

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/11/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345144	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/24/2022
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NAME OF PROVIDER OR SUPPLIER PINE RIDGE HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOD ROAD THOMASVILLE, NC 27360
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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E 000	Initial Comments A complaint investigation was conducted 1/17/22 to 2/2/22. The facility was not found in compliance with the requirement CFR 483.73, Emergency Preparedness, and was cited at E0001. Event ID # 54P511. Immediate Jeopardy was identified at: CFR 483.73 at tag E0001 at a scope and severity (L)	E 000		
E 001 SS=L	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.)	E 001		3/22/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/04/2022

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.

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E 001	Continued From page 1 *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on North Carolina State of Emergency press releases, email review, text message review, record review, resident, emergency/disaster relief staff, Emergency Medical Services (EMS), police, and facility staff interviews, the facility failed to enact the facility emergency preparedness plan which impacted all residents during a governor declared state of emergency involving inclement weather. The result of the failure to prepare resulted in one Licensed Practical Nurse (LPN) and two Nursing Assistants (NAs) to take care of 98 residents at the facility starting at 2:00 PM on 1/16/22. On 1/16/22 at 8:09 PM three police officers arrived at the facility for a wellness check to investigate a 911 call from a resident at the facility who had	E 001	Pine Ridge Health and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents and to meet requirements established by state and federal law. The Plan of Correction is submitted as a written allegation of compliance. Pine Ridge Health and Rehabilitation Center's response to this Statement of Deficiencies and Pine Ridge Health and Rehabilitation Center's earlier submitted credible allegation of immediate jeopardy		

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E 001	<p>Continued From page 2</p> <p>called and complained of not having seen staff members for a long period of time. When 911 dispatch attempted to call the facility, the calls went unanswered. The police officers who arrived then contacted the city fire department and county Emergency Medical Services (EMS). Due to a lack of facility staff the county Emergency Preparedness Director took over operations of the facility and utilized resources to obtain a combination of skilled individuals to provide care, assess, assist with an evening meal, and other services for the residents of the facility.</p> <p>Immediate Jeopardy began on 1/16/22 when the facility failed to plan, prepare, and respond for inclement weather (snow/ice). On 1/13/22, the potential for inclement weather was announced by the Governor of the State of North Carolina through his enactment of a state of emergency for the entire state related to the predicted winter storm. The facility failed to enact their emergency preparedness plan. The immediate jeopardy was removed on 1/18/22 when the facility provided an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity level of F (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training, to ensure monitoring systems put into place are effective, and to share the Emergency Preparedness Plan with the Fire Marshall. Every resident of the facility was placed at risk of severe harm.</p> <p>Findings included:</p> <p>A review of the facility's supplied Emergency</p>	E 001	<p>removal does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate or that any individual resident suffered or was likely to suffer actual harm or a serious adverse outcome. Further, Pine Ridge Health and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.</p> <p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice</p> <p>On 1/14/22, the Assistant Regional Vice President (ARVP), and Human Resources Consultant reviewed the emergency preparedness plan onsite with the Administrator.</p> <p>On 1/16/22 at 11:45 PM the administrator, with the assistance from the ARVP, initiated the Emergency Preparedness Plan due to the inclement weather. This was to ensure residents received medications, meals in a timely manner, received other necessary care and services, and staff provided supervision and an environment without severe risk of harm to include in the dementia unit.</p> <p>On 1/17/22 the ARVP assisted the administrator and DON with implementation of the Emergency</p>		

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E 001	Continued From page 3 Preparedness (EP) plan material revealed prior to 1/17/22, the EP plan had last been reviewed on 5/4/21 by Administrator #1, who was in place until August 2021. The review did not reveal the EP plan was reviewed by Administrator #2, who was in place from August until suspended on 1/17/22. Page A-5 documented in part-Analysis of the facility ' s current level of preparedness to manage any given disaster. This process should also involve the input of community agencies. The healthcare facility will not be responding in a vacuum, and there may be community resources to support the facility. The phone number for the Thomasville Emergency Manager Agency on page A-12 was disconnected when an attempt was made to call the number on 1/18/22. On page A-15 there was a hazard vulnerability assessment ranked assessment for events, the first was Bio-Terrorism, the second was utility outage, the third was extreme temperature, and the fourth was severe weather. The facility administrator and other key facility leadership shall participate with community-specific Emergency Management Agencies, collaborations and/or coalitions to better respond to future emergencies and disasters, was documented on page A-19. Under communication on page C-5 read in part; Part of this emergency program is a communication system for sharing and integrating hazard-specific actions which may be taken to reduce exposure to harm such as: Severe Weather Events-Monitor local media or official weather service forecasts, paying particular attention to "hazardous weather outlooks" or similar products and independently monitor local weather conditions as severe weather conditions as severe weather is often a very localized event. Further review revealed on page C-5 a specific	E 001	Preparedness Plan which included ensuring sufficient staff was present to provide care and services to residents. How the facility identified other residents having the potential to be affected by the same deficient practice On 1/16/22 at approximately 11:30 PM, the DON arrived at the facility and provided medications and direct care. On 1/16/22 at 11:45 PM, a call was held with the Administrator and Corporate support staff to implement Emergency Preparedness Plan, which implementation would include getting sufficient staff to the facility to provide assessment of residents and care and services to residents. On 1/17/22 at 8:02 AM, the Mobile Certified Dietary Manager arrived in the kitchen, and the dietary department provided breakfast as scheduled. On 1/17/22 at 10:47 AM, the Corporate Clinical Director arrived in the facility and provided direct care. On 1/17/22 at 11:00 AM, Corporate Employee Experience personnel arrived at the facility, to assist with securing staff on the schedule. On 1/17/22 at 11:10 AM, the Regional RN MDS Consultant arrived at the facility to provide direct resident care.		

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E 001	<p>Continued From page 4</p> <p>section for Winter Storms; Monitor local media or official weather service forecasts; winter weather is rarely a surprise event and to make alternative staffing arrangements should the facility be cut-off (meaning routes to and from the facility are impassable). Page F-5 had a specific section for Procedures for a Winter Weather Emergency which included when severe winter weather is anticipated or conditions are observed which may impact on the facility, there is a responsibility to monitor available weather information. The policy further documented if a significant impact was anticipated, due to accumulation of snow, icy roads or drifting snow conditions, the Director of Facilities or her designee will be notified to begin notification of key personnel. These individuals will then assess the impact the weather event may have on staffing, delivery of supplies or access to the facility.</p> <p>An executive order from the Governor of North Carolina was released on 1/13/22 at 9:18 AM regarding a winter weather advisory and implementing a state of Emergency for the entire State of North Carolina.</p> <p>An email was sent to a nursing home administrator email group, which was validated to include Administrator #2, on 1/13/22 at 10:00 AM from the Section Chief of the Division of Health Service Regulation, Nursing Home Licensure and Certification Section of the North Carolina (NC) Department of Health and Human Services (DHHS). The subject of the email was "bad weather coming." The email included an NC Emergency Management Hazardous Weather update. The key takeaways from the email</p>	E 001	<p>On 1/17/22 at 11:30 AM, the supporting RN facility consultant arrived to assist with direct resident care.</p> <p>On 1/17/22 at 12:00 noon, the assigned RN facility consultant arrived to assist with direct resident care.</p> <p>On 1/17/22 at 1:00 PM, an additional RN consultant arrived to assist with direct resident care.</p> <p>On 1/17/22 at 2:30 PM, sufficient facility staff were in the facility to meet the needs of residents and provide care and services to the residents.</p> <p>Beginning on 1/17/22-1/20/22 the Physician or Nurse Practitioner assessed all residents for changes in condition. Orders were written and carried out for all identified areas of concern.</p> <p>On 1/30/22-2/13/22, the social worker talked with 100% of alert and oriented residents to provide psycho-social support.</p> <p>On 1/17/22 at approximately 5:30 PM, the ARVP suspended the Administrator for failure to implement the Emergency Preparedness Plan. Acting as the Governing Body, the ARVP assigned himself as the Interim Administrator during the investigation.</p>	

