 6/7/21, at approximately 4:00 PM, the Administrator was notified by Employee #1 that a dirty linen cart and a Hoyer lift was in front of the door of Resident #1's room. The cart and lift were blocking the door preventing Resident #1's exit from the room. Employee #2 removed the objects from the doorway. The Administrator viewed camera footage and noted at 3:45 PM Registered Nurse (RN) #5 assisted Resident #1 to his room due to him being naked in the hallway. RN #5 immediately exited Resident #1's room and talked with Certified Nursing Assistant (CNA) #4. RN #5 then returned to her medication cart. CNA #4 pushed a linen/laundry cart into the doorway of Resident #1. Resident #1 pushed the cart away from the door and CNA # 4 put the cart back in front of Resident #1's door and pushed a total lift in front of the laundry cart to hold it in place. Employee #1 and Employee #2 exited the therapy department, which is next door to Resident #1's door and saw the door blocked. Employee #2 removed the cart and lift to allow Resident #1 to exit the room. RN #5 then helped Resident #1 back to his room to get dressed. The Administrator did not suspend RN #5 pending investigation. RN #5 was allowed to complete her scheduled shift on 6/7/21. RN #5 also worked in the facility on 6/8/21, 6/9/21, 6/10/21, 6/13/21, 6/14/21, and 6/15/21. The facility's failure to protect Resident #1 from involuntary seclusion and allow a staff member to work in the facility following an incident of	F 603	Employee #1 that a dirty linen cart and a Hoyer lift was in front of the door of Resident #1's room. Employee #2 removed the objects from the doorway @ 3:52 pm on June 7, 2021. Certified Nurse Assistant #4 was put on investigative leave on June 7, 2021 and terminated June 8, 2021 by the Administrator. An in-service on June 7, 2021 by Administrator on resident's rights, abuse, neglect, and involuntary seclusion of vulnerable adults was conducted for all employees at facility. Registered Nurse #5 was terminated June 18, 2021 by the Director of Nursing. Resident #1 was assessed on June 7, 2021 for any physical or mental anguish or bodily injury by Employee #3. None were noted. Resident #1 was provided a staff member to monitor him during waking hours on June 18, 2021, and to keep him engaged in an activity to help reduce the behavior of disrobing in public. Frequent well checks were also initiated on June 7, 2021, by Director of Nursing. Resident #1 was discharged home with father on June 25, 2021. • All residents have the potential to be affected by this when an allegation is made against an employee and they are not placed on investigative leave. • Frequent well checks for Resident #1 were continued through June 18, 2021, by Director of Nursing. On June 18, 2021, Staff Development Nurse in-serviced all available staff on resident rights, abuse, neglect, involuntary seclusion and reporting of such. In-services will be conducted by Ombudsman on July 29,	

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F 603	Continued From page 3 witnessed involuntary seclusion placed Resident #1 and other residents at risk in a situation that was likely to cause serious injury, harm, impairment or death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care which began on 6/7/21 when the involuntary seclusion occurred. The facility's Administrator was notified of the IJ and SQC on 6/18/21 at 5:30 PM and provided with the IJ templates. A credible Removal Plan was provided by the facility on 6/19/21, in which the facility alleged all corrective actions were completed as of 6/18/21, and the IJ was removed on 6/19/21. The State Agency (SA) validated the Removal Plan on 6/21/21 and determined the IJ was removed on 6/19/21. Therefore, the scope and severity for 42 CFR(s): 483.12 (a)(1) Free from Involuntary Seclusion, (F603) lowered from a "J" to a "D" while the facility develops and implements a plan of correction and monitors for the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Review of the facility's policy titled, "Abuse Program", revised May 23, 2017, revealed,"It is the policy of this facility to take all steps necessary to maintain an environment free of abuse and neglect. Each resident has the right to be free from verbal, sexual, physical, and mental abuse, neglect, exploitation, misappropriation of resident property, and involuntary seclusion. The facility is committed to protecting the residents from abuse by anyone including, but not	F 603	2021 on her job duties, how to interact with residents and how she can do be of assistance for residents. • In-services on resident rights, abuse, neglect, involuntary seclusion, and reporting will be conducted by Administrator, Director of Nursing or Staff Development Nurse monthly at all staff in-service beginning June 29, 2021. Social Services will interview five residents weekly for three months for reporting of any type of abuse, neglect, involuntary seclusion and reporting of such to begin July 14, 2021. This will be monitored through the review of in-service sign in sheets monthly for six months by the Administrator or Director of Nursing. Any negative finding through either in-services, interviews, or investigations will be brought to the Quality Assurance Committee by the Administrator quarterly for review beginning July 28, 2021 for six months. Negative outcomes will be addressed with an action place through the Quality Assurance Committee beginning July 28, 2021.	

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necessarily limited to facility staff, other residents, consultants, volunteers, sponsors, visitors, surrogates, friends, and other caregivers who provide care and services on behalf of the facility...
Involuntary Seclusion is defined as separation of a resident from other residents or from her/his room or confinement to his/her room (with or without roommates) against the residents will, or the will of the resident's legal representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs".

Record review of a self-reported complaint allegation submitted to the SA on 6/10/21 and documented 6/7/21, revealed CNA #4 placed a laundry cart and a lift in the doorway of Resident #1's room to prevent his exit from his room.

A telephone interview, on 6/17/21 at 5:46 PM, with Certified Nursing Assistant (CNA) #4, revealed on the day of the incident, 6/7/21, she was getting vital signs when Registered Nurse (RN) #5 told her to get one of the residents and change him because his family was waiting for him. CNA #4 stated that while she was in the room changing that resident, RN #5 came in the room and told her that Resident #1 was in the hallway naked and was hitting her and said she needed some help. CNA #4 stated that she left the resident and went into the hallway to help. Resident #1 was in his room naked, and RN #5 told her to put the laundry cart in front of his door. CNA #4 stated she put the laundry cart in

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Resident #1's doorway and was going back to finish the other resident when Resident #1 moved the laundry cart. She stated she put the linen cart back in front of his door and got the lift and put it in front of the linen cart. CNA #4 confirmed she locked the wheels on the linen cart and the lift. She stated that when she came out of the other resident's room the cart and lift had been moved. CNA #4 stated that RN #5 told her that she had already taken care of Resident #1. CNA #4 stated that about a week before, RN #5 had told her she could put the cart in Resident #1's door. She confirmed she had done this one time before to keep Resident #1 from going into his room. When asked why she did not report this, she stated it was because the RN #5 was on the hall and she (CNA #4) asked RN #5 if this was okay, and she was told by RN #5 that it was fine to do it. CNA #4 stated she thought it was okay to put the cart in the doorway because the nurse said it was.

