

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445479	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/12/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Gray		STREET ADDRESS, CITY, STATE, ZIP CODE  791 Old Gray Station Road Gray, TN 37615	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0603</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from separation (from other residents, his/her room, or confinement to his/her room).</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37078</b></p> <p>Based on facility policy review, medical record review, facility documentation review, observation, and interview, the facility failed to protect the resident's right to be free from involuntary seclusion for 1 of 6 (Resident #1) sampled residents reviewed for abuse/involuntary seclusion. On [DATE], Resident #1 was observed by staff to be secluded in the dining/day room of the secured unit for an unspecified amount of time. Resident #1, a vulnerable and severely cognitively impaired resident, was found in the dining/day room with the doors closed and 2 wheelchairs with their wheels locked blocking the doors when a staff member made rounds early in the morning on [DATE]. The facility's failure to ensure freedom from involuntary seclusion placed Resident #1 and other residents on the secured unit in an Immediate Jeopardy situation, (A condition in which facility noncompliance with one or more conditions of participation has resulted in or is likely to result in serious injury, harm, impairment, or death and must be immediately corrected). The facility's failure to ensure freedom from involuntary seclusion had the potential to impact all residents on the secured unit.</p> <p>The Facility Executive Director (ED) was notified of the IJ situation for F-603 on [DATE] at 1:00 PM, in the conference room.</p> <p>The facility was cited Immediate Jeopardy at F-603 at a scope and severity of J, which is substandard quality of care.</p> <p>The IJ began on [DATE] and continued through [DATE]. The IJ ended on [DATE] and was removed on site.</p> <p>An acceptable Allegation of Compliance/Removal Plan which removed the immediacy was provided by the facility and verified on site on [DATE] for F-603.</p> <p>The facilities noncompliance at F-603 continues at a scope and severity of D for monitoring the effectiveness of the corrective action.</p> <p>The facility is required to submit a Plan of Correction (POC).</p> <p>The findings include:</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0603</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the facility's undated policy titled, Protection of Residents: Reducing the Threat of Abuse &amp; Neglect, showed .All residents have the right to be free from .unreasonable confinement .It is the policy and practice of [Named Facility] that all residents will be protected from abuse .Abuse means .unreasonable confinement .Definitions .the willful .unreasonable confinement .Involuntary Seclusion Separation of a resident from other residents .or confinement .with or (without roommates) against the resident's will or of the responsible party .</p> <p>Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Dementia, and Anxiety. The resident discharged to the hospital on [DATE].</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] showed Resident #1's Brief Interview for Mental Status (BIMS) score was 2 indicating the resident had severe cognitive impairment. The resident required assistance of one person with activities of daily living (ADL's) with supervision or touching assistance for walking.</p> <p>Review of an undated statement by The Director of Nursing (DON) showed .On [DATE] [2024] .around 8 AM . [Staff Member A] came to my office .stated he needed to talk with me .he stated he had been at facility for several hours .he went to 400 [secured unit] doing his rounds [night shift was still here] and when he first walked onto the unit he didn't see any staff members but when he got closer to the desk he saw [Resident #1] in the dining room with doors closed and a w/c [wheelchair] parked in the doorway .[Staff Member A] stated he saw one CNA [Certified Nurse Assistant (CNA) A] in chair who said she just got back there and then the nurse [Licensed Practical Nurse (LPN) A] came out of the bathroom as [Staff Member A] was removing the w/c .opening the door .[Resident #1] came out of the dining room [Staff Member A] said he gathered the staff on 400 [secured unit] .[provided] them education .</p> <p>During an interview on [DATE] at 10:30 AM, Staff Member A stated, .I was coming in early on that day [[DATE]] .it was either [4:00 AM or 5:00 AM] in the morning .I walked into station 4 [secured unit] and then I noticed [Resident #1] was in the dining room with the doors shut with wheelchairs [blocking the doors] .they [staff] had 2 wheel chairs parked in front of the doors parked sideways blocking both doors on the outside the lights were on .I got her out of the room and made sure she was alright she didn't seem like she was distressed or hurt .I don't know how long she was in there it could have been one minute it could have been five hours .when she saw me she said bubby can you let me out of here I immediately moved the chairs out of the way and opened the door and she walked out .once she was good I tracked down all the employees that was working back there and told them under no circumstances was [barricading the doorways] allowed . there was one CNA [CNA A] that was rolling up and down the hall in a wheelchair she was just riding back and forth and she was the only one that I seen at that time. The LPN [LPN A] come out of the bathroom about 5 minutes after I got there and the other CNA [CNA B], I don't know where she was at but towards the end of, maybe 10 minutes later she come walking back down the hall .I told all them under no circumstances was that allowed .[LPN A] said she put her in there because she had to go to the restroom and she [Resident #1] was bothering a new admit [admission] .they had a CNA on the floor and she could have watched her .I educated them .I was mad I was upset just barricading somebody behind the door that was why I was upset . [LPN A] took responsibility for that she told me the CNAs had nothing to do with it she said she put [Resident #1] in there .</p> <p>(continued on next page)</p>		

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<p>F 0603</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Observation on [DATE] at 10:45 AM, showed the double doors at the entrance of the dining/day room. Staff Member A demonstrated how 2 wheelchairs were used with 1 wheelchair parked up against each door with the wheels locked blocking Resident #1 from exiting the room.</p> <p>During a telephone interview on [DATE] at 3:45 PM, CNA B stated Resident #1 is often up all night. The CNA stated she overheard Staff Member A telling LPN A that it was the law you can't lock people in the dining room.</p> <p>During a telephone interview on [DATE] at 11:15 AM, LPN B stated, .on several occasions she [Resident #1] was in the dining room with the doors shut and there was always something in front of [dining/day room doors] whether it be a wheelchair or the med [medication] cart .I have witnessed it probably 4 to 6 times I seen that .I would go back there [secured unit] to visit from station 2 .[unable to recall exact dates] .some nights there would be 4 residents in there [unable to recall who the residents were] . LPN B stated [Resident #1] .was restless and a lot for them [staff] back there . it would be after midnight between midnight and [2:00 AM] .they [LPN A, CNA A, and CNA B] wouldn't take them out when I would go back there. LPN B confirmed [LPN A, CNA A, and CNA B] were the staff working when she witnessed the resident locked in the dining room. The LPN stated, .I specifically talked to [CNA B and LPN A] and they said they didn't want them to wake up the other residents .they [residents] were wandering around and [Resident #1] would be banging on the door . LPN B stated she asked staff why they didn't let [Resident #1]out and [LPN A] informed her [LPN B] she was gonna wake everybody on the hall. LPN B stated this happened about 3 months ago and she . figured it stopped because [Staff Member A] busted them doing it .it was only when those [LPN A, CNA A, and CNA B] were working .</p> <p>During an interview on [DATE] at 1:45 PM, the DON stated .[Staff Member A]came and told me he had been here checking the temperatures and the pipes .when he was going to 4 [secured unit] to do his rounds he [Staff Member A]saw [Resident #1] in the dining room with the doors closed and wheelchairs parked in the doorway .[Staff Member A] said the wheelchairs where in front of the doors he didn't say they were blocking the doors .[DON] said did you asked questions when he came up on this situation and he said no .he said that they were trying to tell him something but he was to mad to listen .when I was told those people were no longer on shift this happened hours prior I contacted them and let them know to contact me when they woke up and I obtained statements from them .I spoke with [LPN A, CNA A, and CNA B]and I also spoke with residents back on 4 [secured unit] .[LPN A] stated the resident had been up all night following staff .[LPN A]stated [Resident 1] had to use the restroom and the resident was sitting in a chair outside of the dining room .if somebody intentionally barricaded a door that is definitely an issue .I reviewed it with the [ED] .we didn't report it to any outside authority .</p> <p>During an interview on [DATE] at 2:20 PM, the ED stated .I know [Staff Member A] was the one who walked into that situation he reported to the [DON] .[Staff Member A]told me he saw [Resident #1] in the dining room with the doors shut and a wheelchair in front of the door .[Staff Member A] said he opened the dining room doors and talked to the staff back there while he was back there .[the DON]did the investigation .we did not contact any outside authorities .</p> <p>The facility's corrective actions for the removal plan were issued to the surveyor on [DATE]. The corrective action plan included the following:</p> <p>(continued on next page)</p>		