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E 001	<p>Continued From page 5</p> <p>included a significant winter storm is expected across much of the state later this weekend. Portions of the mountains and piedmont will likely see the greatest impacts.</p> <p>According to a news story titled, This is how much snow fell Sunday, posted on 1/17/22, by WCNC, a television station out Charlotte, NC, Thomasville, NC had three inches of snow and 0.09 inches of ice. The remark for the report documented there were 3 inches of snow and sleet on some roads with a light glaze of ice in the trees. Further review revealed other reports from around Davidson County with similar conditions and 2.5 to 4.0 inches of snow and ice.</p> <p>An interview was conducted with Administrator #2 on 1/17/22 at 2:08 PM. She stated she had been the administrator at the facility since August 2021. She explained for 1/16/22 they were fully staffed on paper, but there were one or two call outs, and the scheduled staff did not come in at 7:00 AM on 1/16/22. She explained a majority of the staff from night shift who worked from 11:00 PM on 1/15/22 to 7:00 AM on 1/16/22 had stayed over to help the 7:00 AM staff who arrived on 1/16/22. She said the staff who stayed over included a majority of the Nursing Assistants (NAs), the medication aides (med aides), and 2 nurses. She said she and the Director of Nursing had tried to come into the building, but they were unable to because of the poor road conditions from the inclement weather. She said she talked with Nurse #7 who arrived at the facility at 7:00 AM on 1/16/22 and was assigned to work until 7:00 PM on 1/16/22 and the nurse told her she had packed a bag and was prepared to stay the night if needed. She then</p>	E 001	<p>Measures put into place or systemic changes made to ensure that the deficient practice will not recur</p> <p>On 1/17/2022 at 1:23 AM, the ARVP arrived at the facility and assumed charge of the facility and directed the corporate staff to implement the shelter-in-place portion of the Emergency Preparedness Plan.</p> <p>On 1/17/22 upon arrival to the facility, the corporate staff reviewed the Emergency Preparedness Plan. A second ARVP began updating the emergency plan, including contact names and numbers.</p> <p>On 1/21/22, the Corporate Director of Special Projects began educating 100% of the facility and agency staff on the Emergency Preparedness plan. The education included: 1) the emergency preparedness program, 2) incident management staff chain of command, 3) evacuation, shelter in place, 4) fire response plan, 5) disaster, 6) infectious disease, 7) power outages/interruptions, 8) workplace violence and active shooter, 9) missing resident, 10) reporting to work during inclement weather, and 11) sleep pay policy. The education will be completed on 3/22/22. Any staff that has not worked and completed the Inservice will complete upon their next scheduled shift. The Mobile Director of Nursing, Director of Nursing, or Clinical Support</p>		

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E 001	Continued From page 6 stated the staff who was scheduled at 3:00 PM for the NAs and 7:00 PM for the nurses called and told her they were not able to make it to the facility and would not be coming in. She said she talked to Nurse #7 later in the day and the nurse told her it was just her and 2 NA ' s for the whole facility. She stated she started to call her administrative team for them to come in and help, people were trying to come in, but they were unable to get to the facility. She said she was corresponding with the dietary staff at around noon and was aware the first shift cook was there, and the second shift cook had come in early to help out and she thought the second shift cook stayed until 8:00 PM. She stated Nurse #7 told her the residents had sandwiches for a dinner meal on 1/16/22. She explained at some time between 9:00 PM and 10:00 PM Nurse #7 had called her and informed her Emergency Management was on site, along with the police, fire department, and they had called the state (DHHS). She then stated she had received calls from her supervisors who had informed them they had been contacted by the Nursing Home Section Chief. She said she was also made aware the Davidson County Emergency Management Coordinator had been trying to contact her and was unable to, but she said she had received no calls from him. She explained she had been talking to Nurse #7 several times through the day and administrative and key staff were to come into the facility to provide help and relief. Administrator #2 stated she was not aware contacting the Davidson County Emergency Management Coordinator was an option to provide assistance. Administrator #2 further stated she had not reviewed the Emergency Preparedness Plan prior to the inclement weather but it may have	E 001	Staff will ensure all newly hired staff and newly scheduled agency staff will complete the Inservice during orientation. On 1/17/22, the interim administrator monitored local and regional weather forecasts for 2 weeks. On 1/18/22 the interim administrator posted contact names and phone numbers at the nurse stations, break room, and in the kitchen for staff to use in the event of an emergency. On 1/21/22, the Fire Marshall visited the facility, the Emergency Preparedness Plan was shared. On 1/22/22, the Corporate Clinical Director proactively educated the interim administrator and interim director of nursing (DON) on Emergency Preparedness Plan and implementation. The education included: 1) Winter storm warnings, 2) Winter storm watch, 3) Winter storm warning for heavy snow, 4) winter storm warning for severe icing, 5) Blizzard warning, 6) Wind chill warning, 7) High wind warning, 8) Winter weather advisory, 9) Tornado watch & Warning, Thunderstorms, Floods, 10) Call corporate support staff, 11) Maintain , update, utilize, implement, communicate, mitigate, prepare, respond, recover. Future administrators and DONs will be educated on the Emergency Preparedness Plan as part of the orientation process.		

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E 001	Continued From page 7 had some information which would have been helpful for the situation. An interview was conducted on 1/18/22 at 2:30 PM with Administrator #3 (who was the Assistant Regional Vice President prior to assuming the administrator role). During the interview he stated he had started in December of 2021. He stated he had been at the facility on 1/14/22 and had discussed with the former administrator and had reviewed inclement weather was coming, sleep pay (a program where employees were paid a wage while sleeping at the facility used during inclement weather), transportation for the facility staff, Personal Protective Equipment (PPE) supplies, and the generator was prepared. He said he reviewed the preparations verbally with her and she affirmed preparations for the potential of inclement weather had been implemented, but she had provided no specific details of the preparations. He explained they had not reviewed the Emergency Preparedness Manual and he was not aware the last time the administrator had reviewed the emergency preparedness manual. He further stated he talked with Administrator #2 the morning of 1/16/22 and she informed him they were dealing with the weather, were making sure everything was covered, and there were no power outages. He said he had not heard from the administrator through the day on 1/16/22 until the night when police, fire, and Emergency Medical Services (EMS) were at the facility, but he would have expected to have heard from her through the day regarding the situation with staffing. He said he was contacted around 9:20 PM Sunday night and was made aware the police department and firefighters were at the facility providing care. He	E 001	During the weekend of 1/22/22 <input type="checkbox"/> 1/23/22, the facility exercised the Emergency Preparedness Plan during an inclement weather warning. Facility staff were on site and staff were paid sleep pay to remain on site during the inclement weather. When the Emergency Preparedness Plan was enacted, the residents received care and services. On 2/28/22 the Interim Administrator contacted the Quality Improvement Organization to discuss the plan of correction and for further recommendations to the action plans. How the facility plans to monitor its performance to make sure that solutions are sustained: Beginning 3/22/22 the Mobile Director of Nursing, Director of Nursing, or clinical support staff will conduct 10 quizzes with staff on the Inclement Weather Emergency Preparedness weekly x 8 weeks. Staff in each department will be included. Any staff that does not pass the quiz after 3 attempts, will no longer be allowed to work until successful completion. The Administrator or Director of Nursing will review and initial the audit tools weekly x 8 weeks for compliance and to ensure all areas of concern were addressed. Beginning 1/18/22, the Administrator will coordinate an Emergency Preparedness		

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E 001	<p>Continued From page 8</p> <p>said he had received notification from the Director of Special Projects for the corporate managing company of the facility. He stated he had discovered there was a presence of community support at the facility due to low staffing at the facility. He said he arrived at the facility at 1:23 AM on 1/17/22. He said when he arrived one of the police officers had informed him police had come to the facility to conduct a wellness check on 1/16/22 due to a call from someone at the facility and the police discovered one LPN and 2 NAs providing care for all of the residents. The morning of 1/17/22 Administrator #2 arrived at the facility, and he said he discussed with her the resources which were available to her through corporate support, and she did not supply an explanation as to how come she had not alerted him or other corporate members the situation regarding the lack of staffing. He said he had told her she should have called him about the staffing situation. The interim administrator stated he was currently in place as the administrator for the facility, former administrator had been suspended, and there was an investigation being conducted by corporate regarding what had happened.</p> <p>An interview was conducted was conducted on 1/17/22 at 2:36 PM with the (Director of Nursing) DON #1. She stated there were people scheduled, the scheduled people had not called out, and she thought they were coming into the facility. She said the facility was fully staffed for the morning of 1/16/22 because the night shift staff had stayed over to help. The staffing for the morning of 1/16/22 was 2 Registered Nurses (RNs), 2 Licensed Practical Nurses (LPNs), 2 med aides, and 2 NAs. The DON stated after 7:00 AM</p>	E 001	<p>Plan exercise with all staff quarterly x 2. The exercise will be a tabletop exercise or participation in a community sponsored exercise. The Administrator or Director of Nursing will review and initial the exercises for compliance and to ensure all areas of concern were addressed.</p> <p>The Administrator will be responsible for forwarding the quizzes and exercises to the Quality Assurance Committee. The facility's Quality Assurance Performance Improvement (QAPI) committee will review the quizzes monthly x 2 months to identify trends and determine the need for further frequency of monitoring.</p>		