On 6/17/21 at 6:14 PM, attempted to interview RN #5 by phone again. No answer. Same recorded message that voice mail was full.

On 6/18/21 at 1:45 PM, an interview with the Director of Nursing (DON) revealed that in a telephone conversation, RN #5 revealed she would not be available due to illness.

Record review of the written statement by RN #5 concerning the incident revealed a resident was out in the hallway with no clothes on and visitors as well as other residents were in the building. I asked CNA #4 to pull the laundry cart in front of the resident's room, to leave the resident's door open so we (staff) could keep an eye on him and perhaps keep him in his room until we could get clothes on the resident. Another resident was

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waiting to be changed and he had family members waiting outside on him.

An interview, on 6/18/21 at 10:00 AM, with Employee #2 revealed that she was walking to the therapy department and noticed a laundry cart in front of the door of Resident #1 with a lift wedged under the laundry cart and blocking the doorway of the room. She stated that she went into therapy and reported it to her supervisor, Employee #1. Employee #2 stated that she saw the Director of Nurses at the medication cart in the hallway talking to the nurses. Employee #2 stated that she unlocked the cart and the lift and moved them. She stated Resident #1 was sitting close to the laundry cart in his room. He appeared to be in no distress. She stated that she did not remember seeing Resident #1 push on the cart. She stated that she moved the equipment across the hall and thinks that she went back to therapy at that time because other people had come to the room. She remembered seeing the Director of Nursing and she saw CNA #4 come out of another room. She stated that she had had not seen seclusion before.

An interview, on 6/18/21 at 10:11 AM, with Employee #1 revealed that Resident #1's room is next door to therapy. Employee #1 stated that Employee #2 showed us the linen cart and the total lift against the door with legs under the cart. Employee #1 stated that Resident #1 was sitting still inside the door when Employee #2 moved the cart and the lift away. Employee #1 stated she went into the therapy room and called the Administrator to report what had been seen.

An interview on 6/18/21 at 10:25 AM, with Employee #7 revealed Employee #2 came into

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therapy room and told them to come look at this. Employee #7 stated she saw a laundry cart against the door and a lift against the laundry cart in front of Resident #1's room. She stated that Resident #1 was sitting calmly behind the cart looking out the door around the side of the cart.

An observation and interview, on 6/18/21 at 11:10 AM, with the Administrator (ADM) confirmed the cart that was placed in front of Resident #1's door was a three (3) compartment cart that held dirty linen in one section, trash in another section and dirty briefs in the other section. She confirmed that he could be injured trying to push the cart out of the way and possible danger due to the dirty items in the bins. The cart was approximately two (2) feet wide by five (5) feet long.

An interview, on 6/18/21 at 4:10 PM, with Certified Nursing Assistant (CNA) #1 revealed that she had seen the dirty laundry cart in front of Resident #1's door. She stated that she works the East hall and about two weeks ago she saw it when she was helping a CNA with another resident in Resident #1's room. CNA #1 stated that she had no idea the cart was to keep Resident #1 from getting back in the room. She stated that she really just did not think about it, she just helped the other CNA and then left. CNA #1 stated that she realizes she should have reported it. She stated that after this happened, they had an in service on abuse and seclusion.

An interview, on 6/18/21 at 4:20 PM with Certified Nursing Assistant (CNA) #2, revealed that Resident #1 takes his clothes off and is stubborn. She stated that there was not enough help when he is in one of his moods. She stated that she had seen the cart in front of his door, and she

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assumed they were trying to keep him out of the room. She stated that she saw the cart there while putting out trays. She stated that she did not move it because the nurses were there in the hallway, one of the nurses was RN #5. She stated that she had seen the cart in front of his door twice within the past two to three weeks. She stated she thought Administration would have seen it on the cameras.

An interview, on 6/18/21 at 4:30 PM, with CNA #3, revealed that she had seen Resident #1 outside the room with a laundry cart halfway blocking the door. She said he may have pushed it out of the way to get out of the room. She stated that she had seen this twice. CNA #3 stated she could not remember when she saw it. CNA #3 stated that Resident #1 does have behaviors and he hits at the nurses, but the cart should not have been in the doorway. She stated that she should have moved it.

An interview, on 6/18/21 at 4:45 PM, with Licensed Practical Nurse (LPN) #1, revealed that she had seen the dirty linen cart in front of Resident #1's door twice. LPN #1 could not recall any dates or times but did not think about it being intentional and had never seen the cart locked. She stated Resident #1 is in and out of his room a lot and comes out into the hallway naked. LPN #1 confirmed that she had never seen the cart in front of any other resident's doorway. She also stated that staffing was not adequate to care for all the residents and take care of Resident #1 when he is having behaviors. She stated they usually just have one CNA per hall on her shift.

An interview, on 6/18/21 at 11:09 AM, with the Administrator (ADM), revealed that she called in

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the seclusion incident to the State Agency within two hours. She confirmed that the therapy staff notified her of the incident. She stated that RN #5 should have been making sure all the residents were taken care of and that the staff was doing what they should have been doing. The ADM confirmed that telling the CNA to put the linen cart in front of a Resident's door was not a prudent practice for any nurse. She stated that she should have sent both of them home, but she thought at the time that it was OK for RN #5 to stay and finish her shift because she was in the building until 10:30 or 11:00 PM. She stated that she had staff that could have covered if she had sent RN #5 home. She stated at the time she did not feel like Resident #1 was in any harm, although, she did agree that the incident should not have happened. The ADM stated that during her interview with RN #5 and CNA #4, they both understood the severity of the situation and RN #5 and CNA #4 knew where they went wrong. No one had reported any other similar incident until this incident on 6/7/21. The Administrator stated, at the time, she felt like she did what she should, but in hindsight she stated she should have sent them both home.