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<p>F 0603</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Resident #1 was discharged on [DATE] to another facility.</p> <p>The Executive Director (ED), Director of Nursing (DON) and Interdisciplinary Team (IDT) completed a Root Cause Analysis (RCA) on [DATE]. The root cause was identified as identifying and implementing appropriate wandering and behavioral intervention and identifying specific types of abuse were not discussed in associate education, which included involuntary seclusion.</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents with a BIMS of 10 or higher will be interviewed for any allegations of abuse/neglect/misappropriation by the ED of a sister facility and the Administrator in Training (AIT) from a sister facility on [DATE]. No allegations of abuse were identified.</p> <p>All residents with BIMS of 9 or less will have a skin assessment completed to identify any potential unreported abuse by a licensed nurse by [DATE]. No abuse was identified.</p> <p>All residents comment cards for the past 90 days will be reviewed for any allegations of abuse/neglect/misappropriation by the ED on [DATE]. No allegations of abuse were identified.</p> <p>Attempt to interview all active associates to identify any potential unreported abuse by the ED or DON initiated on [DATE] and will be completed by [DATE].</p> <p>Attempt to interview all active associates to identify any potential unreported abuse by a member of the Regional Team. The regional team consist of the Regional [NAME] President (RVP), Regional Director of Clinical Services (RDCS), Regional Director of Rehab (RDR), Regional Business Development Director (RBDD) initiated on [DATE] and will be completed by [DATE].</p> <p>Identification of above will be reported to the appropriate state agencies and investigated per policy by the ED and DON.</p> <p>On [DATE] RDBD and RVP identified through an interview with an LPN a resident (Resident #10) and Resident #1 were in the secured unit dining room and were unable to move freely throughout the secured unit. The LPN stated associates were always in direct line of site of the residents. The LPN stated this incident occurred 4 to 6 months ago. on [DATE] LPN was suspended pending investigation by the ED. Investigation completed on [DATE]. Resident #10 expired in the facility due to expected causes related to several medical diagnoses on [DATE].</p> <p>3. What measures will be put into place or systemic changes to ensure the deficient practice will not re-occur?</p> <p>(continued on next page)</p>		

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<p>F 0603</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] the RDCS provided education to the ED and DON on the following to ensure abuse policies were implemented to ensure alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately but no later than 2 hours after that allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events do not involve abuse and do not result in serious bodily injury to the Administrator and to other officials including the State Survey Agency and Adult Protective Services (APS) and to ensure all allegations of abuse are promptly and thoroughly investigated. Abuse-screening of employee and residents, identification of types, protection of residents, coordination with the Quality and Performance Improvement (QAPI) Program and Quality QAA committee, resident rights, and secured unit placement.</p> <p>The ED, DON, ADON, Staff Development Coordinator (SDC) and/or licensed nurse will provide education to all facility associates on the following policies to ensure abuse policies are implemented to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately but no later than 2 hours after that allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events do not involve abuse and do not result in serious bodily injury to the Administrator and to other officials including the State Survey Agency and Adult Protective Services (APS) and to ensure all allegations of abuse are promptly and thoroughly investigated. Abuse-screening of employee and residents, identification of types, protection of residents, coordination with the Quality and Performance Improvement (QAPI) Program and Quality QAA committee, and resident rights.</p> <p>Any associate who has not completed training by [DATE] will not be able to work until training is completed. The ED, DON, SDC, and or licensed nurse will provide education to all new associates upon hire during orientation.</p> <p>Assigned interdisciplinary team members will perform daily compliance rounds on the secured unit that include monitoring of identifying and reporting allegations of abuse and types of abuse through interviews of 2 staff members and resident observations. (Process) the ED and or DON will be responsible for reviewing the compliance rounds for any allegation/identification of abuse and ensuring appropriate reporting and investigation, initiated on [DATE]. Medial Director reviewed and agreed with this plan of removal on [DATE] QAPI meeting held [DATE] regarding plan of removal.</p> <p>Refer to F609, F610, and F675.</p> <p>The Removal Plan was validated onsite by the surveyor on [DATE] and included the following:</p> <p>1. Progress notes showed Resident #1 was discharged on [DATE] to the hospital, the resident's daughter found a facility closer to home, and the resident would not be returning to facility.</p> <p>(continued on next page)</p>		

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<p>F 0603</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>2. Audit 2A Resident Interviews showed 100% of resident interviews were completed on [DATE] with no concerns, Audit Tool: Skin Assessment showed 100% of resident skin assessments were completed on [DATE] with no concerns, Grievance Complaint Logs and Resident Council Minutes for ,d+[DATE], , d+[DATE], and ,d+[DATE] were reviewed, signed by Administrator and dated [DATE] with no concern, employee lists for interviewing for unreported abuse 100% complete with 1 employee stating she witnessed abuse, suspended pending investigation form showed the employee was suspended on [DATE] pending investigation, investigation was completed on [DATE], progress notes showed Resident #10 expired on [DATE] at the facility with family at bedside.</p> <p>3. Facility sign in sheet dated [DATE] and interview with the ED and DON showed the ED and the DON were educated on abuse-screening of employee and residents, identification of types, protection of residents, coordination with the Quality and Performance Improvement (QAPI) Program and Quality QAA committee, resident rights, and secured unit placement by the RDCS. Interviews with 2 night shift CNAs (6:00 PM - 6:00 AM), 2 night shift LPNs (6:00 PM - 6:00 AM), 4 day shift CNAs (6:00 AM - 6:00 PM), 2 day shift LPNs (6:00 AM - 6:00 PM) 2 housekeeping staff and facility sign in sheet dated [DATE] compared to facility associate list of employees showed 100% of associates were educated on Abuse-screening of employee and residents, identification of types, protection of residents, coordination with the Quality and Performance Improvement (QAPI) Program and Quality QAA committee, and resident rights, Quality Rounds Checklists dated , d+[DATE] and [DATE] showed daily compliance rounds had been started, a typed document signed by the ED on [DATE] showed the AOC was reviewed by the ED and Medical Director agreed with the AOC plan. A typed document signed by the ED on [DATE] showed a QAPI meeting was held to discuss AOC with no concerns noted.</p> <p>The facility is required to submit a Plan of Correction.</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37078</b></p> <p>Based on facility policy review, medical record review, facility documentation review, witness statement review, observation, and interview, the facility failed to report an allegation of abuse to the State Survey Agency for 1 of 6 (Resident #1) sampled residents reviewed for abuse. Resident #1, a vulnerable and severely cognitively impaired resident, was found in the dining/day room with the doors closed and 2 wheelchairs with their wheels locked blocking the doors when a staff member made rounds early on the morning of [DATE]. The facility's failure to report an allegation of abuse placed Resident #1 and other residents on the secured unit in an Immediate Jeopardy situation (IJ), (A condition in which facility noncompliance with one or more conditions of participation has resulted in or is likely to result in serious injury, harm, impairment, or death and must be immediately corrected). The facility's failure to report an allegation of abuse had the potential to impact all residents on the secured unit.</p> <p>The Facility Executive Director (ED) was notified of the IJ for F-609 on [DATE] at 1:00 PM, in the conference room.</p> <p>The facility was cited Immediate Jeopardy at F-609 at a scope and severity of J, which was substandard quality of care.</p> <p>The IJ began on [DATE] and continued through [DATE]. The IJ ended on [DATE] and was removed on site.</p> <p>An acceptable Allegation of Compliance which removed the immediacy was provided by the facility and verified on site on [DATE] for F-609.</p> <p>The facility's noncompliance at F-609 continues at a scope and severity of D for monitoring the effectiveness of the corrective action.</p> <p>The facility is required to submit a Plan of Correction (POC).</p> <p>The findings include:</p> <p>Review of the facility's undated policy titled, Protection of Residents: Reducing the Threat of Abuse &amp; Neglect, showed .All residents have the right to be free from .unreasonable confinement .It is the policy and practice of [Named Facility] that all residents will be protected from abuse .Abuse means .unreasonable confinement .Definitions .the willful .unreasonable confinement .Involuntary Seclusion Separation of a resident from other residents .or confinement .with or (without roommates) against the resident's will or of the responsible party .</p> <p>Review of the facility's policy titled, Reporting Alleged Abuse, revised ,d+[DATE] showed .Federal requirements mandate that facilities must ensure all allegations of abuse are reported immediately to their state survey agency .The immediate reports should be submitted as soon as possible, but no later than 24 hours of a facility learning of the allegation. Failure to do so will mean that the facility is not in compliance with the federal regulations .</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Dementia, and Anxiety. The resident discharged to the hospital on [DATE].</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] showed Resident #1's Brief Interview for Mental Status (BIMS) score was 2 indicating the resident had severe cognitive impairment. The resident required assistance of one person with activities of daily living (ADL's) with supervision or touching assistance for walking.</p> <p>Review of the undated statement by the Director of Nursing (DON) showed on [DATE], Staff Member A reported to her that when he made early morning rounds on the secured unit at first he didn't observe any staff present but when he got closer to the desk he observed Resident #1 in the dining/day room with the double doors closed and 2 locked wheelchairs parked sideways blocking the doors. Staff Member A reported that night shift staff were still here at the time. He then saw Certified Nurse Assistant (CNA) A in a chair and she told him she had just gotten back there. As he was removing the wheelchairs and letting Resident #1 out of the dining/day room, Licensed Practical Nurse (LPN) A came out of the bathroom. Staff Member A told the DON that he gathered staff present and provided them education.</p> <p>During an interview on [DATE] at 10:30 AM, Staff Member A explained that he arrived to work early on the morning of [DATE], around 4:00 AM or 5:00 AM. Staff Member A reported to this surveyor that when he walked onto the secured unit he noticed Resident #1 was in the dining room with the doors shut and 2 locked wheelchairs parked sideways blocking the dining room double doors. Staff Member A said when Resident #1 saw him she said, Bubby can you let me out of here. Staff Member A proceeded to tell this surveyor that he removed the chairs and opened the doors so Resident #1 could walk out. Staff Member A stated, .Once she [Resident #1] was good I tracked down all the employees that was working back there and told them under no circumstances was that [blocking the doors with a resident inside] allowed . Continued interview with Staff Member A revealed he saw only one staff member at the time and that was (CNA A) rolling up and down the hall in a wheelchair. About 5 minutes after he arrived on the secured unit (LPN A) came out of the bathroom. Staff Member A told this surveyor (LPN A) said she put Resident #1 in the dining room because she had to go to the restroom and Resident #1 was bothering a newly admitted resident. Staff Member A stated, I was mad .upset .barricading somebody behind the door that was why I was upset . Continued interview with Staff Member A revealed another CNA (CNA B) appeared about 10 minutes later walking down the hall, .I told them all under no circumstances was that allowed .