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E 001	Continued From page 9 on 1/16/22 she had tried to drive into the facility, but she was unable to make it because of the road conditions, and she went back home. She explained through the day, the night shift staff started telling her they were tired from having worked all night, and having been there during the day, and started to go home, and she couldn ' t convince them to stay. She said at 2:00 PM the med aide who was there for the day shift left and it left one LPN and 2 NAs for 98 residents. The DON explained she was calling every staff member she could for them to go into the facility, but there was no answer, or the call went to voicemail. She said she then heard the police, and the fire department were at the facility. She said the police department were able to pick her up and she was able to arrive to the facility at about 11:30 PM on 1/16/22. The DON explained the staff were just doing what they wanted to do, staff were just leaving whenever they wanted to. She said she had offered bonuses, a place to stay, everything which could be offered, the only people who could stay were the 2 NAs and the nurse, which was not sufficient staffing for 98 residents. The DON explained there was an inclement weather plan, but she did not think the weather was going to be that bad. She explained it was difficult because the facility staffing was mostly through agency staffing and she could not make them stay. She said she was trying to get the administrative staff in. She said the plan was to come into the facility the morning of 1/16/22 and stay at the facility. She explained typically there would have been 4 nurses and 7 NAs to cover and care for 98 residents for evening and night shifts. During a meeting with the city police department	E 001			

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E 001	Continued From page 10 and State Bureau of Investigation (SBI) a review was conducted of the text messages exchange between Administrator #2 and Administrator #3. The review of text message exchange revealed the following: 1/15/22 at 11:47 AM from the interim administrator, "How are we looking for the storm?" Response from the former administrator on 1/15/22 at 11:53 AM was, "We are looking good. We reached out to our landscapers and they are salting the parking lot. Maintenance is aware he might have to pick up employees that live close." From the interim administrator on 1/15/22 at 11:56 AM, "Awesome. Thanks. Be safe." On 1/16/22 at 7:35 AM the former administrator texted, "Good morning (interim administrator name). Staffing concerns at Pine Ridge. 1 nurse and 1 med aide (medication aide) 2 CNAs (Certified Nursing Assistants) for 87 patients. Nurse on 500 hall here from last night. Working to call other employees. I will keep you posted." The response from the interim administrator on 1/16/22 at 7:39 AM was, "OK. Thanks." On 1/16/22 at 9:13 AM the interim administrator texted, "How are you guys holding up?" The response from the previous administrator was, "No power outages. Kitchen is altering the meal related to staff. DON #1 tried to go in and started sliding allover the road. She is on the phone with the charge nurse to give instructions. No adverse resident events." The interim administrator responded on 1/16/22 at 9:53 AM, "OK. Hang in there. You all are a good team." There was no further text or phone conversation between the former administrator and the interim administrator until they had a phone conversation at 9:19 PM on 1/16/22. Review of the facility punch detail report revealed	E 001			

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E 001	<p>Continued From page 11</p> <p>the Maintenance Director clocked in at 11:02 AM and clocked out at 11:33 AM on 1/16/22.</p> <p>An interview was conducted with the Maintenance Director on 1/20/22 at 3:31 PM. He stated he and Administrator #2 had discussed his use of an all-wheel drive vehicle to pick up staff who lived within a 10-minute radius of Thomasville in the event of inclement weather during the week prior to 1/16/22. He explained he had come to the facility on 1/16/22 from 11:00 AM to 11:30 AM and had talked with the former administrator. He said during the conversation she had not asked him to pick up any staff members. He further stated he was aware there were not many staff members at the facility, maybe 5 people, but he was aware the staff who was there had already notified DON #1. He said he had not heard from DON #1 nor Administrator #2 regarding picking up staff on 1/16/22. He said he was expecting to see other department heads at the facility on 1/16/22, but he was the only one at the facility.</p> <p>A phone interview was conducted on 1/18/22 with Nurse #7 on 1/18/22 at 3:41 PM. She said she worked on 1/16/22 and started at 7:00 AM and worked until 7:00 AM 1/17/22. She explained she had worked from 7:00 AM to 7:00 PM on 1/15/22 and it was a normal day. She explained she was aware of the potential for inclement weather, but there was no one from management who had discussed inclement weather with her, or preparations for inclement weather on 1/15/22. She said the employees of the facility were joking about it and making statements such as pack your bags and be prepared to stay in case it snows on 1/15/22. She said when she left her</p>	E 001			

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E 001	Continued From page 12 house on 1/16/22 it was just starting to snow. When she arrived at the facility, she explained she was unable to find the schedule, and she did not know who was supposed to work, or who was supposed to be there without the schedule, and without the schedule, she did not know how to make assignments or who would be assigned to what halls. She said she called DON #1 at around 7:30 AM to let her know she was the only nurse who had arrived for the day shift, she couldn ' t find the schedule, and the night nurse was going to only stay until 11:00 AM. She further explained there were only 2 Nursing Assistants (NAs) who had arrived to work day shift, and typically there would have been 2 medication aides, 3 nurses, and 8-10 NAs. She said she had talked to the DON and the Administrator #2 multiple times throughout the day, but on one occasion when she talked to her the DON had told her she had just gotten back into her driveway after trying to get to the facility, she didn ' t know anyone who had a truck who could come get her, and she would try to find some staff to come to the facility to help her. She said when she had talked to the former administrator, she told her she was sorry, and she was going to call DON #1. The nurse described the residents received a hot breakfast, but at lunch time, bagged lunches were pushed out onto the hallway by the dietary staff, and her and the 2 NAs passed out the bagged lunches, which were actually lunch and dinner combined into one bag. She added there was a medication aide (MA) (NA #3) who had come in at 7:00 AM and left at 2:00 PM and there were 2 NAs who had stayed over to help from night shift, but they had left before lunch time. She explained the NA shifts go from 7:00 AM to 3:00 PM, and no NAs arrived at the facility	E 001			

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E 001	Continued From page 13 at 3:00 PM. She further explained the nurses work 12 hour shifts from 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM, and no nurses arrived at the facility at 7:00 PM. The nurse described the day as chaotic, residents were asking for their medications, she was trying to prioritize medications such as antibiotics and insulin to ensure residents received them timely, she and the other staff were unable to answer the facility phone, she was communicating with DON #1 and the former administrator via her personal cell phone which she was carrying with her, she was making periodic rounds on the dementia unit because there was not enough staff to have someone on that unit at all times, at about 4:30 PM one of the NAs was crying, asking if anyone else was going to come to help, and had a panic attack to the point where she felt like she was going to have to call 911 for the NA. The nurse further stated at one point during a conversation with the DON, the DON told her she had too much responsibility in the building and to go lay down for a while and she responded to the DON she was there to take care of the residents and that was her main priority. She said she did not know how long it had been, but at one point there were two police officers behind her, and they had informed her they had received 911 calls regarding the situation at the facility. She said through discussion with the police officers they had asked her who was in charge of the facility, and she responded she was, she was in the only nurse in the facility, there were two NAs, and they were providing care for all of the residents. She explained shortly after that the facility was "swarming" with police, EMS, and firemen. She said they sat her down and were asking questions,	E 001			

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E 001	<p>Continued From page 14</p> <p>seemed concerned about her and well-being, and she felt relieved to know she was going to get some help for caring for the residents. She further stated at 11:00 PM when the night shift NAs were supposed to arrive, no NAs arrived at the facility and the 2 NAs who had been there since 7:00 AM remained at the facility with her. She explained she did not know who the interim administrator was.</p> <p>Review of the Davidson County Emergency Communications (911 Dispatch) call records revealed a call from a resident from Pine Ridge at 5:19 PM on 1/16/22. The caller stated she was calling from Pine Ridge Nursing Home, and she was trying to find out if there were any staff at the facility to help her because she was wet, in her bed, had not seen staff in hours, and had been told there was only one nurse. She said she had tried calling the facility number to the front desk and on one had answered. She further stated maybe the police could call the administrator or the DON to get them some help.</p> <p>Review of the Davidson County Emergency Communications (911 Dispatch) call records reveal a call from the same resident from Pine Ridge who called at 5:19 PM, called again at 8:00 PM on 1/16/22. The caller stated she had called earlier from Pine Ridge Nursing Home, but she still hadn't seen anyone, and she needed help because there were only 2 NAs which were here from 7:00 AM and they had been working at least 2 halls each. She said they had no supper, only what the 2 NAs and nurse could find.</p> <p>A phone interview was conducted on 1/20/22 at</p>	E 001			