An interview, on 6/19/21 at 1:10 PM with Resident #2, revealed that he had seen the staff put the cart in front of Resident #1's door at least one time, but he could not remember exactly when this was.

Record review of other employee personnel files revealed CNA #4 was hired on 4/28/18 and had one prior discipline in her employee file, dated 4/5/2020. RN #5 was hired by the facility on 2/19/21 and had no prior disciplines or corrective actions in her employee file.

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Review of the timecard for RN #5 revealed she continued to work in the facility on 6/7/21, 6/8/21, 6/9/21, 6/10/21, 6/13/21, 6/14/21, and 6/15/21 after the incident of involuntary seclusion occurred.

Record review of an in-service attendance record dated 4/18/21, with the topic of abuse and neglect revealed RN #5 was in attendance.

Record review of the Face Sheet revealed the facility admitted Resident #1 on 3/6/19. Admitting diagnoses included Conversion disorder with seizures or convulsions, Unspecified Psychosis not due to a substance or known physiological condition; Epilepsy unspecified, not intractable, without status epilepticus; Cerebral Palsy, Unspecified; Persistent Mood (affective) disorder; Unspecified, Impulse disorder, Unspecified Convulsions; Cognitive communication deficit; Restlessness and agitation.

Record review of Resident #1's Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 4/28/21 revealed a Brief Interview for Mental Status (BIMS) score of 99 which indicated the resident was unable to complete the interview.

The facility submitted an acceptable Removal Plan on 6/19/21, for the IJ.

Review of the facilities Removal Plan revealed the facility took the following corrective actions to remove the IJ:

1. On 06/07/2021 at 4:00 pm, the Administrator was notified by Employee # 1 that Employee # 2

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had observed a dirty linen cart and a Hoyer lift in front of room #23 where Resident #1 resides. Employee #1 removed the dirty linen cart and Hoyer lift from in front of Resident #1's doorway which was blocking his exit out of his room and Employee #1 notified the Administrator immediately.

2. Administrator began an investigation on 06/07/2021 at 4:30 pm by reviewing camera footage to see persons involved. Administrator determined Employee # 4 had placed dirty linen cart and Hoyer lift in front of resident # 1 doorway. Administrator called Employee # 4 to Administrator office for statement. Employee #4 stated she was told by Employee #5 to place the dirty linen cart in front of the Resident #1's door until she could get to dress him. Employee # 4 was then placed on investigative leave. Employee # 5 was called to Administrator office for statement. Employee # 5 was in-serviced one on one on resident's rights, abuse, neglect, and involuntary seclusion of vulnerable adult by the Administrator and Employee # 5 was allowed to finish her shift until 11:00 PM under the supervision of the Administrator and was told not to return to work until the investigation was finished. Employee # 5 continued to work her scheduled shifts on 6/8/2021, 6/9/2021, 6/10/2021, 6/13/2021, 6/14/2021, and 6/15/2021.

3. Employee # 3 assessed Resident #1 for any physical or mental anguish or potential body injury, and none was noted 06/07/2021 at 4:45PM.

4. Administrator in-serviced all available staff on 3-11 shift on 06/07/2021 beginning at 5:00 pm. Resident # 1 was put on frequent well-being

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checks by nursing staff each two hours.

5. On 06/07/2021 through 06/10/2021, all staff on each shift were in-serviced on resident's rights, abuse, neglect, and involuntary seclusion of vulnerable adults.

6. CNA # 4 who was involved was put on investigative leave on 06/07/2021 at 5:45 PM and terminated on 06/08/2021 by telephone after investigation was complete.

7. On 06/10/2021, cognitive residents that were cared for by CNA # 4 and RN # 5 were interviewed by Employee # 6 with no adverse outcomes.

8. On 6/11/2021, Psychiatric Nurse Practitioner came to facility to assess Resident # 1 for a routine visit. Psychiatric Nurse Practitioner noted there were no new concerns noted from the recent incident on 06/07/2021.

The following steps were taken to remove the immediacy:

A. Staffing was immediately reviewed by Administrator and Director of Nursing to ensure adequate staff were in place for the following shifts. There were no adjustments needed to the staff scheduled.

B. On 6/18/2021, at 5:45 PM, the Staff Development Coordinator immediately began in-servicing all available staff on resident rights, abuse, neglect, and involuntary seclusion of vulnerable adults, and the reporting of such.

C. All staff are to be in-serviced on resident's

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rights, abuse, neglect, and involuntary seclusion prior to returning to work. No staff will be allowed to return to work until in-service education has been completed.

D. Resident #1 was observed during the wellness checks 06/07/2021 through 06/18/2021 for any negative outcomes, mental anguish, or changing behaviors and none were noted.

E. RN Employee # 5 was terminated on 6/18/2021 at 7:12 PM and was reported to the Board of Nursing on 6/18/2021 at 9:13 PM by the Director of Nursing.

F. On 6/18/2021 at 6:00 pm the Quality Assurance Meeting was conducted with the Medical Director via phone, Human Resource Director, Maintenance Supervisor, Wound Care Registered Nurse (RN), Staff Development Coordinator/Infection Control Nurse, Dietary Manager, Business Office Manager, Social Service Director, Housekeeping Supervisor, RN MDS Coordinator, Medical Records Licensed Practical Nurse (LPN), Activities Director, Director of Nursing, and the Nursing Home Administrator. The Quality Assurance Committee discussed increasing Resident # 1's daily activities, purchasing a cd player/radio for entertainment, reaching out to specialty services to get ideas to assist with resident behaviors, increase staff if behaviors are noted, in-service staff on how to react to resident behavior(s), and view camera more frequently. The policy on Abuse Prohibition was reviewed during the Quality Assurance Meeting and there were no changes needed.