[LPN A] took responsibility .told me the CNAs had nothing to do with it .</p> <p>Observation on [DATE] at 10:45 AM, showed double doors at the entrance of the dining/day room. Staff Member A demonstrated how 2 wheelchairs were used with 1 wheelchair parked up against each door with the wheels locked blocking Resident #1 from exiting the room.</p> <p>During a telephone interview on [DATE] at 3:45 PM, CNA B stated .CNA B stated Resident #1 is often up all night. The CNA stated she overhead Staff Member A telling LPN A that it was the law you can't lock people in the dining room.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on [DATE] at 11:15 AM, LPN B stated, .on several occasions she [Resident #1] was in the dining room with the doors shut and there was always something in front of it whether it be a wheelchair or the med [medication] cart . LPN B told this surveyor she had witnessed Resident #1 blocked in the dining room probably 4 to 6 times. LPN B explained sometimes on night shift she would go to the secured unit to visit from (nurses') station 2 and some nights there would be 4 residents blocked in the dining room. LPN B could not recall exact dates that she witnessed this. Continue interview with LPN B revealed she would go to the secured unit sometime between midnight and 2:00 AM and that's when she observed residents blocked in the dining room with either a wheelchair or the medication cart. LPN B confirmed LPN A, CNA, and CNA B were the staff working when she witnessed the resident locked in the dining room. LPN B stated, I specifically talked to [CNA B and LPN A] and they said the</p> <p>During an interview on [DATE] at 1:45 PM, the DON confirmed she was notified of the incident by Staff Member A on [DATE] and stated .we didn't report it to any outside authority .</p> <p>During an interview on [DATE] at 2:20 PM, the Executive Director (ED) stated .I know that [Staff Member A] was the one who walked into that situation he reported to [DON] that morning what he had found .no we did not contact any outside authorities .</p> <p>Refer to F603, F610, and F675.</p> <p>The facility's corrective actions for the removal plan were issued to the surveyor on [DATE]. The corrective action plan included the following:</p> <p>1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>The ED, DON and Interdisciplinary Team (IDT) completed a Root Cause Analysis (RCA) on [DATE]. The root cause was identified as identifying and implementing appropriate wandering and behavioral intervention and identifying specific types of abuse were not discussed in associate education, which included involuntary seclusion.</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents with a BIMS of 10 or higher will be interviewed for any allegations of abuse/neglect/misappropriation by the ED of a sister facility and the Administrator in Training (AIT) from a sister facility on [DATE]. No allegations of abuse were identified.</p> <p>All residents with BIMS of 9 or less will have a skin assessment completed to identify any potential unreported abuse by a licensed nurse by [DATE]. No abuse was identified.</p> <p>All residents comment cards for the past 90 days will be reviewed for any allegations of abuse/neglect/misappropriation by the ED on [DATE]. No allegations of abuse were identified.</p> <p>Attempt to interview all active associates to identify any potential unreported abuse by the ED or DON initiated on [DATE] and will be completed by [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Attempt to interview all active associates to identify any potential unreported abuse by a member of the Regional Team. The regional team consist of the Regional [NAME] President (RVP), Regional Director of Clinical Services (RDCS), Regional Director of Rehab (RDR), Regional Business Development Director (RBDD) initiated on [DATE] and will be completed by [DATE].</p> <p>Identification of above will be reported to the appropriate state agencies and investigated per policy by the ED and DON.</p> <p>On [DATE] RBDD and RVP identified through an interview with LPN B a resident (Resident #10) and Resident #1 were in the secured unit dining room and were unable to move freely throughout the secured unit. The LPN stated associates were always in direct line of site of the residents. The LPN stated this incident occurred 4 to 6 months ago. on [DATE] LPN B was suspended pending investigation by the ED. Resident #10 expired in the facility due to expected causes related to several medical diagnosis on [DATE].</p> <p>3. What measures will be put into place or systemic changes to ensure the deficient practice will not recur?</p> <p>On [DATE] the RDCS provided education to the ED and DON on the following to ensure abuse policies were implemented to ensure alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately but no later than 2 hours after that allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events do not involve abuse and do not result in serious bodily injury to the Administrator and to other officials including the State Survey Agency and Adult Protective Services (APS) and to ensure all allegations of abuse are promptly and thoroughly investigated. Abuse-reporting and response-no crime suspected, neglect, exploitation allegation investigation checklist, Elder Justice Act fact sheet, incident and reportable event management, witness interview/statement policy, witness interview/statement form.</p> <p>The ED, DON, ADON, Staff Development Coordinator (SDC) and/or licensed nurse will provide education to all facility associates on the following policies to ensure abuse policies are implemented to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately but no later than 2 hours after that allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events do not involve abuse and do not result in serious bodily injury to the Administrator and to other officials including the State Survey Agency and Adult Protective Services (APS) and to ensure all allegations of abuse are promptly and thoroughly investigated.</p> <p>Abuse-reporting and response-no crime suspected, neglect, exploitation allegation investigation checklist, Elder Justice Act fact sheet, incident and reportable event management, witness interview/statement policy, witness interview/statement form.</p> <p>Any associate who has not completed training by [DATE] will not be able to work until training is completed. The ED, DON, SDC, and or licensed nurse will provide education to all new associates upon hire during orientation.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Signage will be posted by time clock and at each nursing station identifying all allegations are to be reported to the ED immediately with their contact number. It will also include a second person and their contact number to be notified, when ED cannot be reached, this was completed on [DATE] by the ED.</p> <p>Assigned interdisciplinary team members will perform daily compliance rounds on the secured unit that include monitoring of identifying and reporting allegations of abuse and types of abuse through interviews of 2 staff members and resident observations. (Process) the ED and or DON will be responsible for reviewing the compliance rounds for any allegation/identification of abuse and ensuring appropriate reporting and investigation, initiated on [DATE].</p> <p>The RVP and/or RDCS will be notified of any allegation of abuse and/or neglect at the time the ED or DON are notified and provide documentation that the allegation has been reported as required (Process).</p> <p>The RVP will review the abuse reporting log and investigations during facility visits. (Process)</p> <p>Medial Director reviewed and agreed with this plan of removal on [DATE], Quality Assurance and Performance Improvement (QAPI) meeting held [DATE] regarding plan of removal.</p> <p>The Removal Plan was validated onsite by the surveyor on [DATE] and included the following:</p> <ol style="list-style-type: none"> <li>1. Progress notes showed Resident #1 was discharged on [DATE] to the hospital, the resident's daughter found a facility closer to home and the resident would not be returning to facility.</li> <li>2. Audit 2A Resident Interviews showed 100% of resident interviews were completed on [DATE] with no concerns, Audit Tool: Skin Assessment showed 100% of resident skin assessments were completed on [DATE] with no concerns, Grievance Complaint Logs and Resident Council Minutes for ,d+[DATE] , , d+[DATE], and ,d+[DATE] were reviewed, signed by Administrator and dated [DATE] with no concern, Employee lists for interviewing for unreported abuse 100% complete with 1 employee stating she witnessed abuse, Suspended Pending Investigation Form showed the employee was suspended on [DATE] pending investigation, investigation was completed on [DATE], Progress notes showed Resident #10 expired on [DATE] at the facility with family at bedside.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>3. Facility sign in sheet dated [DATE] and interview with the ED and DON showed the ED and the DON were educated on Abuse-reporting and response-no crime suspected, neglect, exploitation allegation investigation checklist, Elder Justice Act fact sheet, incident and reportable event management, witness interview/statement policy, witness interview/statement form by the RDCS. Interviews with 2 night shift CNAs (6:00 PM - 6:00 AM), 2 night shift LPNs (6:00 PM - 6:00 AM), 4 day shift CNAs (6:00 AM - 6:00 PM), 2 day shift LPNs (6:00 AM - 6:00 PM) 2 housekeeping staff and facility sign in sheet dated [DATE] compared to facility associate list of employees showed 100% of associates were educated on Abuse-reporting and response-no crime suspected, neglect, exploitation allegation investigation checklist, Elder Justice Act fact sheet, incident and reportable event management, witness interview/statement policy, witness interview/statement form. Observation of signage posted at station 1, 2, 3, and 4 showed Any allegation of abuse must be reported immediately to: Primary .Director of Social Services Contact .Secondary .Executive Director contact . photos of the signs in the binder showed signs were posted on [DATE], Quality Rounds Checklists dated ,d+[DATE] (2024) and [DATE] showed daily compliance rounds had been started, incident reporting system form showed on [DATE] allegation of abuse was reported with RVP and RDCS notified, facility F-609 reporting of allegation of abuse logs showed the log was started on [DATE] and signed by the RVP, a typed document signed by the ED on [DATE] showed the AOC was reviewed by the ED and Medical Director agreed with the AOC plan, a typed document signed by the ED on [DATE] showed a QAPI meeting was held to discuss AOC with no concerns noted.