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E 001	Continued From page 15 1:14 PM with Police Officer #2. He stated he and 2 other police officers arrived at Pine Ridge Nursing Home at about 8:09 PM on 1/16/22. He stated there was one car in the parking lot and with the snow, it was evident no one had come or gone from the facility via a vehicle for a while. He stated there were usually several cars in the parking lot and it was very odd for there to have been only one car. He stated there were also no foot tracks in the snow coming into or going out near the entrance of the facility. He said the front door, which was typically secured, was not locked, and there was no one at the reception area at the front of the building. He said he was calling out "hello" as he entered, but there was no answer. He stated he continued into the facility, continued to call out, and there was no response. To the nurses ' station, no staff observed, no response. He said there were some residents observed wandering in the halls, and he and the other police officers split up in an attempt to discover staff at the facility. He said he eventually discovered a nurse on a hall, and she questioned him as to how he had gotten into the facility because the front door should have been locked. The police officer then described the nurse, "Almost broke down into tears" and stated she was by herself, she did not know where all of the other staff were, she had been at the facility for 16 hours, she had conversations with DON #1 and was told by the DON there was nothing she could do to help her but at midnight to find a room to lay down and get some rest, and she had two residents who had died. The police officer inquired to her if the residents had been fed and the nurse responded they had received breakfast but had not had lunch or dinner. The police officer stated it	E 001			

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E 001	<p>Continued From page 16</p> <p>was at that point that he reached out to community resources which included Emergency Medical Services (EMS) and the fire department to assist in assessing and providing care for the residents of the facility. He explained he and the other police officers remained at the facility and continued to provide support and assistance to the staff at the facility and the residents. The police officer explained several residents were observed to have been crying, stated they had not received food or their medications, and some had said they had not seen a nurse all day. The police officer also described the smell at the facility to be "horrible" of stool and urine. He said he had not spoken to the NAs who were at the facility because he had not seen them and was not even aware they were there until another police officer made him aware there were 2 NAs. He said administrator #2 arrived at the facility at some point and he was taken to the Emergency Operations Center (EOC) to be debriefed about the situation and was observed to have been sitting there and just shaking his head. The police officer described the road conditions to have been OK in Thomasville on 1/15/22. He explained there had been snow in the morning, which turned to sleet for the rest of the day, but people were able to get out, were able to drive safely, take their time, and they were OK. The police officer said he believed people could have driven to work at the facility.</p> <p>A phone interview was conducted on 1/20/22 at 1:14 PM with the Emergency Management Coordinator of Davidson County. During the interview he stated he arrived at Pine Ridge Nursing Home on 1/16/22 between 9:00 PM and 10:00 PM and set up an Emergency Operations</p>	E 001			

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E 001	<p>Continued From page 17</p> <p>Center (EOC) in the dining room of the facility. He said he was able to coordinate resources from the police department, EMS, fire department, and the triad coalition to provide care and services to the residents of the facility. He stated it was necessary for the county emergency system to intervene due to police officers responding to 911 calls finding just one nurse and 2 nursing assistants to provide care for all the residents of the facility. The coordinator stated the facility did not have a very good incident plan regarding the situation with inclement weather. He further stated he had not met, talked to on the phone, or had any type of information exchange with the Administrator #2 of the facility, while he had received communication from other facilities in the area. He explained through conversations with DON #1, she had felt one nurse and two NAs were sufficient to handle the facility, which he did not believe to be sufficient staffing and as evidence of that he stated the nurse who was on site when he arrived seemed "severely overwhelmed." He explained he stayed at the facility until 7:00 AM on 1/17/22 when the Administrator #3 informed him there was sufficient staffing to provide care for the residents of the facility.</p> <p>Interviews were conducted from 1/17/22 through 2/2/22 with several members of the nursing home administration team and key staff members including the two social workers, central supply coordinator, medical records director, payroll, and the Assistant Director of Nursing (ADON). The interviews revealed during the daily department head meetings, including the meetings on Friday, administrator #2 had not asked department heads</p>	E 001			

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E 001	<p>Continued From page 18</p> <p>and key staff to prepare to come to the facility in the event of inclement weather, staying at the facility, or other preparations for the department heads. Several department heads and key staff stated during inclement weather there would be a posting at the time clock or staff were made aware sleep pay had been activated, but there was no such posting, or announcement, which they felt was unusual. They stated they were not requested to come to the facility on Sunday or the request to come to the facility had been received after they went into bed. Many department heads and key staff stated they were not aware of the situation regarding staffing until they arrived at the facility the morning of 1/17/22.</p> <p>Several interviews were conducted with multiple residents from 1/17/22 through 2/2/22. The interviews revealed residents who stated they had to wait for an extended period of time for care on 1/16/22. They stated they were aware there was only one nurse and two NAs at the facility. They explained they had not received an evening meal until they received peanut butter and jelly sandwiches which was served to them by the police, fire department, or EMS. Several residents stated they had to wait an extended period of time while having been incontinent of urine and stool. Some residents said it had been hours since they had seen staff members.</p> <p>During an interview conducted on 2/2/22 at 1:23 PM with the Administrator #3 he stated it was his expectation for the Emergency Preparedness policy and procedure to reviewed, updated, and utilized in how to respond in the event of an emergency. He further explained the facility</p>	E 001			

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E 001	<p>Continued From page 19</p> <p>needed to have well established communication on who to contact, how to contact, and for there to be oversight as well. He stated as the current administrator he would make sure the entire team is well informed, there would be postings for any questions, as well as people to contact in the event of an emergency. He stated the facility staff needed to know there was a living breathing system in the event of an emergency.</p> <p>Administrator #3 was made aware of the Immediate Jeopardy (IJ) on 1/21/22 at 12:31 PM.</p> <p>The facility shared the following credible allegation of immediate jeopardy removal.</p> <p>The entity ' s removal plan must include the following:</p> <ul style="list-style-type: none"> Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and <p>The Administrator did not react to the National Weather Service and North Carolina State weather advisories. On January 14, 2022, the Assistant Regional Vice President (ARVP), and Human Resources Consultant reviewed the emergency preparedness plan onsite with the Administrator. Despite this review, the Administrator did not implement a plan for administrative staff to already be in the building and for direct care staff and staff from other departments to already be in the building. After working the evening shift, nurses and nursing assistants left the facility during the day shift. Training had not been provided to the nurses, nursing assistants, dietary, maintenance,</p>	E 001			

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E 001	<p>Continued From page 20</p> <p>laundry, housekeeping, social services, bookkeeping, receptionist, or any other facility staff prior to the inclement weather.</p> <p>The Administrator was in charge of staff coming and going for all departments. The Administrator failed to read the Emergency Preparedness Plan and failed to implement the Plan. As a result, the Administrator failed to inform staff of the sleep pay. There was no preparation to secure back-up transportation in the event staff needed assistance getting to the facility during inclement weather.</p> <p>At 8:09 PM, after a resident called 911, local law enforcement arrived at the facility for a wellness check. It was determined that there was 1 licensed practical nurse (LPN) and 2 nursing assistants (NAs) on site and there were 97 residents who were in need of care and services.</p> <p>All residents were likely to suffer as a result of the Administrator not implementing the emergency management plan.</p> <p>It was determined that the facility was non-compliant with Tag E0001 based on a failure to enact an emergency preparedness plan, resulting in residents not receiving medications or meals in a timely manner, and not receiving other necessary care and services.</p> <p>As set forth in the immediate jeopardy preliminary findings, all residents were likely to suffer a serious adverse outcome based on the non-compliance with emergency preparedness.</p> <p>Specify the action the entity will take to alter the process or system failure to prevent a</p>	E 001			

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E 001	<p>Continued From page 21</p> <p>serious adverse outcome from occurring or recurring, and when the action will be complete.</p> <p>Emergency Preparedness Plan was installed 1/16/22 at 11:45 PM</p> <p>On 1/16/22 at 9:52 PM, after receiving notification that emergency services were present in the facility, the Assistant Regional Vice President (ARVP) updated the Divisional Vice President (DVP) about the situation. The DVP initiated a conference call with the facility administrator and corporate staff (Chief Operating Officer, ARVP, Assistant Vice President Operations Support and Reimbursement, Corporate Clinical Director). During the Ad Hoc Quality Assurance Performance Improvement (QAPI) conference call, the administrator stated the Emergency Preparedness Plan was not implemented. During the call the QAPI group implemented the Emergency Preparedness Plan, including any immediate changes discussed in the meeting. Upon arrival to the facility the corporate staff reviewed the Emergency Preparedness Plan. A second ARVP began updating the emergency plan, including contact names and numbers.</p> <p>As part of that Emergency Preparedness Plan implementation the following action steps were taken to remove the immediate threat, including those discussed during the QAPI conference call.</p> <p>On 1/16/22 at 9:20 PM the Administrator informed the Assistant Regional Vice President (ARVP) that the fire and police personnel were at the facility.</p> <p>On 1/16/22 at 9:52 PM, the ARVP updated the Divisional Vice President (DVP) and the DVP initiated a conference call with corporate support</p>	E 001			