Corrective actions to remove the Immediate Jeopardy was completed on 6/18/21.

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The facility alleges the IJ was removed on 6/19/21.

On 6/21/21, the State Agency (SA) validated the facility's Removal Plan through observation, staff interviews, review of in-service sign in sheets and record reviews of documents across all disciplines. The SA verified the facility had implemented the following measures to remove the IJ:

The State Agency validated that Resident #1 was free from involuntary seclusion that occurred on 6/7/21 when RN #5 instructed CNA #4 to put a laundry cart in front of Resident #1's doorway to prevent him from leaving his room and CNA #4 also putting a body lift in front of the laundry cart to prevent the resident from leaving his room. The Administrator knew of the incident on 6/7/21 and failed to protect the resident by not suspending RN #5.

A. The SA validated through interview and record review that adequate staffing was in place.
B. The SA validated through staff interviews and record review that in-service education had been initiated on 6/18/21 concerning resident rights, abuse, neglect, involuntary seclusion of vulnerable adults, and the reporting of such.
C. The SA validated through record review and staff interviews that no staff would be allowed to return to work until in service education had been completed.
D. The SA validated by observation, staff interview, and record review that Resident #1 had been observed during the Wellness checks for any negative outcomes. None were noted.
E. The SA validated through interview and record review that RN Employee #5 was terminated on

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F 603	Continued From page 15 6/18/21 at 7:12 PM and was reported to the Board of Nursing on 6/18/21 at 9:13 PM by the Director of Nursing. F. The SA validated through record review and interviews the Quality Assurance Performance Improvement (QAPI) meeting was held on 6/18/21. The SA validated that all corrective actions were completed as of 6/18/21 and the IJ was removed on 6/19/21.	F 603		
F 610 SS=J	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to report an allegation of involuntary seclusion to State Board of Nursing and allowed staff to continue caring for residents following the allegation for one (1) of	F 610	• Employee #4 was placed on investigative leave June 7, 2021 and termed June 8, 2021 by Administrator. Employee #5 was placed on investigative leave June 7, 2021, but worked June 8, 9,	8/1/21

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F 610	Continued From page 16 five (5) residents reviewed. Resident #1. On 6/7/21, at approximately 4 PM, the Administrator was notified by Employee #1 that a dirty linen cart and a Hoyer lift was in front of Resident #1's doorway blocking the door where he could not exit the room. Employee #2 removed the objects from the doorway. The Administrator viewed camera footage and noted at 3:45 PM Registered Nurse (RN) #5 assisted Resident #1 to his room due to him being naked in the hallway. RN #5 immediately exited Resident #1's room and talked with Certified Nursing Assistant (CNA) #4. RN #5 then returned to her medication cart. CNA #4 pushed a linen/laundry cart into the doorway of Resident #1. Resident #1 pushed the cart away from the door and CNA # 4 put the cart back in front of Resident #1's door and pushed a total lift in front of the laundry cart to hold it in place. Employee #1 and Employee #2 exited the therapy department, which is next door to Resident #1's door and saw the door blocked by a laundry cart and a lift. Employee #2 removed the cart and lift to allow Resident #1 to exit the room. RN #5 then helped Resident #1 back to his room to get dressed. The Administrator did not suspend RN #5 pending investigation. RN #5 was allowed to complete her scheduled shift on 6/7/21. RN #5 also worked in the facility on 6/8/21, 6/9/21, 6/10/21, 6/13/21, 6/14/21, and 6/15/21. The facility's failure to protect Resident #1 from involuntary seclusion and allow a staff member to work in the facility following an incident of witnessed involuntary seclusion placed Resident #1 and other residents at risk in a situation that was likely to cause serious injury, harm, impairment or death.	F 610	10, 13, 14, and 15. She was termed June 18, 2021 and the Board of Nursing was notified June 18, 2021 by the Director of Nursing. No negative outcomes were noted from Employee #5 working until termination on June 18, 2021. • Any resident has the potential to be affected by this when an allegation is made against an employee ant they are not placed on investigative leave. • Administrator and Director of Nursing were in-serviced June 18, 2021, by Director of Operations on the facility policy stating that for any type of allegation against an employee, said employee will be placed on investigative leave until investigation is complete. Director of Clinical Operations will review all reportables, allegations, and grievances weekly for six months to determine if any employee should have been placed on investigative leave beginning July 19, 2021. • Director of Clinical Operations will immediately review all reportable allegations of violation of resident's rights, abuse, neglect, and involuntary seclusion of vulnerable adults to ensure the vulnerable adult was immediately protected and the accused employee was immediately suspended pending investigation for six months beginning July 19, 2021. The Director of Clinical Operations will review all reportable allegations weekly for six months to ensure compliance beginning July 19, 2021. Any negative findings will be brought to Quality Assurance Committee quarterly by Administrator for review	

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F 610	Continued From page 17 The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care which began on 6/7 21 when the involuntary seclusion occurred. The facility's Administrator was notified of the IJ and SQC on 6/18/21 at 5:30 PM and provided with the IJ templates. An acceptable credible Removal Plan was provided by the facility on 6/19/21, in which the facility alleged all corrective actions were completed as of 6/18/21, and the IJ was removed on 6/19/21. The State Agency (SA) validated the Removal Plan on 6/21/21 and determined the IJ was removed on 6/19/21. Therefore, the scope and severity for 42 CFR (s): 483.12 (c)(2)-(4) Investigate, Prevent, Correct Alleged Violation (F610) was lowered from a "J" to a "D" while the facility develops and implements a plan of correction and monitors for the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Review of the facility's policy titled, "Compliance with Reporting Allegations of Abuse, Neglect, Exploitation", with a review date of 4/30/18, revealed, "It is the policy of this facility to report all allegations of abuse, neglect, exploitation, or mistreatment, including injuries of unknown sources and misappropriation of resident property are reported immediately to the administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed time frames... #4. Identification: The facility will identify events,	F 610	beginning July 28, 2021. Negative outcomes will be addressed with action plan through Quality Assurance Committee beginning July 28, 2021 for six months.	