</p> <p>The facility is required to submit a Plan of Correction.</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37078</b></p> <p>Based on facility policy review, medical record review, facility documentation review, witness statement review, observation, and interview, the facility failed to thoroughly investigate an allegation of abuse for 1 of 6 (Resident #1) sampled residents reviewed for abuse. On [DATE], a staff member observed Resident #1 barricaded in the dining/day room of the secured unit for an undetermined amount of time with wheelchairs blocking the doors. Resident #1, a vulnerable and severely cognitively impaired resident, was found in the dining/day room with the doors closed and 2 wheelchairs with their wheels locked blocking the doors when a staff member made rounds early in the morning on [DATE].The facility's failure to thoroughly investigate an allegation of abuse placed Resident #1 and other residents on the secured unit in an Immediate Jeopardy (IJ) situation, (A condition in which facility noncompliance with one or more conditions of participation has resulted in or is likely to result in serious injury, harm, impairment, or death and must be immediately corrected). The facility's failure to thoroughly investigate an allegation of abuse had the potential to impact all residents on the secured unit.</p> <p>The Facility Executive Director (ED) was notified of the IJ for F-610 on [DATE] at 1:00 PM, in the conference room.</p> <p>The facility was cited Immediate Jeopardy at F-610 at a scope and severity of J, which is substandard quality of care.</p> <p>The IJ began on [DATE] and continued through [DATE]. The IJ ended on [DATE] and was removed on site.</p> <p>An acceptable Allegation of Compliance (AOC/Removal Plan) which removed the immediacy was provided by the facility and verified on site on [DATE] for F-610.</p> <p>The facilities non-compliance at F-610 continues at a scope and severity of D for monitoring the effectiveness of the corrective action.</p> <p>The facility is required to submit a Plan of Correction (POC).</p> <p>The findings include:</p> <p>Review of the facility's undated Policy titled, Protection of Residents: Reducing the Threat of Abuse &amp; Neglect showed .All residents have the right to be free from .unreasonable confinement .It is the policy and practice of [Named Facility] .all residents will be protected from abuse .Abuse means .unreasonable confinement .Definitions .the willful .unreasonable confinement .Involuntary Seclusion Separation of a resident from other residents .or confinement .with or (without roommates) against the resident's will or of the responsible party .</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the facility's Policy titled, Abuse - Conducting an Investigation reviewed [DATE] showed .it is the policy of this facility that allegations of abuse .are promptly and thoroughly investigated .Have evidence that all alleged violations are thoroughly investigated .The alleged victim will be examined for any signs of injury, including .psychosocial assessment .Protection will be provided to the alleged victim .such as .staffing changes as needed .to protect the resident(s) from the alleged perpetrator .if the investigation is being conducted by the designee, the administrator will be consulted daily concerning the progress of the investigation .the facility must thoroughly collect evidence to allow the Administrator to determine what actions are necessary .for the protection of residents .it is expected that the investigation would include . Conducting interviews with .witnesses .The administrator/designee will review the Incident Report for completeness and assure that the physician and resident representative have been notified of the circumstances .The written summary of the investigation should include .A review of the Incident Report. An interview with the person(s) reporting the incident .A review of the residents medical record .A review of the employee's file, as needed .A review of all circumstances surrounding the incident. If the accused individual is an employee, the alleged perpetrator will be removed from resident care areas immediately and placed on suspension pending results of the investigation .</p> <p>Review of the medical record showed Resident #1 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Dementia, and Anxiety. The resident discharged to the hospital on [DATE].</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] showed Resident #1's Brief Interview for Mental Status (BIMS) score was 2 indicating the resident had severe cognitive impairment. The resident required assistance of one person with activities of daily living (ADL's) with supervision or touching assistance for walking.</p> <p>Review of a facility provided list of new admissions for ,d+[DATE] on the secured unit showed 3 new admissions in January one of which was Resident #8 on [DATE].</p> <p>Review of facility's undated investigation showed 4 witness interview statements for the Director of Nursing (DON), Licensed Practical Nurse (LPN) A, Certified Nurse Assistant (CNA) A, and CNA B all dated [DATE] all written by the DON and a typed document by the DON dated [DATE] stating the DON spoke with residents on the secured unit, nursing staff on station 2, and the Registered Nurse (RN) supervisor A with no concerns noted. The DON's statement showed .On [DATE] .around 8 AM .[Staff Member A/Maintenance Director] came to my office [and] stated he needed to talk with me .he stated he had been at facility for several hours .he said when he went to 400 [secured unit] doing his rounds-that night shift was still here and when he first walked onto the unit he didn't see any staff members but when he got closer to the desk he saw [Resident #1] in dining room with doors closed and w/c [wheelchair] parked in doorway states saw one CNA [CNA A] in chair who said she just got back there and then the nurse [LPN A] came out of the bathroom as he was removing the w/c + opening the door + the resident [Resident #1] came out of the dining room -he said he gathered the staff on 400 [secured unit] [provided] them education .I asked if the resident was upset he said no. she was smiling + patting me on the shoulder calling me bubba like she always does. I asked if he saw how resident got in the dining room. He stated No . A statement by the DON for [LPN A] showed Staff Member A had been in the secured unit and provided education to the LPN and both [CNA A and CNA B]and none of the statements by the DON for the secured unit staff showed the resident had been in the dining/day room with doors shut and blocked by wheelchairs. Documentation showed no further investigation or witness statements from [LPN A, CNA A, and CNA B] had been completed.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility investigation into Staff Member A's allegation of resident abuse did not include a head to toe assessment, including a psychosocial assessment, of Resident #1, an incident report, a list of residents interviewed, a list of staff from station 2 who were interviewed, and documentation the MD and Resident #1's responsible party (RP) were notified of the allegation.</p> <p>During an interview on [DATE] at 10:30 AM, Staff Member A stated, .I was coming in early on that day [[DATE]] .it was either [4:00 AM or 5:00 AM] in the morning .I walked into station 4 [secured unit] and then I noticed [Resident #1] was in the dining room with the doors shut with wheelchairs blocking it .they [staff] had 2 wheel chairs parked in front of the doors parked sideways blocking both doors on the outside the lights were on .I got her out of the room and made sure she was alright she didn't seem like she was distressed or hurt .I don't know how long she was in there it could have been one minute it could have been five hours . when she saw me she said bubby can you let me out of here I immediately moved the chairs out of the way and opened the door and she walked out .once she was good I tracked down all the employees that was working back there and told them under no circumstances was that [barricading doorways with residents inside]allowed .there was one CNA [CNA A] that was rolling up and down the hall in a wheelchair she was just riding back and forth and she was the only one that I seen at that time the LPN [LPN A] come out of the bathroom about 5 minutes after I got there and the other CNA [CNA B], I don't know where she was at but towards the end, maybe 10 minutes later she come walking back down the hall .I told all them under no circumstances was that [barricading doorways with residents inside] allowed .[LPN A] said she put her in there because she had to go to the restroom and she [Resident #1] was bothering a new admit [admission] . they had a CNA on the floor and she could have watched her .I educated them .I was mad I was upset just barricading somebody behind the door that was why I was upset .[LPN A] took responsibility for that she told me the CNAs had nothing to do with it she said she put her in there .I told [DON] everything I just told you I told her [LPN A] said she put [Resident #1]in there .</p> <p>Observation on [DATE] at 10:45 AM, of the secured unit dining/dayroom with Staff Member A showed 2 doors (double doors) at the entrance to the dining/day room. Staff Member A demonstrated how 2 wheelchairs were used with 1 wheelchair parked up against each door with the wheels locked blocking Resident #1 from exiting the room.</p> <p>During a telephone interview on [DATE] at 3:45 PM, CNA B stated, .I know that back in January .[Resident #1] sometimes she will be up all night .I remember [Staff Member A] at the front of the desk [nurses' station] . [Staff Member A] said you know there's a law you can't lock people in the dining room .my nurse [LPN A] was like you can go back and carry on so I went back down the hall .when I left the nurses station [LPN A] and [Staff Member A] were talking I didn't hear what was said .</p> <p>During a telephone interview on [DATE] at 7:30 PM, LPN A stated, .I remember talking to him [Staff Member A] one morning but he was up back there [secured unit] several times around the first of the year .I don't even remember what he said I don't remember anything specific .</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on [DATE] at 11:15 AM, LPN B stated, .on several occasions she [Resident #1] was in the dining room with the doors shut and there was always something in front of it whether it be a wheelchair or the med [medication] cart .I have witnessed it probably 4 to 6 times I seen that .I would go back there [secured unit] to visit from station 2 .I can't remember the exact dates if I was working a shift I would go back to visit some nights there wouldn't be any one [residents] in there [dining/day room] and some nights there would be 4 residents in there I cannot remember who the residents were but she [Resident #1] was one she was restless a lot for them [staff] back there at that time .I told my supervisor at the time [RN Supervisor A] .I told her that they had them in the dining room that they had them locked in the dining room with the med cart in front of it .it would be after midnight between midnight and [2:00 AM]I'd have a little bit of down time so I would go back there and see what was going on .they [LPN A, CNA A, and CNA B] wouldn't take them out when I would go back there I said why [were the residents barricaded in the dining room] and they said well we don't want them down the hall waking up everybody else .