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E 001	<p>Continued From page 22</p> <p>staff. The AVRVP and Corporate staff put in place the Emergency Preparedness Plan to obtain additional staff and address the issues at the facility impacting residents.</p> <p>The DON arrived at the facility approximately 11:30 PM and provided medications and direct care. At 11:45 PM, a call was held with the Administrator and Corporate support staff to implement Emergency Preparedness Plan.</p> <p>On 1/17/2022 at 1:23 AM, the ARVP arrived at the facility and assumed charge of the facility, and directed the corporate staff to implement the "shelter-in-place" portion of the Emergency Preparedness Plan.</p> <p>At 8:02 AM, the Mobile Certified Dietary Manager arrived in the kitchen, and the dietary department provided breakfast as scheduled.</p> <p>At 10:47 AM, the Corporate Clinical Director arrived in the facility and provided direct care.</p> <p>At 10:50 AM, the Divisional Vice President arrived at the facility and assisted in securing staff, passing out meal trays.</p> <p>At 11:00 AM, Corporate Employee Experience personnel arrived at the facility, to assist with securing staff on the schedule.</p> <p>At 11:10 AM, the Regional RN MDS Consultant arrived at the facility to provide direct resident care.</p> <p>At 11:30 AM, the supporting RN facility consultant arrived to assist with direct resident care. At 12:00</p>	E 001			

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E 001	Continued From page 23 noon, the assigned RN facility consultant arrived to assist with direct resident care. At 1:00 PM, an additional RN consultant arrived to assist with direct resident care. At 1/17/22 at 2:30 PM sufficient facility staff were in the facility providing care for the residents. On 1/17/22, all residents were assessed by clinical staff for acute change of condition and no change in condition were noted. On 1/17/22, the social worker talked with 100% of alert and oriented residents to provide psycho-social support. On 1/17/22 at approximately 5:30 PM, the ARVP suspended the Administrator for failure to implement the Emergency Preparedness Plan. Acting as the Governing Body, the ARVP assigned himself as the Interim Administrator during the investigation. Date of alleged Immediate Jeopardy removal: 1/18/22 The facility ' s credible allegation of compliance was validated through an on-site review process which included record review, observations, interviews with staff and residents. Date of IJ removal was validated as 1/18/22.	E 001			
F 000	INITIAL COMMENTS A complaint investigation was conducted from 1/17/22 through 2/2/22. Event ID# 54P511	F 000			

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F 000	<p>Continued From page 24</p> <p>5 of the 6 complaint allegations were substantiated resulting in deficiencies E0001, F550, F580, F584, F600, F677, F684, F689, F725, F802, F809, F835, and F837.</p> <p>Immediate Jeopardy was identified at:</p> <p>CFR 483.73 at tag E0001 at a scope and severity (L) CFR 483.12 at tag F600 at a scope and severity (L) CFR 483.35 at tag F725 at a scope and severity (L) CFR 483.60 at tag F802 at a scope and severity (L) CFR 483.70 at tag F835 at a scope and severity (L) CFR 483.70 at tag F837 at a scope and severity (L)</p> <p>Further Immediate Jeopardy (IJ) deficiencies were identified after the case was transferred to Centers for Medicare and Medicaid Services (CMS). The State Agency notified the facility on 2/22/22 that both tags F677 and F689 would be cited at the immediate jeopardy level. A member of the survey team returned to the facility on 2/24/22 and validated the immediate jeopardy allegation of removal for F677 and F689. Please see event ID #54P511. The survey exit date was changed to 2/24/22.</p> <p>CFR 483.24 at tag F677 at a scope and severity (L) CFR 483.25 at tag F689 at a scope and severity (K)</p>	F 000			

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F 000	Continued From page 25 The tags F550, F600, F677, F684, and F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 1/16/22 and was removed on 1/18/22. A partial extended survey was conducted. The facility will remain out of compliance at a scope and severity level H (actual harm that is not immedicate jeopardy (IJ)) until all of the nursing staff can be inserviced. The facility will then implement monitoring of its corrective action.	F 000			
F 550 SS=H	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		3/22/22	

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F 550	<p>Continued From page 26</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, police, resident, and staff interviews, the facility failed to treat residents in a dignified manner, when residents did not receive incontinence care for several hours during a period when there was just one Licensed Practical Nurse (LPN) and two Nursing Assistants in the facility to provide care for 98 residents. Two of five interviewed residents (Resident #7 and Resident #11) stated the lack of incontinent care for an extended period of time made them feel like they were defeated, not treated with dignity, neglected, dirty, mad, sad, helpless, and abandoned. Emergency personnel reported that residents were observed crying. This deficient practice negatively impacted residents in the facility.</p> <p>The findings included: 1. Resident #7 was admitted to the facility on 10/28/21 and the resident ' s diagnoses included: Heart failure, generalized weakness, and lack of</p>	F 550	<p>This plan of correction constitutes Pine Ridge Health and Rehabilitation Center's written allegation of compliance for the deficiency cited. However, preparation and execution of the plan of correction is not an admission by Pine Ridge Health and Rehabilitation Center of the truth of the facts alleged, conclusions set forth in the statement of deficiencies, or that any individual resident suffered or had the potential to suffer minimal harm or actual harm. This plan of correction is prepared and executed to meet requirements established by state and federal law.</p> <p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice</p> <p>On 1/16/22 at 11:30 PM, the Director of</p>		

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F 550	<p>Continued From page 27 coordination.</p> <p>Review of Resident #7's most recent Minimum Data Set (MDS) revealed an admission comprehensive assessment with an Assessment Reference Date (ARD) of 11/4/21. The resident was coded as cognitively intact. The resident was coded as having had no hallucinations or delusions and the resident was coded as requiring extensive assistance of one to two people for bed mobility, transfer (such as transfer from the bed to the wheelchair), dressing, toileting, and personal hygiene. The resident was coded as always continent of both bowel and bladder.</p> <p>The care plan for Resident #7, most recently revised on 12/7/21, specified the resident had "Focus" areas which included: The resident needed assistance with ADLs/Personal care and the interventions included the resident having been continent of bowel and bladder. Further review revealed a focus area about the resident having the potential for urinary incontinence related to physical immobility and the interventions included encouraging the resident to call for assistance for toileting, praise and encourage attempts to comply with toileting. The resident also had a focus area for her being at risk for skin breakdown, or development of further pressure ulcers related to: Immobility.</p> <p>During an interview with Resident #7 on 1/17/22 at 12:19 PM the resident stated on 1/16/22 there was only one nurse and two nursing assistants for the entire facility. She said she had turned her call light on during the day on 1/16/22 because her brief needed to be changed and she needed</p>	F 550	<p>Nursing (DON) arrived at the facility and assisted with providing direct care to resident #7 and #11.</p> <p>On 1/17/22 at 1:23 AM, the Assistant Regional Vice President (ARVP) arrived at the facility, assumed charge of the facility, and initiated the Emergency Preparedness Plan. Initiation of the Emergency Preparedness Plan included calling in additional facility staff, additional agency staff, and additional corporate support staff to assist in providing basic goods and services to include but not limited to incontinent care.</p> <p>On 1/17/22 at 11:30 AM, the supporting RN facility consultant arrived to assist with direct resident care to include incontinence care.</p> <p>On 1/17/22 at 12:00 noon, the assigned RN facility consultant arrived to assist with direct resident care to include incontinence care. At 1:00 PM, an additional RN consultant arrived to assist with direct resident care to include incontinence care. Residents #7 and #11 received incontinence care and other services in a manner to promote maintenance of Residents #7 and #11 quality of life</p> <p>On 1/17/22, 100% head to toe skin assessment were completed to include resident #7 and # 11 by clinical support staff to ensure they are being treated with</p>		

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F 550	<p>Continued From page 28</p> <p>incontinent care and it wasn ' t until 11:00 PM the call light was answered, and she received incontinent care. She further explained she did not receive incontinent care again until 3:00 AM. She then stated after 3:00 AM, it wasn ' t until 10:15 AM on 1/17/22 she had received incontinent care. She said she had put her call light on at 7:15 AM on 1/17/22 and it was not answered until 9:20 AM when breakfast was brought in, and she said the staff who delivered her breakfast were unable to provide incontinent care. She stated she had to eat breakfast while sitting in her incontinent brief and she felt uncomfortable about it. She said they had only received a bag of chips and a sandwich for supper at 9:45 PM on 1/16/22, so she wanted to eat breakfast and did not want to skip breakfast. She explained by 10:15 AM on 1/17/22 the urine had soaked through the brief and soaked through the incontinent pad she was on to the point her bed was wet. She described how she had to sit with her brief full of urine for many hours between 1/16/22 and 1/17/22 and how she felt defeated and was not being treated with dignity due to having to wait so long for receiving basic care.</p> <p>2. Resident #11 was admitted to the facility on 12/14/21 and the resident ' s diagnoses included: Diabetes, dysphagia (difficulty swallowing), chronic kidney disease, depression, lack of coordination, anxiety, and fibromyalgia.</p> <p>Review of Resident #11's most recent Minimum Data Set (MDS) revealed an admission comprehensive assessment with an Assessment Reference Date (ARD) of 12/21/21. The resident was coded as cognitively intact. The resident was</p>	F 550	<p>dignity and respect. During the skin assessments incontinent care was provided by the clinical staff when needed.</p> <p>On 1/30/22-2/13/22, the social worker talked with 100% of alert and oriented residents to provide psycho-social support.</p> <p>On 1/17/22, the Interim Administrator and Human Resource Support Staff reviewed the staffing schedule for the upcoming 7 days to make certain a sufficient number of staff were scheduled to ensure residents to include #7 and # 11 are treated in a dignified manner including providing incontinence care. The Interim Administrator and Human Resource Support Staff ensured there was enough staff, on each shift, in each department, to provide care to all residents to include #7 and # 11 in accordance with the resident plan of care.</p> <p>How the facility identified other residents having the potential to be affected by the same deficient practice</p> <p>As set forth above, a corrective action plan was put in place and implemented for all residents.</p> <p>Measures put into place or systemic changes made to ensure that the deficient practice will not recur</p>		