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occurrences, patterns and trends that may constitute:...b. Abuse: The willful infliction of injury unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish...v. Involuntary seclusion refers to the separation of a resident from other residents or from his/ her room, or confinement to his/ her room against the residents will or the will of the resident's legal representative. Emergency or short term monitored separation will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention as long as the least restrictive approach is used for the minimum amount of time...

#7 Protection: The facility will protect residents from harm during an investigation.

#8 Reporting/ Response: The facility will report all alleged violations an all-substantiated incidents to the state agency and to all other agencies as required, and take all necessary corrective actions depending on the results of the investigation. The facility will analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences...Procedure for Response and Reporting Allegations of Abuse /Neglect/ Exploitation...When suspicion of abuse, neglect, exploitation, or reports of abuse, neglect, exploitation occur, the following procedure will be initiated:...2. The Director of Nursing Services, Administrator, or designee will:...c. Suspend the accused employee pending completion of the investigation...e. Report to the state nurse aide registry or nursing board any knowledge of any actions which would indicate an employee is unfit for service."

Record review of the incident report dated 6/7/21,

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at approximately 4 PM, the Administrator was notified by Employee #1 that a dirty linen cart and a Hoyer lift was in front of Resident #1's entrance door, blocking the door so he could not exit the room. Employee #2 removed the objects from the doorway. The Administrator viewed camera footage and noted at 3:45 PM Registered Nurse (RN) #5 assisted Resident #1 to his room due to him being naked in the hallway. RN #5 immediately exited Resident #1's room and talked with Certified Nursing Assistant (CNA) #4. RN #5 then returned to her medication cart. CNA #4 pushed a linen/laundry cart into the doorway of Resident #1. Resident #1 pushed the cart away from the door and CNA # 4 put the cart back in front of Resident #1's door and pushed a total lift in front of the laundry cart to hold it in place. Employee #1 and Employee #2 exited the therapy department, which is next door to Resident #1's door and saw the door blocked. Employee #2 removed the cart and lift to allow Resident #1 to exit the room. RN #5 then helped Resident #1 back to his room to get dressed. The Administrator did not suspend RN #5 pending investigation. RN #5 was allowed to complete her scheduled shift on 6/7/21. RN #5 also worked in the facility on 6/8/21, 6/9/21, 6/10/21, 6/13/21, 6/14/21, and 6/15/21.

An interview, on 6/18/21 at 11:09 AM, with the Administrator (ADM), revealed that she called in the seclusion incident to the state within two hours. She confirmed that the therapy staff notified her of the incident. She stated that RN #5 should have been making sure all the residents were taken care of and that the staff was doing what they should have been doing. The ADM confirmed that telling the CNA to put the linen cart in front of a residence door was not a prudent

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practice for any nurse. She stated that she should have sent both of them home, but she thought at the time that it was OK for RN #5 to stay and finish her shift because she was in the building until 10:30 or 11:00 PM. She stated that she had staff that could have covered if she had sent RN #5 home. She stated at the time she did not feel like Resident #1 was in any harm, although, she does agree that the incident should not have happened. The ADM stated that during her interview RN #5 and CNA #4, they both understood the severity of the situation and RN #5 and CNA #4 knew where they went wrong. No one had reported any other similar incident until this incident on 6/7/21. The Administrator stated, at the time, she felt like she did what she should, but in hindsight she stated she should have sent them both (CNA #4 and RN #5) home.

Review of the timecard for RN #5 revealed she continued to work in the facility on 6/7/21, 6/8/21, 6/9/21, 6/10/21, 6/13/21, 6/14/21, and 6/15/21 after the incident of involuntary seclusion occurred.

The facility submitted an acceptable Removal Plan on 6/19/21, for the IJ.

Review of the facilities Removal Plan revealed the facility took the following corrective actions to remove the IJ.

1. On 06/07/2021 at 4:00 pm, the Administrator was notified by Employee # 1 that Employee # 2 had observed a dirty linen cart and a Hoyer lift in front of room #23 where Resident # 1 resides. Employee #1 removed the dirty linen cart and Hoyer lift from in front of Resident #1's doorway which was blocking his way of exit out of his room

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and Employee #1 notified the Administrator immediately.

2. Administrator began an investigation on 06/07/2021 at 4:30 pm by reviewing camera footage to see persons involved. Administrator determined Employee # 4 had placed dirty linen cart and Hoyer lift in front of resident # 1 doorway. Administrator called CNA # 4 to Administrator office for statement. CNA #4 stated she was told by RN #5 to place the dirty linen cart in front of the Resident #1's door until she could get to dress him. CNA # 4 was then placed on investigative leave. RN #5 was called to the Administrator office for a statement. RN #5 was in-serviced one-on-one concerning resident rights, abuse, neglect, and involuntary seclusion of a vulnerable adult by the Administrator. RN #5 was allowed to finish her shift until 11:00PM under the supervision of the Administrator and told not to return to work until the investigation was finished. RN #5 continued to work her scheduled shifts on 6/8/21, 6/8/21, 6/10/21, 6/13/21, 6/14/21, and 6/15/21.

3. Employee # 3 assessed Resident #1 for any physical or mental anguish or potential body injury, and none was noted 06/07/2021 at 4:45pm.

4. Administrator in-serviced all available staff on 3-11 shift on 06/07/2021 beginning at 5:00 pm. Resident # 1 was put on frequent well-being checks by nursing staff each two hours.

5. On 06/07/2021 through 06/10/2021, all staff on each shift were in-serviced on resident's rights, abuse, neglect, and involuntary seclusion of vulnerable adults.

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6. Employee # 4 who was involved was put on investigative leave on 06/07/2021 at 5:45 pm and terminated on 06/08/2021 by telephone after investigation was complete.

7. On 06/10/2021, cognitive residents that were cared for by Employee # 4 and Employee # 5 were interviewed by Employee # 6 with no adverse outcomes.