[LPN A, CNA A, and CNA B] were the ones working when I saw it .I specifically talked to [CNA B and LPN A] and they said they didn't want them to wake up the other residents .they were just kind of wandering around Resident #1 would be banging on the door and I said why don't you let her out to [LPN A] and she just said she's goanna wake up everybody on the hall .it was about 3 months ago the first time I saw it and about a month ago it stopped and I figured it stopped because [Staff Member A] busted them doing it .it was only when those three were working .</p> <p>During an interview on [DATE] at 1:45 PM, the DON stated, .[Staff Member A] came and told me .when he was going to 4 [secured unit] to do his rounds he saw [Resident #1] in the dining room with the doors closed with wheelchairs parked in the doorway .he[Staff Member A] the wheelchairs were in front of the doors he didn't say they were blocking the doors .I said did you asked questions when he came up on this situation and he said no .he said that they were trying to tell him something but he was too mad to listen .when I was told those people were no longer on shift, this happened hours prior, I contacted them and let them know to contact me when they woke up and I obtained statements from them .I spoke with [LPN A, CNA A, and CNA B] and I also spoke with residents back on 4[secured unit] .[LPN A] stated that the resident had been up all night following staff .she stated she had to use the restroom and the resident was sitting in a chair outside of the dining room .they all said they did not witness her in the situation that [Staff Member A] said that he saw . if somebody intentionally barricaded a door that is definitely an issue .I reviewed it with my [ED] .there was nothing to prove it was done on purpose .we [DON and Administrator]didn't report it to any outside authority .</p> <p>During an interview on [DATE] at 2:20 PM, the ED stated, .I know [Staff Member A] was the one who walked into that situation he reported to the [DON] .[Staff Member A]told me he saw [Resident #1] in the dining room with the doors shut and a wheelchair in front of the door .[Staff Member A] said he opened the dining room doors and talked to the staff back there while he was back there .[the DON]did the investigation .we did not contact any outside authorities .</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of a written statement provided to this surveyor on [DATE] by Staff Member A showed .I came in on [DATE] between the time of [3:00 am or 5:00 AM] .when I walked into station 4 [secured unit] I seen a Resident barricaded behind the dining room double Doors with wheelchairs blocking the exit the resident could not leave the dining room as the chairs were blocking the doors. I immediately let her out of the room by removing the wheelchairs .the resident seemed okay besides just wanting to be let out .once the patient was let out .I noticed [CNA A] rolling back and fourth through the hall in a wheel chair about 5 minutes later [LPN A] came out of the bathroom .I educated both of [CNA A and LPN A] that under NO circumstances is that allowed to happen. [LPN A] told me this was my fault, the CNAs had nothing to do with it Towards the end of our conversation the CNA [CNA B] showed up and I also educated her as well .Around 8 AM on [DATE] I went to the DON's office and Reported what I had witnessed .she assured me that she will handle it [DATE]rd 2024 I reviewed the DON's written statement, (I have never seen it before that day) .there was some key parts of my statement that were missing, there was no mention of [LPN A] taking Responsibility for what occurred it also seems that it was pointing in the Direction that the doors were not barricaded (which they were) XXX[DATE] [2024] .</p> <p>Review of a statement by LPN B sent via email to this surveyor on [DATE], showed On 4 to 6 occasions I have witnessed the resident in question [Resident #1] locked in dining room/day room .This transpired over approximately 4 months. Along with this resident there [were]3 or 4 more residents. There are no locks on the doors so wheelchairs or the med [medication] cart was placed in front of the doors. The [Resident #1]was pounding on door asking to be let out other than asking to be let out she was not crying or showing other distress when asked why they [residents]were in there [barricaded in the dining/day room]the response from staff was we don't want them waking up other residents.</p> <p>During an interview on [DATE] at 10:00 AM, the Executive Director (ED) stated .it was after the investigation when I was aware of the incident .[DON] was the first person who told me about it and it was after the investigation .in this situation [DON] took care of the investigation and informed me of it after the investigation .she told me what [Staff Member A] had told her that he found [Resident #1] in the dining room back on station 4 [secured unit] with the doors shut .and a wheelchair kind of in front of where the doors were there and [DON] said that [Staff Member A] had addressed the situation with the staff on station 4 [secured unit] and he had gotten [Resident #1] back out onto the hallway .I don't know what he discussed with the staff back there .</p> <p>Refer to F603, F609, and F675.</p> <p>The facility's corrective actions for the removal plan were issued to the surveyor on [DATE]. The corrective action plan included the following:</p> <p>1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Resident #1 was discharged on [DATE] to another facility.</p> <p>On [DATE] the nurse on duty the date of the allegation of involuntary seclusion was suspended pending investigation by ED.</p> <p>On [DATE] the Maintenance Director was suspended pending investigation by the ED.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Life Care Center of Gray		STREET ADDRESS, CITY, STATE, ZIP CODE  791 Old Gray Station Road Gray, TN 37615	
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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The ED, DON, and Interdisciplinary Team (IDT) completed a Root Cause Analysis (RCA) on [DATE]. The RCA was identified as identifying and implementing appropriate wandering and behavioral interventions and identifying specific types of abuse were not discussed in associate education, which included involuntary seclusion.</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents with a BIMS of 10 or higher will be interviewed for any allegations of abuse/neglect/misappropriation by the ED of a sister facility and the Administrator in Training (AIT) from a sister facility on [DATE]. No allegations of abuse were identified.</p> <p>All residents with BIMS of 9 or less will have a skin assessment completed to identify any potential unreported abuse by a licensed nurse by [DATE]. No abuse was identified.</p> <p>All residents comment cards for the past 90 days will be reviewed for any allegations of abuse/neglect/misappropriation by the ED on [DATE]. No allegations of abuse were identified.</p> <p>Attempt to interview all active associates to identify any potential unreported abuse by the ED or DON initiated on [DATE] and will be completed by [DATE].</p> <p>Attempt to interview all active associates to identify any potential unreported abuse by a member of the Regional Team. The regional team consist of the Regional [NAME] President (RVP), Regional Director of Clinical Services (RDCS), Regional Director of Rehab (RDR), Regional Business Development Director (RBDD) initiated on [DATE] and will be completed by [DATE].</p> <p>Identification of above will be reported to the appropriate state agencies and investigated per policy by the ED and DON.</p> <p>On [DATE] RBDD and RVP identified through an interview with LPN B a resident (Resident #10) and Resident #1 were in the secured unit dining room and were unable to move freely throughout the secured unit. The LPN stated associates were always in direct line of site of the residents. The LPN stated this incident occurred 4 to 6 months ago. On [DATE] LPN was suspended pending investigation by the ED. Resident #10 expired in the facility due to expected causes related to several medical diagnoses on [DATE].</p> <p>3. What measures will be put into place or systemic changes to ensure the deficient practice will not reoccur?</p> <p>On [DATE] the RDCS provided education to the ED and DON on the following to ensure abuse policies were implemented to ensure alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately but no later than 2 hours after that allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events do not involve abuse and do not result in serious bodily injury to the Administrator and to other officials including the State Survey Agency and Adult Protective Services (APS) and to ensure all allegations of abuse are promptly and thoroughly investigated.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Abuse-conducting an investigation, neglect, exploitation allegation checklist, incident and reportable event management, witness interview/statement policy, witness interview/statement form.</p> <p>The ED, DON, ADON, SDC, and/or licensed nurse will provide education to all facility staff on the following:</p> <p>Abuse-conducting an investigation, incident and reportable event management, witness interview/statement policy, witness interview/statement form.</p> <p>Any associate who has not completed the training by [DATE] will not be allowed to work until training is completed, the ED, DON, SDC and or licensed nurse will provide education to all new associates upon hire during orientation.</p> <p>Assigned interdisciplinary team members will perform daily compliance rounds on the secured unit that include monitoring of identifying and reporting allegations of abuse and types of abuse through interviews of 2 staff members and resident observations. (Process) the ED and or DON will be responsible for reviewing the compliance rounds for any allegation/identification of abuse and ensuring appropriate reporting and investigation, initiated on [DATE].</p> <p>Prior to submitting final investigation to required agencies a member of the Regional Team RVP, RDCS, RDOR will review investigations to ensure a thorough investigation was completed (Process)</p> <p>The RVP will review the abuse reporting log and investigations during facility visits (Process).</p> <p>Medial Director reviewed and agreed with this plan of removal on [DATE]. Quality Assurance and Performance Improvement meeting held [DATE] regarding plan of removal.</p> <p>The Removal Plan was validated onsite by the surveyor on [DATE] and included the following:</p> <ol style="list-style-type: none"> <li>1. Progress notes showed Resident #1 was discharged on [DATE] to the hospital and resident's daughter found a facility closer to home and the resident would not be returning to facility, Suspended Pending Investigation Forms showed on [DATE] LPN A was suspended and on [DATE] Staff Member A was suspended pending investigation by the ED, an investigation report showed a thorough investigation was completed on [DATE].