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F 550	<p>Continued From page 29</p> <p>coded as having had no hallucinations or delusions and the resident was coded as requiring total or extensive assistance of one to two people for bed mobility, transfer (such as transfer from the bed to the wheelchair), dressing, toileting, and personal hygiene. The resident was coded as always continent of both bowel and bladder.</p> <p>The care plan for Resident #11, most recently revised on 12/14/21, specified the resident had "Focus" areas which included: The resident needed assistance with ADLs/Personal care and the interventions included the resident having occasional incontinence and requiring assistance with toileting.</p> <p>During an interview with Resident #11 on 1/17/22 at 12:57 PM the resident spoke about the events that occurred on 1/16/22 and asked if the facility had some type of disaster plan that should have been followed? She stated the facility was short of help, she felt neglected, and expressed no one seemed to care. She further stated there were only two Nursing Assistants (NAs) to cover the whole building from 7:00 AM until 11:00 PM. She said there was only one nurse to cover the whole building. She said NA # 2 had told her she hadn ' t even had an opportunity to go to the bathroom while she was working. She said the staff refused to help her out of bed on 1/16/22 and that had upset her because she likes to get out of bed because her leg hurts her, and it feels better to get out of bed and change position. She said when she was wet, she had to wait a very long time for someone to come and change her on 1/16/22 and into the morning of 1/17/22. She said the staff who were there did not even have the opportunity</p>	F 550	<p>On 2/18/22, the Mobile Director of Nursing initiated an inservice with all staff on Resident's rights/treating residents with dignity and respect to include providing timely incontinence care. The education was completed on 3/22/22. Any staff that has not worked and completed the inservice will complete upon their next scheduled shift. The Mobile Director of Nursing, Director of Nursing, or Clinical Support Staff will ensure all newly hired staff and newly scheduled agency will complete the inservice during orientation.</p> <p>On 2/28/22 the Interim Administrator contacted the Quality Improvement Organization to discuss the plan of correction and for further recommendations to the action plans.</p> <p>How the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>Beginning 3/22/22, the Mobile Director of Nursing, Director of Nursing, treatment nurse, or Clinical Support will complete audits to ensure residents are being treated with dignity and respect to include providing timely incontinent care. 10 audits will be completed weekly x 8 weeks and documented on a Resident Care Audit Tool. Staff will be trained by the Mobile Director of Nursing, Director of Nursing, treatment nurse, or Clinical Support during</p>	

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F 550	<p>Continued From page 30</p> <p>to offer her a bedpan so she would not have to be incontinent. On 1/16/22 she received incontinence care twice, for the whole day she stated. She further stated she had to lay in her own pee or poop for many hours and at the time of the interview her bottom felt uncomfortable. She explained while this was happening, she felt dirty, mad, sad, neglected, abandoned, and helpless. She stated she felt she was not being treated with dignity and respect because she was not able to receive routine incontinence care or be assisted with toileting. She said she received incontinence care at 10:00 PM on 1/16/22 and did not receive incontinence care again until 6:00 AM on 1/17/22.</p> <p>During a phone interview conducted on 1/19/22 at 10:28 AM with NA #2 she stated she arrived at 7:00 AM on 1/16/22 and they were unable to find the schedule. She and NA #1 had no idea about who else was supposed to work. She explained her and the only other NA split the halls of the facility to provide care for the residents. She said most of the staff who were assigned to leave at 7:00 AM (the end of night shift) did not wait for someone to take their place and left because it was starting to snow. She said 2 nurses from night shift stayed in the morning to assist with morning care and help with breakfast. She explained the two nurses helped a lot with covering the dementia unit, which was a locked unit. She said after the 2 nurses left, it was just her and the other NA to provide care for 98 residents. She further stated her, and the other NA provided as much care as they could to each resident. She said the residents who were alert and oriented were upset and they knew what was going on and she had a discussion with one resident who</p>	F 550	<p>the audit for any identified areas of concerns. The Administrator or Director of Nursing will review and initial the audit tools weekly x 8 weeks for compliance and to ensure all areas of concern were addressed.</p> <p>The Administrator will be responsible for forwarding the audit tools to the Quality Assurance Committee. The facility's Quality Assurance Performance Improvement (QAPI) committee will review the audit tools results monthly x 2 months to determine need for further frequency of monitoring.</p>		

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F 550	<p>Continued From page 31</p> <p>informed her she was going to call 911 regarding the situation at the facility, lack of care, and her current state. She said it was after 3:00 PM when she realized the other NAs who were scheduled at 3:00 PM had not arrived, and most likely were not going to arrive, which made her and the nurse very mad and upset. She said the phones were often ringing, they did not have time to answer the phones, and the receptionist who would usually answer the phone at the front desk had also not come to work. She said there was no other staff at the facility at that time, no dietary staff, no receptionist, no housekeeping, and no laundry staff. She explained at one point she became very angry and upset and the nurse was concerned for her health and considered sending her to the hospital, but she said she eventually got moving again and just went back to work. She said it was unreal, she was so busy, and had never had an experience like that before. She said she just kept working and at some point, she didn ' t even remember when, she saw the police officers in the building, then more police officers, then the fire department and Emergency Medical Services.</p> <p>An interview was conducted on 1/20/22 at 1:55 PM with NA #1. He stated on 1/16/22 he and NA #2 were the only two NAs at the facility providing care for the residents, and there was only one nurse. He said the residents felt there was not enough staff to provide help for the residents. He further stated the residents felt angry because due to the lack of staff they had to wait, but when he and the other NA were able get to them to provide care for them, they were grateful to them. He said he wasn ' t scared during the period when it was just the three of them, just kind of disappointed, he</p>	F 550			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 550	Continued From page 32 said it felt like no one was making an effort to get other staff into the facility to help the residents and help them care for the residents. He explained the worst part of it was the residents having to wait such a long time to receive assistance and care. A phone interview was conducted on 1/20/22 at 1:14 PM with Police Officer #2. He stated he and 2 other officers arrived at Pine Ridge Nursing Home at about 8:09 PM on 1/16/22. The police officer stated he reached out to community resources which included Emergency Medical Services (EMS) and the fire department to assist in assessing and providing care for the residents of the facility. He explained he and the other police officers remained at the facility and continued to provide support and assistance to the staff at the facility and the residents. The police officer explained several residents were observed to have been crying, stated they had not received food or their medications, and some had said they had not seen a nurse all day. The police officer also described the smell at the facility to be "horrible" of stool and urine. He said he had not spoken to the NAs who were at the facility because he had not seen them and was not even aware they were there until another police officer made him aware there were 2 NAs. During an interview conducted on 2/2/22 at 1:23 PM with Administrator #3 (who was the Assistant Regional Vice President prior to assuming the administrator role) he stated it was his expectation to preserve the dignity level of the residents through adequate care and staffing which will meet the needs of the residents.	F 550			
F 580	Notify of Changes (Injury/Decline/Room, etc.)	F 580		3/22/22	

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F 580 SS=H	Continued From page 33 CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident	F 580			

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F 580	<p>Continued From page 34 representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews and physician interview the facility failed to notify the Physician of signs of infection after completion of an antibiotic for an infection to a surgical site; failed to start an antibiotic when it was ordered; and the facility failed to notify the Physician when a resident was first observed to have developed a limp and pain to her hip for 1 of 1 resident, Resident #8, reviewed for a change in condition.</p> <p>Findings included: 1. Resident #8 admitted to the facility on 11/3/2020 and discharged on 11/24/2021 after an x-ray revealed she had a fracture to her right hip. Resident #8 returned to the facility on 11/30/2021 after having surgical repair of a right hip fracture. Resident #8's medical diagnoses included dementia and osteoarthritis.</p> <p>Review of Resident #8's medical record revealed she had a significant change Minimum Data Set (MDS) assessment dated 12/2/2021 that indicated she was severely cognitively impaired and had a history of falls.</p>	F 580	<p>This plan of correction constitutes Pine Ridge Health and Rehabilitation Center's written allegation of compliance for the deficiency cited. However, preparation and execution of the plan of correction is not an admission by Pine Ridge Health and Rehabilitation Center of the truth of the facts alleged, conclusions set forth in the statement of deficiencies, or that any individual resident suffered or had the potential to suffer minimal harm or actual harm. This plan of correction is prepared and executed to meet requirements established by state and federal law.</p> <p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #8 did not return to the facility after being admitted to the hospital on 1/1/22. Resident #8 no longer resides at the facility.</p> <p>How the facility identified other residents</p>		