8. On 6/11/2021, Psychiatric Nurse Practitioner came to facility to assess Resident # 1 for a routine visit. Psychiatric Nurse Practitioner noted there were no new concerns noted from the recent incident on 06/07/2021.

The following steps were taken to remove the immediacy:

A. Staffing was immediately reviewed by Administrator and Director of Nursing to ensure adequate staff were in place for the following shifts. There were no adjustments needed to the staff scheduled.

B. On 6/18/2021, at 5:45 pm, the Staff Development Coordinator immediately began in-servicing all available staff on resident rights, abuse, neglect, and involuntary seclusion of vulnerable adults, and the reporting of such.

C. All staff are to be in-serviced on resident's rights, abuse, neglect, and involuntary seclusion prior to returning to work. No staff will be allowed to return to work until in-service education has been completed.

D. Resident #1 was observed during the wellness

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checks 06/07/2021 through 06/18/2021 for any negative outcomes, mental anguish, or changing behaviors and none were noted.

E. RN Employee # 5 was terminated on 6/18/2021 at 7:12 pm and was reported to the Board of Nursing on 6/18/2021 at 9:13 pm by the Director of Nursing.

F. On 6/18/2021 at 6:00 pm the Quality Assurance Meeting was conducted with the Medical Director via phone, Human Resource Director, Maintenance Supervisor, Wound Care Registered Nurse (RN), Staff Development Coordinator/Infection Control Nurse, Dietary Manager, Business Office Manager, Social Service Director, Housekeeping Supervisor, RN MDS Coordinator, Medical Records Licensed Practical Nurse (LPN), Activities Director, Director of Nursing, and the Nursing Home Administrator. The Quality Assurance Committee discussed increasing Resident # 1's daily activities, purchasing a cd player/radio for entertainment, reaching out to specialty services to get ideas to assist with resident behaviors, increase staff if behaviors are noted, in-service staff on how to react to resident behavior(s), and view camera more frequently. The policy on Abuse Prohibition was reviewed during the Quality Assurance Meeting and there were not changes that needed.

Corrective actions to remove the Immediate Jeopardy was completed on 6/18/21. The facility alleges the IJ was removed on 6/19/21.

On 6/21/21, the State Agency (SA) validated the facility's Removal Plan through observation, staff interviews, review of in-service sign in sheets and record reviews of documents across all diciplines.

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The SA verified the facility had implemented the following measures to remove the IJ:

The State Agency validated that Resident #1was free from involuntary seclusion that occurred on 6/7/21 when RN #5 instructed CNA #4 to put a laundry cart in front of Resident #1's door doorway to prevent him from leaving his room and CNA #4 also putting a body lift in front of the laundry cart to prevent the resident from leaving his room. The administrator knew of the incident on 6/7/21 and failed to protect the resident by not suspending RN #5.

A. The SA validated through interview and record review that adequate staffing was in place.
B. The SA validated through staff interviews and record review that in service education had taken place concerning resident rights, abuse, neglect, involuntary seclusion of vulnerable adults, and the reporting of such.
C. The SA validated through record review and staff interviews that no staff would be allowed to return to work until in service education had been completed.
D. The SA validated by observation, staff interview, and record review that Resident#1 had been observed during the Wellness checks for any negative outcomes. None were noted.
E. The SA validated through interview and record review that RN Employee #5 was terminated on 6/18/21 at 7:12 PM and was reported to the Board of Nursing on 6/18/21 at 9:13 PM by the Director of Nursing.
F. The SA validated through record review and interviews the Quality Assurance Performance Improvement (QAPI) meeting was held on 6/18/21.

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F 610	Continued From page 25 The SA validated that all corrective actions were completed as of 6/18/21 and the IJ was removed on 6/19/21.	F 610		
F 725 SS=J	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to ensure	F 725	• Staffing was reviewed immediately on June 18, 2021 by the Director of Nursing	8/1/21

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adequate staffing to care for residents, as evidenced by involuntary seclusion for one (1) of five (5) residents reviewed. Resident #1.

On 6/7/21, at approximately 4:00 PM the Administrator was notified by Employee #1 that a dirty linen cart and a Hoyer lift was in front of Resident #1's door, blocking the doorway so that he could not exit the room. Employee #2 removed the objects from the doorway. The Administrator viewed camera footage and noted at 3:45 PM Registered Nurse (RN) #5 assisted Resident #1 to his room due to him being naked in the hallway. RN #5 immediately exited Resident #1's room and talked with Certified Nursing Assistant (CNA) #4. RN #5 then returned to her medication cart. CNA #4 pushed a linen/laundry cart into the doorway of Resident #1. Resident #1 pushed the cart away from the door and CNA # 4 put the cart back in front of Resident #1's door and pushed a total lift in front of the laundry cart to hold it in place. Employee #1 and Employee #2 exited the therapy department, which is next door to Resident #1 and saw the door blocked. Employee #2 removed the cart and lift to allow Resident #1 to exit the room.

The facility's failure to ensure sufficient qualified nursing staff was available to meet the resident's needs safely caused the involuntary seclusion of Resident #1 and placed other residents in a situation which was likely to cause serious injury, harm, impairment or death.

The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care which began on 6/7 21 when the involuntary seclusion occurred. The facility's administrator was notified of the IJ and SQC on 6/18/21 at 5:30

and Administrator to ensure adequate staff were in place for the following shifts. On June 19, 2021, Resident #1 was assigned a staff member to monitor to him during waking hours and to keep him engaged in an activity to help reduce the behaviors of disrobing in public. Resident #1 was discharged from facility on June 25, 2021, home with his father. The Medical Records Licensed Practical Nurse will review behaviors by reviewing the Behavior Monitoring Documentation from the Medication Administration Record three times a week for four weeks, then weekly for four weeks to ensure that all adverse behaviors are addressed starting on July 19, 2021. Any adverse behaviors will be reported to the Director of Nursing immediately for review for addition staffing needs.