</li> <li>2. Audit 2A Resident Interviews showed 100% of resident interviews were completed on [DATE] with no concerns, Audit Tool: Skin Assessment showed 100% of resident skin assessments were completed on [DATE] with no concerns, Grievance Complaint Logs and Resident Council Minutes for ,d+[DATE], , d+[DATE], and ,d+[DATE] were reviewed, signed by Administrator and dated [DATE] with no concern, Employee lists for interviewing for unreported abuse 100% complete with 1 employee stating she witnessed abuse, Suspended Pending Investigation Form showed the employee was suspended on [DATE] pending investigation, investigation was completed on [DATE], Progress notes showed Resident #10 expired on [DATE] at the facility with family at bedside.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>3. Facility sign in sheet dated [DATE] and interview with the ED and DON showed the ED and the DON were educated on Abuse-conducting an investigation, neglect, exploitation allegation checklist, incident and reportable event management, witness interview/statement policy, witness interview/statement form by the RDCS. Interviews with 2 night shift CNAs (6:00 PM - 6:00 AM), 2 night shift LPNs (6:00 PM - 6:00 AM), 4 day shift CNAs (6:00 AM - 6:00 PM), 2 day shift LPNs (6:00 AM - 6:00 PM) 2 housekeeping staff and facility sign in sheet dated [DATE] compared to facility associate list of employees showed 100% of associates were educated on Abuse-conducting an investigation, incident and reportable event management, witness interview/statement policy, witness interview/statement form. Quality Rounds Checklists dated ,d+[DATE] and [DATE] showed daily compliance rounds had been started, incident reporting system form showed on [DATE] allegation of abuse was reported with RVP and RDCS notified, facility F-609 reporting of allegation of abuse logs showed the log was started on [DATE] and signed by the RVP, a typed document signed by the ED on [DATE] showed the AOC was reviewed by the ED and Medical Director agreed with the AOC plan, a typed document signed by the ED on [DATE] showed a QAPI meeting was held to discuss AOC with no concerns noted.</p> <p>The facility is required to submit a Plan of Correction.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37078</b></p> <p>Based on review of facility policy review, medical record review, facility documentation review, witness statement review, observation, and interviews, the facility failed to implement a behavioral and wandering care plan. The facility's failure to implement a behavioral and wandering care plan resulted in 1 of 6 (Resident #1) sampled residents being secluded in the dining/day room area of the secured unit for an unspecified amount of time.</p> <p>The findings include:</p> <p>Review of the facility's undated policy titled, Protection of Residents: Reducing the Threat of Abuse &amp; Neglect, showed .All residents have the right to be free from .unreasonable confinement .It is the policy and practice of [Named Facility] that all residents will be protected from abuse .Abuse means .unreasonable confinement .Definitions .the willful .unreasonable confinement .Involuntary Seclusion Separation of a resident from other residents .or confinement .with or (without roommates) against the resident's will or of the responsible party .</p> <p>Review of the facility's policy titled, Person Centered Care Planning, reviewed 8/22/2023, showed .Each resident will have a person-centered comprehensive care plan .implemented to .address the resident's . mental and psychosocial needs .Interventions - are actions .or activities designed to meet an objective . Objective - a statement describing the results to be achieved to meet resident's goals .The care plan will be . implemented to ensure consistency with implementation across all shifts .</p> <p>Review of the medical record showed Resident #1 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Dementia, and Anxiety. The resident discharged to the hospital on 3/29/2024.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] showed Resident #1's Brief Interview of Mental Status (BIMS) score was 2 indicating the resident had severe cognitive impairment. The resident required assistance of one person with activities of daily living (ADL's) with supervision or touching assistance for walking. No behaviors were identified on the MDS.</p> <p>Review of Resident #1's current care plan last reviewed 3/18/2024, showed .dx [diagnosis] of dementia with behaviors .wandering on unit .[Resident #1] will not experience behaviors, that are harmful to self and others . Anticipate and meet The resident's needs .Intervene as necessary to protect the rights and safety of others . Divert attention. Remove from situation and take to alternate location as needed .secured unit due to wandering .Date Initiated 10/06/2021 . The facility had not diverted the resident's attention away from other residents in the secured unit.</p> <p>Review of facility's BEHAVIOR/INTERVENTION MONTHLY FLOW RECORD for Resident #1 for the month of 1/2024, showed documentation the resident had a behavior of wandering 4 days during that month on 1/3, 1/4, 1/8, and on 1/9/2024 with interventions documented that included redirect, activity, return to room, give food, and give fluids. No other documentation of behaviors were noted.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a facility provided list of new admissions for 1/2024 on the secured unit showed 3 new admissions in January one of which was Resident #8 on 1/17/2024.</p> <p>Review of an undated statement by the Director of Nursing (DON) showed .On 1/18/24 .around 8 AM .[Staff Member A] came to my office + [and] stated he needed to talk with me .he stated he had been at facility for several hours .he said when he went to 400 [secured unit] doing his rounds-that night shift was still here and when he first walked onto the unit he didn't see any staff members but when he got closer to the desk he saw [Resident #1] in dining room with doors closed and w/c [wheelchair] parked in doorway states saw one CNA [Certified Nurse Assistant (CNA) A] in chair who said she just got back there and then the nurse [Licensed Practical Nurse (LPN) A] came out of the bathroom as he was removing the w/c [wheelchair] + opening the door + the resident came out of the dining room -he said he gathered the staff on 400 [secured unit] + [provided] them education .</p> <p>Review of a written statement provided to this surveyor on 4/4/2024 by Staff Member A showed .I came in on 1/18/24 [2024] between the time of 3AM - 5AM[3:00 AM-5:00 AM] .when I walked into station 4 [secured unit] I seen a Resident [Resident #1] barricaded behind the dining room double Doors with wheelchairs blocking the exit the resident could not leave the dining room as the chairs were blocking the doors. I immediately let her out of the room by removing the wheelchairs .the resident seemed okay besides just wanting to be let out .once the patient was let out .I noticed [CNA A] rolling back and fourth through the hall in a wheel chair . about 5 minutes later [LPN A] came out of the bathroom .I educated both of [CNA A and LPN A] that under NO circumstances is that allowed to happen. [LPN A] told me 'this was my fault, the CNAs had nothing to do with it' Towards the end of our conversation the CNA [CNA B] showed up and I also educated her as well . 4/4/24[2024] .</p> <p>Review of a statement by LPN B sent via email to this surveyor on 4/8/2024, showed .On 4 to 6 occasions I have witnessed the resident in question [Resident #1] [locked] in dining room/day room .This transpired over approximately 4 months. Along with this resident there [were] 3 or 4 more residents. There are no locks on the doors so wheelchairs or the med [medication] cart was placed in front of the doors [to prevent the dining room/day room doors from opening]. The resident [Resident #1] was pounding on door asking to be let out other than asking to be let out she was not crying or showing other distress . When asked why they (residents) were in there (barricaded in dining room/day room) the response from staff was .we don't want them waking up other residents .</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/1/2024 at 10:30 AM, Staff Member A stated, .I was coming in early on that day [1/18/2024] .it was either 4 or 5 [4:00 AM or 5:00 AM]in the morning .I walked into station 4 [secured unit] and then I noticed [Resident #1] was in the dining room with the doors shut with wheelchairs blocking it .they [staff] had 2 wheel chairs parked in front of the doors parked sideways blocking both doors on the outside . the lights were on .I got her [Resident #1] out of the room and made sure she was alright she didn't seem like she was distressed or hurt .I don't know how long she was in there it could have been one minute it could have been five hours .when she saw me she said bubby can you let me out of here I immediately moved the chairs out of the way and opened the door and she walked out .once she was good I tracked down all the employees that was working back there [secured unit] and told them under no circumstances was that allowed[barricading doorways with residents inside] .there was one CNA [CNA A] that was rolling up and down the hall in a wheelchair she was just riding back and forth and she was the only one that I seen at that time. The LPN [LPN A] come out of the bathroom about 5 minutes after I got there and the other CNA [CNA B], I don't know where she was at but maybe 10 minutes later, she come walking back down the hall .I told all them under no circumstances was that [barricading doorways with residents inside] allowed .[LPN A] said she put her [Resident #1] in there because she had to go to the restroom and she [Resident #1] was bothering a new admit [admission] .they had a CNA on the floor and she could have watched her .I educated them .I was mad I was upset just barricading somebody behind the door that was why I was upset .[LPN A] took responsibility for that she told me the CNAs had nothing to do with it she said she [LPN A] put her in there .</p> <p>Observation on 4/1/2024 at 10:45 AM, of the secured unit dining/dayroom with Staff Member A showed 2 doors (double doors) at the entrance to the dining/day room. Staff Member A demonstrated how 2 wheelchairs were used with 1 wheelchair parked up against each door with the wheels locked blocking Resident #1 from exiting the room.</p> <p>During a telephone interview on 4/1/2024 at 3:45 PM, CNA B said Resident #1 would sometimes be up all night. CNA B told this surveyor she remembered Staff Member A at the nurses' station, and he said there was a law you can't lock people in the dining room. CNA B said her nurse (LPN A) told her she could go back to what she was doing, so she didn't hear everything Staff Member A said when he and LPN A were talking at the nurses' station.</p> <p>During a telephone interview on 4/1/2024 at 7:30 PM, LPN A stated .I remember talking to him [Staff Member A] one morning but he was up back there [secured unit] several times around the first of the year .I don't even remember what he said I don't remember anything specific .</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 4/2/2024 at 11:15 AM, LPN B stated .on several occasions she [Resident #1] was in the dining room with the doors shut and there was always something in front of it [the doors] whether it be a wheelchair or the med [medication] cart .I have witnessed it probably 4 to 6 times I seen that . I would go back there [secured unit] to visit from station 2 .I can't remember the exact dates if I was working a shift I would go back to visit some nights there wouldn't be any one [residents] in there [dining/day room] and some nights there would be 4 residents in there I cannot remember who the residents were but she [Resident #1] was one .she was restless a lot for them [staff] back there at that time .it would be after midnight between midnight and 2 o'clock [2:00 AM] I'd have a little bit of down time so I would go back there [secured unit] and see what was going on .they [LPN A, CNA A, and CNA B] wouldn't take them [residents]out when I would go back there I said why and they said well we don't want them down the hall waking up everybody else .[LPN A, CNA A, and CNA B] were the ones working when I saw it .I specifically talked to [CNA B and LPN A] and they said they didn't want them to wake up the other residents .they were just kind of wandering around [Resident #1] would be banging on the door and I said why don't you let her out to [LPN A] and she just said she's goanna wake up everybody on the hall .it was about 3 months ago the first time I saw it and about a month ago it stopped and I figured it stopped because [Staff Member A] busted them doing it .it was only when those three were working .</p>		