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F 580	<p>Continued From page 35</p> <p>a. A Wound Flowsheet dated 12/8/2021 completed by the Wound Care Nurse/Assistant Director of Nursing on 12/8/2021 stated Resident #8 had a right hip incision measuring 11 centimeters by 0.2 centimeters and there was redness and bruising at the incision site. The Flowsheet further stated the current treatment was to monitor for signs of infection.</p> <p>Review of Resident #8's Physician's Orders revealed an order for Ciprofloxacin 500 milligrams twice a day for 7 days and the area may be covered by a dressing which was ordered on 12/9/2021 and written by Nurse #5 due to cellulitis of the right hip.</p> <p>Resident #8's Medication Administration Record (MAR) for 12/2021 indicated she received an antibiotic, Ciprofloxacin 500 milligrams twice a day for 7 days, from 12/14/2021 to 12/20/2021 for cellulitis of her right hip. The 12/2021 MAR also indicated Resident #8 had a dressing to her right hip incision daily beginning 12/14/2021 and ended 12/29/2021.</p> <p>A Physician's Progress Note dated 12/13/2021 written by the Orthopedic Surgeon indicated Resident #8 could begin weight bearing as tolerated to the right lower extremity, daily dressing change to incision, and follow up in one month or sooner if worsening drainage. The Physician's Progress Note written by the Orthopedic Surgeon dated 12/13/2021 did not indicate the condition of Resident #8's incision.</p> <p>A Wound Flowsheet dated 12/22/2021 written by the Assistant Director of Nursing/Wound Care</p>	F 580	<p>having the potential to be affected by the same deficient practice:</p> <p>On 2/28/22-3/1/22 the Director of Nursing assessed all wounds to include surgical incisions for signs and symptoms of infections with documentation on a wound audit tool. There were no identified areas of concerns noted during the audit.</p> <p>On 2/28/22, all residents were assessed by a RN for acute changes in condition to include new or worsening pain and/or gait. For any resident identified with worsening pain and/or gait, records were reviewed to determine if changes in conditions had been reported to their physician and/or resident representative.</p> <p>On 2/28/22 the RN Facility Consultant completed an audit of all ordered antibiotics for current residents from 1/31/22 to 2/28/22 to ensure the antibiotic was started when ordered. There were no areas of concern.</p> <p>Measures put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>On 2/18/22 the Corporate Clinical Director initiated an in-service with 100% of all nurses to include agency regarding notification to the physician and following physician's orders to include antibiotics. Any nurse that has not worked and completed the inservice will complete upon</p>		

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F 580	<p>Continued From page 36</p> <p>Nurse stated Resident #8 had a right hip surgical incision with a small amount of drainage.</p> <p>A Wound Flowsheet dated 12/29/2021 written by the Assistant Director of Nursing/Wound Care Nurse indicated Resident #8 had a right hip surgical incision with no drainage.</p> <p>A Skin Check dated 1/1/2022 by Nurse #1 indicated Resident #8 had an incision to the right thigh but did not give a description of the incision.</p> <p>Review of the Emergency Department to Hospital Discharge Summary with an admission dated of 1/2/2022 and a discharge date of 1/6/2022 indicated Resident #8 was seen in the Emergency Department for a fall and drainage was noted from her right hip incision. A Computed Tomography (CT) Scan revealed she had an abscess of the right hip incision and right hip joint. The Emergency Department to Hospital Discharge Summary further indicated on 1/3/2022 she was sent to the operating room for irrigation and drainage and hardware removal of the right hip due to the infection.</p> <p>The Assistant Director of Nursing (ADON) was interviewed on 1/25/2022 at 10:38 am and she stated she had been the Wound Care Nurse when Resident #8 returned from the hospital on 11/30/2021 but her position changed to ADON on 12/28/2021. The ADON stated when Resident #8 returned from the hospital on 11/30/2021 she had an order for the incision to be open to air. The ADON stated when she assessed the incision on 12/29/2021 it did not appear to be infected. The ADON stated Resident #8 was picking at her right</p>	F 580	<p>their next scheduled shift. The Inservice will be completed by 3/22/22. The Mobile Director of Nursing, Director of Nursing, or Clinical Support Staff will ensure all newly hired nurses and newly scheduled agency nurses will complete the inservice during orientation.</p> <p>On 2/28/22 the Interim Administrator contacted the Quality Improvement Organization to discuss the plan of correction and for further recommendations to the action plans.</p> <p>How the facility plans to monitor its performance to make sure that solutions are sustained:</p> <p>Beginning 3/22/22 the Director of Nursing will make wound rounds with the treatment nurse to identify any signs and symptoms of wound infections. The rounds will be completed weekly x 8 weeks utilizing a Wound Audit Tool. The Director of Nursing will ensure that the MD was notified of the infection with documentation in the clinical record for any identified areas of concern. Any nurse identified as not notifying the physician will be retrained by the DON. The Administrator or Director of Nursing will review and initial the audit tools weekly x 8 weeks for compliance and to ensure all areas of concern were addressed.</p> <p>Beginning 3/22/22 the Mobile Director of</p>		

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F 580	<p>Continued From page 37</p> <p>hip incision and the order was changed to a dry dressing. The ADON stated there was more drainage from Resident #8's right hip incision when she went back out to the hospital on 1/1/2022. An attempt was made to reinterview the ADON but she did not return my call.</p> <p>On 1/25/2022 at 3:54 pm an interview was conducted with Nurse #3, and she stated she was employed by agency staffing but worked at the facility regularly. She stated the wound dressing changes were completed by the Wound Care Nurse during the weekdays and by the Nurses on the weekend days. Nurse #3 stated she had observed Resident #8's wound after she finished the antibiotics ordered on 12/14/2021 and completed on 12/20/2021 and the incision had a large amount of bloody drainage that would come through the dressing if the dressing had remained on more than 24 hours. Nurse #3 stated Resident #8's right hip incision looked infected when she was taking the antibiotic and when the antibiotic was completed on 12/20/2021. Nurse #3 stated she did not notify the physician of the condition of Resident #8's wound.</p> <p>During an interview with Nurse #1 on 1/26/2022 at 9:32 am she stated she had not cared for Resident #8 until the end of December. Nurse #1 stated the Wound Care Nurse did the dressing changes through the week. She stated she did remember seeing the wound during the week before Resident #8 discharged back to the hospital and it was red and inflamed, there was a staple that had come loose, and there was a lot of drainage. Nurse #1 stated the wound looked infected and she had told the Wound Nurse she should look at the wound.</p>	F 580	<p>Nursing, Director of Nursing, or clinical support staff will assess residents for signs and symptoms of changes in condition to include new or worsening pain and/or gait weekly x 8 weeks. The Mobile Director of Nursing, Director of Nursing, or clinical support staff will ensure that the physician was notified of the change when it was first observed, with documentation in the clinical record. The audit will be complete weekly x 8 weeks utilizing an Acute Change in Condition audit tool. Any nurse identified as not notifying the physician of an acute change, will be retrained by the Mobile Director of Nursing, Director of Nursing, or clinical support staff. The Administrator or Director of Nursing will review and initial the audit tools weekly x 8 weeks for compliance and to ensure all areas of concern were addressed.</p> <p>Beginning 3/22/22 the Mobile Director of Nursing, Director of Nursing, or clinical support staff will review physician orders weekly x 8 weeks to identify all residents who were ordered antibiotics. The Mobile Director of Nursing, Director of Nursing, or clinical support will check the Medication Administration records of all resident□s with newly ordered antibiotics to ensure the medication was started when it was ordered. The audit will be documented on an Orders Audit Tool. The Mobile Director of Nursing, Director of Nursing, or clinical support staff will contact the physician, complete a medication error report, and retrain any nurse identified that did not</p>		