- All residents have the potential to be affected if staffing is not sufficient on days that there are increased behaviors.
- Staffing will be reviewed daily by Director of Nursing and Administrator for sufficient staffing. On days that Administrator or Director of Nursing deem necessary, staffing will be increased. This will begin July 14, 2021 and on days that Director of Nursing and Administrator are not in the facility, they will be notified by Nursing of any issues that may need to be evaluated to determine if more staff is needed. In-service was conducted with Nurse Supervisors and Charge Nurses on July 14, 2021, by Administrator on this new protocol. Administrator and Director of Nursing will monitor staffing for possible increases needed weekly for three

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PM and provided with the IJ templates. An acceptable credible Removal Plan was provided by the facility on 6/19/21, in which the facility alleged all corrective actions were completed as of 6/18/21, and the IJ was removed on 6/19/21.

The State Agency (SA) validated the Removal Plan on 6/21/21 and determined the IJ was removed on 6/19/21. Therefore, the scope and severity for 42 CFR (s): 483.35 (a) (1) (2) Sufficient Nursing Staff (F725) was lowered from a "J" to a "D" while the facility develops and implements a plan of correction and monitors for the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.

Findings include:

Review of the facility's policy titled, "Abuse Program", revised May 23, 2017, revealed, "...Protection:...4.a. The distribution of staff on each shift in sufficient numbers to meet the needs of the residents and assure that staff assigned has knowledge of individual care needs".

Review of a self-reported complaint allegation submitted to the SA on 6/10/21 and documented 6/7/21 revealed CNA #4 placed a laundry cart and a lift in the doorway of Resident #1 to prevent his exit from his room.

A telephone interview, on 6/17/21 at 5:46 PM, with Certified Nursing Assistant (CNA) #4, revealed on the day of the incident, 6/7/21, she was getting vital signs when Registered Nurse (RN) #5 told her to get one of the residents and change him because his family was waiting for

months beginning July 14, 2021.
• Director of Clinical Operations will review staffing weekly for six months to begin July 19, 2021. Any negative findings will be brought to Quality Assurance Committee quarterly for review by Administrator beginning July 28, 2021. Negative outcome will be addressed with an action plan through Quality Assurance Committee beginning July 28, 2021.

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him. CNA #4 stated that while she was in the room changing that resident, RN #5 came in the room and told her that Resident #1 was in the hallway naked and was hitting her and said she needed some help. CNA #4 stated that she left the resident and went into the hallway to help. Resident #1 was in his room naked, and RN #5 told her to put the laundry cart in front of his door. CNA #4 stated she put the laundry cart in Resident #1's doorway and was going back to finish the other resident when Resident #1 moved the laundry cart. She stated she put the cart back in front of his door and got the lift and put it in front of the linen cart. CNA #4 confirmed she locked the wheels on the linen cart and the lift. She stated that when she came out of the other resident's room the cart and lift had been moved. CNA #4 stated that RN #5 told her that she had already taken care of Resident #1.

CNA #4 stated that about a week before this incident, RN #5 had told her she could put the cart in Resident #1's door. She confirmed she had done this one time before to keep Resident #1 from going into his room. When asked why she did not report this, she stated it was because the RN #5 was on the hall and she (CNA #4) asked RN #5 if this was okay, and she was told by RN #5 that it was fine to do it. CNA #4 stated she thought it was okay to put the cart in the doorway because the nurse said it was.

Record review of the written statement by RN #5 concerning the incident revealed "A resident was out in the hallway with no clothes on and visitors as well as other residents were in the building. I asked CNA #4 to pull the laundry cart in front of the resident's room, to leave the resident's door open so we (staff) could keep an eye on him and

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perhaps keep him in his room until we could get clothes on the resident. Another resident was waiting to be changed and he had family members waiting outside on him."

An interview, on 6/18/21 at 4:10 PM with Certified Nursing Assistant (CNA) #1 revealed that she had seen the dirty laundry cart in front of Resident #1's door. She stated that she works the east hall and about two weeks ago she saw it when she was helping a CNA with another resident. CNA #1 stated that she had no idea the cart was to keep Resident #1 from getting back in the room. She stated that she really just did not think about it, she just helped the other CNA and then left. CNA #1 stated that she realizes she should have reported it. She stated that after this happened, they had an in service on abuse and seclusion.

An interview, on 6/18/21 at 4:20 PM with Certified Nursing Assistant (CNA) #2, revealed that Resident #1 takes his clothes off and is stubborn. She stated that there was not enough help when he is in one of his moods. She stated that she had seen the cart in front of his door, and she assumed they were trying to keep him out of the room. She stated that she saw the cart there while putting out trays. She stated that she did not move it because the nurses were there in the hallway, one of the nurses was RN #5. She stated that she had seen the cart in front of his door twice within the past two to three weeks. She stated she thought administration would have seen it on the cameras.

An interview, on 6/18/21 at 4:45 PM with Licensed Practical Nurse (LPN) #1, revealed that she had seen the dirty linen cart in front of Resident #1's door twice, but did not think about it

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being intentional and had never seen it locked. She stated Resident #1 is in and out of his room a lot and comes out into the hallway naked. LPN #1 confirmed that she had never seen the cart in front of any other resident's doorway. She also stated that staffing was not adequate to care for all the residents and take care of Resident #1 when he is having behaviors. She stated they usually just have one CNA per hall on her shift.

Review of the Face Sheet revealed the facility admitted Resident #1 on 3/6/19. Admitting diagnoses included Conversion Disorder with Seizures or Convulsions, Unspecified Psychosis not due to a substance are known physiological condition; Epilepsy unspecified, not intractable, without status epilepticus; Cerebral Palsy, unspecified; Persistent Mood (affective) Disorder; unspecified, Impulse Disorder, unspecified; Unspecified convulsions; Cognitive Communication Deficit; Restlessness and Agitation.

Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 4/28/21 revealed a brief interview for mental status BIMS score of 99 which indicated the resident was unable to complete the interview.

The facility submitted an acceptable Removal Plan on 6/19/21, for the IJ.