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<p>F 0675</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Honor each resident's preferences, choices, values and beliefs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37078</b></p> <p>Based on facility policy review, medical record review, facility documentation review, witness statements, observation, and interview, the facility failed to provide an environment which enhanced the resident's quality of life. The facility's failure to provide an environment for quality of life resulted in 1 resident (Resident #1) of 6 sampled residents being secluded in the dining/day room area of the secured unit for an unspecified amount of time on [DATE]. Resident #1, a vulnerable and severely cognitively impaired resident, was found in the dining/day room with the doors closed and 2 wheelchairs with their wheels locked blocking the doors when a staff member made rounds early in the morning on [DATE].The facility's failure to provide an environment that humanized and individualized each resident's quality of life placed Resident #1 and other residents on the secured unit in an Immediate Jeopardy (IJ) situation, (A condition in which the facility's noncompliance with one or more conditions of participation has resulted in or is likely to result in serious injury, harm, impairment, or death and must be immediately corrected). The facility's failure to provide an environment that enhanced quality of life had the potential to impact all residents on the secured unit.</p> <p>The Facility Executive Director (ED) was notified of the IJ for F-675 on [DATE] at 1:00 PM, in the conference room.</p> <p>The facility was cited Immediate Jeopardy at F-675 at a scope and severity of J, which is substandard quality of care.</p> <p>An acceptable Allegation of Compliance (AOC)/Removal Plan which removed the immediacy was provided by the facility and verified on site on [DATE] for F-675.</p> <p>The facility's noncompliance at F-675 continues at a scope and severity of Dfor monitoring the effectiveness of the corrective actions.</p> <p>The facility is required to submit a Plan of Correction (POC).</p> <p>The findings include:</p> <p>Review of the facility's undated Policy titled, Protection of Residents: Reducing the Threat of Abuse &amp; Neglect, showed .All residents have the right to be free from .unreasonable confinement .It is the policy and practice of [Facility] that all residents will be protected from abuse .Abuse means .unreasonable confinement . Definitions .the willful .unreasonable confinement .Involuntary Seclusion Separation of a resident from other residents .or confinement .with or (without roommates) against the resident's will or of the responsible party .</p> <p>Review of the medical record showed Resident #1 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Dementia, and Anxiety. The resident discharged to the hospital on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0675</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] showed Resident #1's Brief Interview for Mental Status (BIMS) score was 2 indicating the resident had severe cognitive impairment. The resident required assistance of 1 person with activities of daily living (ADL's) with supervision or touching assistance for walking.</p> <p>Review of an undated statement by the Director of Nursing (DON) showed, . On [DATE] [[DATE]] .around 8 AM [8:00 AM] .[Staff Member A] came to my office .stated he [Staff Member A] needed to talk with me [DON] .he [Staff Member A] stated he had been at facility for several hours .he said when he went to 400 [secured unit] doing his rounds .night shift [staff] was still here [in the facility] and when he first walked onto the unit he didn't see any staff members [present on the unit] but when he got closer to the desk he saw [Resident #1] in dining room with doors closed and w/c [wheelchairs] parked in doorway [the w/c's were parked in front of the door so the resident could not leave the dining room] states saw one CNA [Certified Nurse Assistant (CNA) A] in chair who said she just got back there [on the secured unit] and the nurse[Licensed Practical Nurse (LPN) A] came out of the bathroom as he [Staff Member A] was removing the w/c .opening the door [to the dining room ] .[Resident #1] came out of the dining room .he [Staff Member A] said he gathered the staff on 400 [secured unit] .[provided] them education [education related to involuntary seclusion] .</p> <p>During an interview on [DATE] at 10:30 AM, Staff Member A stated, .I was coming in [to the facility] early on that day [[DATE]] .it was either 4 or 5 in the morning [4:00 AM or 5:00 AM] .I [Staff Member A] walked into station 4 [400] [secured unit] and then I noticed [Resident #1] was in the dining room with the doors shut with wheelchairs blocking it [blocking the doors] .they [staff] had 2 wheel chairs parked in front of the doors parked sideways blocking both doors on the outside .the lights were on .I got her [Resident #1] out of the room and made sure she was alright she didn't seem like she was distressed or hurt .I don't know how long she was in there it could have been one minute it could have been five hours .when she saw me she said [Nickname for Staff Member A] can you let me out of here I[Staff Member A] immediately moved the chairs out of the way and opened the door and she walked out .once she was good I tracked down all the employees that was working back there [on the secured unit] and told them under no circumstances was that allowed [barricading doorways with residents inside] .there was one CNA [CNA A] that was rolling up and down the hall in a wheelchair she was just riding back and forth and she was the only one that I seen at that time. The LPN [LPN A] come out of the bathroom about 5 minutes after I got there and the other CNA [CNA B], I don't know where she was at but towards the end of, maybe 10 minutes later she come walking back down the hall .I told all them under no circumstances was that [barricading doorways with residents inside] allowed .[LPN A] said she put her in there because she had to go to the restroom and she [Resident #1] was bothering a new admit [admission] .they had a CNA on the floor and she could have watched her .I educated them .I was mad I was upset just barricading somebody behind the door that was why I was upset .[LPN A] took responsibility for that she told me the CNAs had nothing to do with it she said she [LPN A] put her [Resident #1] in there .</p> <p>During an observation on [DATE] at 10:45 AM, of the secured unit dining/dayroom, Staff Member A showed the surveyor 2 doors (double doors) at the entrance to the dining/day room. Staff Member A demonstrated how 2 wheelchairs were used with a wheelchair parked up against each door with the wheels locked blocking Resident #1 from exiting the room.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Life Care Center of Gray		STREET ADDRESS, CITY, STATE, ZIP CODE  791 Old Gray Station Road Gray, TN 37615	
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<p>F 0675</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on [DATE] at 3:45 PM, CNA B stated, .I know that back in January .[Resident #1] sometimes she will be up all night .I remember [Staff Member A] at the front of the desk [nurses' station] . [Staff Member A] said you know there's a law you can't lock people in the dining room [referring to Resident #1 being barricaded in the dining room/day room] .my nurse [LPN A] was like you can go back and carry on so I went back down the hall .when I left the nurses station [LPN A] and [Staff Member A] were talking I didn't hear what was said .</p> <p>During a telephone interview on [DATE] at 7:30 PM, LPN A stated, .I remember talking to him [Staff Member A] one morning but he was up back there [secured unit] several times around the first of the year .I don't even remember what he said I don't remember anything specific .</p> <p>During a telephone interview on [DATE] at 11:15 AM, LPN B stated, .on several occasions she [Resident #1] was in the dining room with the doors shut and there was always something in front of it [the doors] whether it be a wheelchair or the med [medication] cart .I have witnessed it probably 4 to 6 times .I [LPN B] would go back there [secured unit] to visit from station 2 .I can't remember the exact dates if I was working a shift I would go back to visit some nights there wouldn't be anyone [residents] in there [dining/day room] and some nights there would be 4 residents in there I cannot remember who the residents were but she [Resident #1] was one .she was restless a lot .it would be after midnight between midnight and 2 o'clock [12:00 AM-2:00 AM] I'd [LPN B] have a little bit of down time so I would go back there [the secured unit] and see what was going on .they [LPN A, CNA A, and CNA B] wouldn't take them [residents] out [of the barricaded dining room/day room] when I would go back there I said why [asking why the residents were barricaded in the room] and they [LPN A, CNA A, and CNA B] said well we don't want them [residents] down the hall waking up everybody else [other residents who resided on the secured unit] .[LPN A, CNA A, and CNA B] were the ones working when I saw it .I specifically talked to [CNA B and LPN A] and they said they didn't want them to wake up the other residents .they were just kind of wandering around [Resident #1] would be banging on the door and I said why don't you let her out to [LPN A] and she just said she was gonna wake up everybody on the hall .it was about 3 months ago the first time I saw it and about a month ago it stopped and I figured it stopped because [Staff Member A] busted them doing it .[Resident #1 was barricaded in the dining/day room] was only when those three [LPN A, CNA A and CNA B] were working .</p> <p>During an interview on [DATE] at 1:45 PM, the DON stated .[Staff Member A]came and told me he had been here checking the temperatures and the pipes .when he was going to 4 [secured unit] to do his rounds he [Staff Member A]saw [Resident #1] in the dining room with the doors closed and wheelchairs parked in the doorway .[Staff Member A] said the wheelchairs where in front of the doors he didn't say they were blocking the doors .[DON] said did you asked questions when he came up on this situation and he said no .he said that they were trying to tell him something but he was to mad to listen .when I was told those people were no longer on shift this happened hours prior I contacted them and let them know to contact me when they woke up and I obtained statements from them .I spoke with [LPN A, CNA A, and CNA B]and I also spoke with residents back on 4 [secured unit] .[LPN A] stated the resident had been up all night following staff .[LPN A]stated [Resident 1] had to use the restroom and the resident was sitting in a chair outside of the dining room .if somebody intentionally barricaded a door that is definitely an issue .I reviewed it with my Executive Director .we didn't report it to any outside authority .</p> <p>(continued on next page)</p>		

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<p>F 0675</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 2:20 PM, the ED stated .I know [Staff Member A] was the one who walked into that situation he reported to the [DON] .[Staff Member A]told me he saw [Resident #1] in the dining room with the doors shut and a wheelchair in front of the door .[Staff Member A] said he opened the dining room doors and talked to the staff back there while he was back there .[the DON]did the investigation .we did not contact any outside authorities .</p> <p>Review of a written statement provided to this surveyor on [DATE] by Staff Member A showed .I [Staff Member A] came in [to the facility] on [DATE] [[DATE]] between the time of [3:00 AM or 5:00 AM] .when I walked into station 4 [400] [secured unit] I seen a Resident [Resident #1] barricaded behind the dining room double Doors with wheelchairs blocking the exit the resident could not leave the dining room as the chairs were blocking the doors. I immediately let her out of the room by removing the wheelchairs .the resident seemed okay besides just wanting to be let out .once the patient [Resident #1] was let out .I [Staff Member A] noticed [CNA A] rolling back and fourth [forth] through the hall in a wheel chair .about 5 minutes later [LPN A] came out of the bathroom .I educated both .[CNA A and LPN A] that under NO circumstances is that [barricading a resident in a room] allowed to happen. [LPN A] told me 'this was my fault, the CNAs had nothing to do with it' Towards the end of our conversation the CNA [CNA B] showed up and I also educated her as well XXX[DATE] [2024] .</p> <p>Review of a witness statement by LPN B sent via email to this surveyor on [DATE] showed .On 4 to 6 occasions I [LPN B] have witnessed the resident [Resident #1] in question lock [locked] in dining room/day room .This transpired over approximately 4 months. Along with this resident there [were] 3 or 4 more residents [that were locked inside the dining room/day room]. There are no locks on the doors so wheelchairs or the med [medication] cart was placed in front of the doors [to prevent the dining room/day room doors from opening]. The resident [Resident #1] was pounding on door asking to be let out other than asking to be let out she was not crying or showing other distress . when asked why they (residents) were in there (barricaded dining room/day room), the response from staff was .we don't want them waking up other residents .</p> <p>Refer to F603, F609, and F610.</p> <p>The facility's corrective actions for the removal plan were issued to the surveyor on [DATE]. The corrective action plan included the following:</p> <p>1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Resident #1 was discharged on [DATE] to another facility.</p> <p>The Executive Director (ED), Director of Nursing (DON) and Interdisciplinary Team (IDT) completed a Root Cause Analysis (RCA) on [DATE]. The root cause was identified as identifying and implementing appropriate wandering and behavioral intervention and identifying specific types of abuse were not discussed in associate education, which included involuntary seclusion.</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>(continued on next page)</p>		

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<p>F 0675</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>All residents with a BIMS of 10 or higher will be interviewed for any allegations of abuse/neglect/misappropriation by the ED (Executive Director) of a sister facility and the Administrator in Training (AIT) from a sister facility on [DATE]. No allegations of abuse were identified.</p> <p>All residents with BIMS of 9 or less will have a skin assessment completed to identify any potential unreported abuse by a licensed nurse by [DATE]. No abuse was identified.</p> <p>All residents comment cards for the past 90 days will be reviewed for any allegations of abuse/neglect/misappropriation by the ED on [DATE]. No allegations of abuse were identified.</p> <p>Attempt to interview all active associates to identify any potential unreported abuse by the ED or DON initiated on [DATE] and will be completed by [DATE].</p> <p>Attempt to interview all active associates to identify any potential unreported abuse by a member of the Regional Team. The regional team consist of the Regional [NAME] President (RVP), Regional Director of Clinical Services (RDCS), Regional Director of Rehab (RDR), Regional Business Development Director (RBDD) initiated on [DATE] and will be completed by [DATE].</p> <p>Identification of above will be reported to the appropriate state agencies and investigated per policy by the ED and DON.</p> <p>On [DATE] RDBD and RVP identified through an interview with an LPN a resident (Resident #10) and Resident #1 were in the secured unit dining room and were unable to move freely throughout the secured unit. The LPN stated associates were always in direct line of site of the residents. The LPN stated this incident occurred 4 to 6 months ago. on [DATE] LPN was suspended pending investigation by the ED. Investigation completed on [DATE]. Resident #10 expired in the facility due to expected causes related to several medical diagnoses on [DATE].</p> <p>3. What measures will be put into place or systemic changes to ensure the deficient practice will not reoccur?</p> <p>On [DATE] the RDCS provided education to the ED and DON on the following to ensure abuse policies were implemented to ensure alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately but no later than 2 hours after that allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events do not involve abuse and do not result in serious bodily injury to the Administrator and to other officials including the State Survey Agency and Adult Protective Services (APS) and to ensure all allegations of abuse are promptly and thoroughly investigated.</p> <p>Abuse-screening of employee and residents, identification of types, protection of residents, coordination with the Quality and Performance Improvement (QAPI) Program and Quality QAA committee, resident rights, and secured unit placement.</p> <p>(continued on next page)</p>		

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<p>F 0675</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The ED, DON, ADON, Staff Development Coordinator (SDC) and/or licensed nurse will provide education to all facility associates on the following policies to ensure abuse policies are implemented to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately but no later than 2 hours after that allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events do not involve abuse and do not result in serious bodily injury to the Administrator and to other officials including the State Survey Agency and Adult Protective Services (APS) and to ensure all allegations of abuse are promptly and thoroughly investigated. Abuse-screening of employee and residents, identification of types, protection of residents, coordination with the Quality and Performance Improvement (QAPI) Program and Quality QAA committee, and resident rights.</p> <p>Any associate who has not completed training by [DATE] will not be able to work until training is completed. The ED, DON, SDC, and or licensed nurse will provide education to all new associates upon hire during orientation.</p> <p>Assigned interdisciplinary team members will perform daily compliance rounds on the secured unit that include monitoring of identifying and reporting allegations of abuse and types of abuse through interviews of 2 staff members and resident observations. (Process) the ED and or DON will be responsible for reviewing the compliance rounds for any allegation/identification of abuse and ensuring appropriate reporting and investigation, initiated on [DATE]. Medial Director reviewed and agreed with this plan of removal on [DATE] QAPI meeting held [DATE] regarding plan of removal.</p> <p>The Removal Plan was validated onsite by the surveyor on [DATE] and included the following:</p> <ol style="list-style-type: none"> <li>1. Progress notes showed Resident #1 was discharged on [DATE] to the hospital, the resident's daughter found a facility closer to home and the resident would not be returning to facility.</li> <li>2. Audit 2A Resident Interviews showed 100% of resident interviews were completed on [DATE] with no concerns, Audit Tool: Skin Assessment showed 100% of resident skin assessments were completed on [DATE] with no concerns, Grievance Complaint Logs and Resident Council Minutes for ,d+[DATE], , d+[DATE], and ,d+[DATE] were reviewed, signed by Administrator and dated [DATE] with no concern, employee lists for interviewing for unreported abuse 100% complete with 1 employee stating she witnessed abuse, suspended pending investigation form showed the employee was suspended on [DATE] pending investigation, investigation was completed on [DATE], progress notes showed Resident #10 expired on [DATE] at the facility with family at bedside.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0675</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>3. Facility sign in sheet dated [DATE] and interview with the ED and DON showed the ED and the DON were educated on abuse-screening of employee and residents, identification of types, protection of residents, coordination with the Quality and Performance Improvement (QAPI) Program and Quality QAA committee, resident rights, and secured unit placement by the RDCS. Interviews with 2 night shift CNAs (6:00 PM - 6:00 AM), 2 night shift LPNs (6:00 PM - 6:00 AM), 4 day shift CNAs (6:00 AM - 6:00 PM), 2 day shift LPNs (6:00 AM - 6:00 PM) 2 housekeeping staff and facility sign in sheet dated [DATE] compared to facility associate list of employees showed 100% of associates were educated on Abuse-screening of employee and residents, identification of types, protection of residents, coordination with the Quality and Performance Improvement (QAPI) Program and Quality QAA committee, and resident rights, Quality Rounds Checklists dated , d+[DATE] and [DATE] showed daily compliance rounds had been started, a typed document signed by the ED on [DATE] showed the AOC was reviewed by the ED and Medical Director agreed with the AOC plan. A typed document signed by the ED on [DATE] showed a QAPI meeting was held to discuss AOC with no concerns noted.</p> <p>The facility is required to submit a Plan of Correction.</p>		