Review of the facilities Removal Plan revealed the facility took the following corrective actions to remove the IJ:

1. On 06/07/2021 at 4:00 pm, the Administrator

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was notified by Employee # 1 that Employee # 2 had observed a dirty linen cart and a Hoyer lift in front of room #23 where Resident # 1 resides. Employee #1 removed the dirty linen cart and Hoyer lift from in front of Resident #1's doorway which was blocking his way of exit out of his room and Employee #1 notified the Administrator immediately.
2. Administrator began an investigation on 06/07/2021 at 4:30 pm by reviewing camera footage to see persons involved. Administrator determined Employee # 4 had placed dirty linen cart and Hoyer lift in front of resident # 1 doorway. Administrator called Employee # 4 to Administrator office for statement. Employee #4 stated she was told by Employee #5 to place the dirty linen cart in front of the Resident #1's door until she could get to dress him. CNA # 4 was then placed on investigative leave. RN Employee # 5 was called to Administrator office for statement. RN # 5 was in-serviced one on one on resident's rights, abuse, neglect, and involuntary seclusion of vulnerable adult by the Administrator and RN # 5 was allowed to finish her shift until 11 pm under the supervision of the Administrator and was told not to return to work until the investigation was finished. RN # 5 continued to work her scheduled shifts on 6/8/2021, 6/9/2021, 6/10/2021, 6/13/2021, 6/14/2021, and 6/15/2021.
3. Employee # 3 assessed Resident #1 for any physical or mental anguish or potential body injury, and none was noted 06/07/2021 at 4:45pm.
4. Administrator in-serviced all available staff on 3-11 shift on 06/07/2021 beginning at 5:00 pm. Resident # 1 was put on frequent well-being checks by nursing staff each two hours.
5. On 06/07/2021 through 06/10/2021, all staff on

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each shift were in-serviced on resident's rights, abuse, neglect, and involuntary seclusion of vulnerable adults.
6. Employee # 4 who was involved was put on investigative leave on 06/07/2021 at 5:45 PM and terminated on 06/08/2021 by telephone after investigation was complete.
7. On 06/10/2021, cognitive residents that were cared for by Employee # 4 and Employee # 5 were interviewed by Employee # 6 with no adverse outcomes.
8. On 6/11/2021, Psychiatric Nurse Practitioner came to facility to assess Resident # 1 for a routine visit. Psychiatric Nurse Practitioner noted there were no new concerns noted from the recent incident on 06/07/2021.

The following steps were taken to remove the immediacy:

A. Staffing was immediately reviewed by Administrator and Director of Nursing to ensure adequate staff were in place for the following shifts. There were no adjustments needed to the staff scheduled.

B. On 6/18/2021, at 5:45 PM, the Staff Development Coordinator immediately began in-servicing all available staff on resident rights, abuse, neglect, and involuntary seclusion of vulnerable adults, and the reporting of such.

C. All staff are to be in-serviced on resident's rights, abuse, neglect, and involuntary seclusion prior to returning to work. No staff will be allowed to return to work until in-service education has been completed.

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D. Resident #1 was observed during the wellness checks 06/07/2021 through 06/18/2021 for any negative outcomes, mental anguish, or changing behaviors and none were noted.

E. RN Employee # 5 was terminated on 6/18/2021 at 7:12 PM and was reported to the Board of Nursing on 6/18/2021 at 9:13 PM by the Director of Nursing.

F. On 6/18/2021 at 6:00 pm the Quality Assurance Meeting was conducted with the Medical Director via phone, Human Resource Director, Maintenance Supervisor, Wound Care Registered Nurse (RN), Staff Development Coordinator/Infection Control Nurse, Dietary Manager, Business Office Manager, Social Service Director, Housekeeping Supervisor, RN MDS Coordinator, Medical Records Licensed Practical Nurse (LPN), Activities Director, Director of Nursing, and the Nursing Home Administrator. The Quality Assurance Committee discussed increasing Resident # 1's daily activities, purchasing a cd player/radio for entertainment, reaching out to specialty services to get ideas to assist with resident behaviors, increase staff if behaviors are noted, in-service staff on how to react to resident behavior(s), and view camera more frequently. The policy on Abuse Prohibition was reviewed during the Quality Assurance Meeting and there were not changes that needed.

Corrective actions to remove the Immediate Jeopardy was completed on 6/18/21. The facility alleges the IJ was removed on 6/19/21.

On 6/21/21, the State Agency (SA) validated the facility's Removal Plan through observation, staff interviews, review of in-service sign in sheets and

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record reviews of documents across all disciplines. The SA verified the facility had implemented the following measures to remove the IJ:

The State Agency validated that Resident #1 was free from involuntary seclusion that occurred on 6/7/21 when RN #5 instructed CNA #4 to put a laundry cart in front of Resident #1's doorway to prevent him from leaving his room and CNA #4 also put a body lift in front of the laundry cart to prevent the resident from leaving his room. The administrator knew of the incident on 6/7/21 and failed to protect the resident by not suspending RN #5.

A. The SA validated through interview and record review that adequate staffing was in place.
B. The SA validated through staff interviews and record review that in service education had taken place concerning resident rights, abuse, neglect, involuntary seclusion of vulnerable adults, and the reporting of such.
C. The SA validated through staff interviews and record review that in service education had taken place concerning resident rights, abuse, neglect, involuntary seclusion of vulnerable adults, and the reporting of such.
D. The SA validated through record review and staff interviews that no staff would be allowed to return to work until in service education had been completed.
E. The SA validated by observation, staff interview, and record review that Resident#1 had been observed during the Wellness checks for any negative outcomes. None were noted.
F. The SA validated through interview and record review that RN Employee #5 was terminated on 6/18/21 at 7:12 PM and was reported to the

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F 725	Continued From page 35 Board of Nursing on 6/18/21 at 9:13 PM by the Director of Nursing. G. The SA validated through record review and interviews the Quality Assurance Performance Improvement (QAPI) meeting was held on 6/18/21. The SA validated that all corrective actions were completed as of 6/18/21 and the IJ was removed on 6/19/21.	F 725		