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F 580	<p>Continued From page 38</p> <p>Nurse #1 stated she did not notify the Physician of Resident #8's wound being red and the increased drainage.</p> <p>Resident #8's Physician was interviewed on 1/26/2022 at 11:08 am and stated he remembered Resident #8 had an infection to her right hip incision and he had ordered an antibiotic. The Physician stated he was aware Resident #8's incision was inflamed when the antibiotic was ordered on 12/9/2021 but he had not been notified the incision continued to be red and draining after the antibiotic was completed. The Physician stated the condition of Resident #8's wound should have been reported to either him or the Orthopedic Surgeon if it continued to be inflamed and showed signs of infection.</p> <p>During an interview with the Administrator #3 on 1/31/2022 at 11:00 am he stated he had not been the administrator during Resident #8's stay but nursing should have monitored Resident #8's right hip incision for any signs of infection and reported any signs of infection to the Physician.</p> <p>b. A Nurse's Progress Note dated 11/22/2021 at 3:08 pm written by Nurse #6 stated Resident #8 was walking with a limp and the Physician was notified.</p> <p>On 11/23/2021 at 1:36 pm a Nurse's Progress Note stated Nurse #6 spoke with the Physician regarding the change in Resident #8's gait and an order was received for an x-ray of both hips.</p> <p>Review of Resident #8's Physician's Orders revealed she had order written by her Physician on</p>	F 580	<p>follow the physician's order. The Administrator or Director of Nursing will review and initial the audit tools weekly x 8 weeks for compliance and to ensure all areas of concern were addressed.</p> <p>The Administrator will be responsible for forwarding the audit tools to the Quality Assurance Committee. The facility's Quality Assurance Performance Improvement (QAPI) committee will review the Audit Tools monthly x 2 months to identify any trends and determine need for further frequency of monitoring.</p>		

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F 580	<p>Continued From page 39</p> <p>11/23/2021 for both hips to be x-rayed.</p> <p>A telephone interview was conducted with Nurse #6 on 1/20/2022 at 3:35 pm. Nurse #6 stated she noticed Resident #8 was limping on 11/22/2021 and Resident #8 pointed to her hip when asked if she was hurting. Nurse #6 stated she had attempted to call the Physician on 11/22/2021 but was not able to reach him. Nurse #6 stated she had worked again on the following day, 11/23/2021, but was not assigned to Resident #8, but she spoke with the Nurse who had her that day, Nurse # 12, and asked her to get an x-ray ordered for Resident #8's hips.</p> <p>During the survey attempts were made to call Nurse #12 and the Previous Director of Nursing stated Nurse #12 was out of the country.</p> <p>A Physician's Order dated 11/24/2021 written by Resident #8's Physician requested Resident #8 be sent to the Emergency Department for evaluation of a right femoral neck fracture.</p> <p>An interview was conducted with the Previous Director of Nursing on 1/26/2022 at 8:16 am she stated she was not notified Resident #8 had a limp until the x-ray showing she had a right hip fracture was received on 11/24/2021. The Previous Director of Nursing stated she and Administrator #2 had investigated the hip fracture and had concluded Resident #8 must have fallen and did not tell anyone because of her dementia. The Previous Director of Nursing stated Nurse #6 should have reported Resident #8 developed a limp and had indicated pain to her hip on 11/22/2021.</p> <p>During an interview with the Physician on</p>	F 580			

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F 580	Continued From page 40 1/26/2022 at 11:08 am he stated he had ordered the x-ray of both of Resident #8's hips when Nurse #12 reported Resident #8 was limping. The Physician stated he was not aware Nurse #6 was not able to reach him when she had noticed the limp on 11/22/2021. The Administrator #3 was interviewed on 1/31/2022 at 11:00 am and he stated the staff should have reported Resident #8 was limping immediately. He stated they should have reported the limp and hip pain to the Physician when it was discovered on 11/22/2021.	F 580			
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		3/22/22	

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F 584	<p>Continued From page 41 and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observations, photographs, police, Emergency Medical Technicians (EMTs) and staff interviews, the facility failed to provide a clean environment for 2 of 2 days investigated for environment. Interviews with first responders who arrived at the facility described and provided photographic evidence bags of garbage in the hallways and an observation on 1/17/22 revealed a room with overflowing garbage, garbage on the floor, garbage under the bed, and spilled fluids.</p> <p>The findings included: Review of the Punch History (work start time to work stop time) report for Housekeeping on 1/16/22 revealed Housekeeper #1 arrived at the facility at 5:30 AM and left at 10:00 AM. There were no other housekeeping staff recorded on the</p>	F 584	<p>This plan of correction constitutes Pine Ridge Health and Rehabilitation Center's written allegation of compliance for the deficiency cited. However, preparation and execution of the plan of correction is not an admission by Pine Ridge Health and Rehabilitation Center of the truth of the facts alleged, conclusions set forth in the statement of deficiencies, or that any individual resident suffered or had the potential to suffer minimal harm or actual harm. This plan of correction is prepared and executed to meet requirements established by state and federal law.</p> <p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p>		

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F 584	<p>Continued From page 42</p> <p>punch detail as having worked on 1/16/22. For 1/17/22 there were 4 housekeeping staff on the punch detail report, including Housekeeper #1. Two housekeeping staff were recorded as arriving at 8:57 AM, another at 9:00 AM, and the fourth was at 9:51 AM.</p> <p>During an interview conducted on 1/17/22 at 11:32 AM with Housekeeper #1 she stated she had worked on 1/16/22 from 5:30 AM to 10:00 AM and she was the only housekeeper at the facility. She said after she left there was no other housekeeping staff at the facility. She said that was not the time she would have normally gone home later in the day, but she said she had to leave at 10:00 AM because it had started sleeting. She stated she was the only housekeeper who was at the facility on 1/16/22 and there were no housekeepers at the facility after she left. She said there were two Nursing Assistants (NAs) at the facility. She further stated there were very few staff members in the facility. She also stated no one had come to the facility to do laundry on 1/16/22.</p> <p>A phone interview was conducted with EMT #2 on 1/19/22 at 9:30 PM. He explained he had arrived at the facility at 9:30 PM on 1/16/22. He explained there were areas where drinks had spilled onto the floors of the hallways,</p> <p>During a phone interview conducted on 1/20/22 at 12:49 PM with Police Officer #1 she stated he arrived at the facility at 8:10 PM. She stated there were rooms where there was a strong smell of urine and feces. She further stated there were some rooms which had garbage on the floor,</p>	F 584	<p>On 1/16/22 at 11:45 PM the administrator, with the assistance from the assistant regional vice president (ARVP), initiated the Emergency Preparedness Plan to ensure there was adequate staffing to include housekeeping to ensure a safe/clean/comfortable/homelike environment. The initiation of the Emergency Preparedness Plan included bringing in corporate support staff and additional agency staff.</p> <p>On 1/17/22 all facility and support staff removed the garbage in the hallways, removed the garbage in the trash can in resident's rooms, removed the garbage on the floor and under the bed and clean the spilled drinks. On 1/17/22 the Interim Administrator provide oversight to ensure the facility was cleaned by housekeeping. How the facility identified other residents having the potential to be affected by the same deficient practice</p> <p>On 1/17/22, the Corporate support staff toured the facility and inspected resident's rooms to determine if there was any garbage to be removed, spills to be cleaned up outside of regular daily housekeeping. On 1/17/22 the Interim Nursing Home Administrator provided oversight to ensure the facility was cleaned by housekeeping.</p> <p>Measures put into place or systemic changes made to ensure that the deficient practice will not recur</p> <p>On 1/17/22 the Interim Administrator reviewed current housekeeping/laundry</p>		

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F 584	<p>Continued From page 43</p> <p>spilled liquids on the floor, and the rooms just appeared like no one had cleaned them for a while.</p> <p>A phone interview was conducted on 1/20/22 at 1:14 PM with Police Officer #2. He stated he and 2 other officers arrived at Pine Ridge Nursing Home at about 8:09 PM on 1/16/22. The police officer stated there was an odor of feces when he entered into the facility. He explained the smell continued to only get stronger as he went through the building and described the smell as horrible and as "pure raw sh*t" at one point.</p> <p>A phone interview was conducted on 1/20/22 at 3:09 PM with Police Officer #3. He stated there was garbage laying around "everywhere" inside of the facility. He also said there was an odor of stool and urine in the hallways, especially in the 200 hall outside of room 207 where there was visible feces below the bed. He further stated down another hall there was a line of reddish fluid on the hallway floor. He said the conditions were of concern enough the detective applied for a search warrant to obtain photographs of the unsanitary conditions.</p> <p>An interview was conducted on 1/18/22 at 2:30 PM with the Assistant Regional Vice President (Administrator #3). He stated he had arrived at the facility at 1:23 AM. He stated after he arrived at the facility, he had wanted to assist in doing what he could at the facility such as taking care of the garbage and helping to clean the facility. However, he said the police who were present hadn ' t wanted him to clean anything up because they had wanted to take pictures of the facility in the state as it have been discovered. He further stated</p>	F 584	<p>staff to assess if additional staff needed to be hired. It was determined that no additional housekeeping staff were required to be hired at that time.</p> <p>On 2/7/22, the housekeeping/laundry supervisor began working at the facility.</p> <p>On 2/28/22 the RN facility consultant initiated an audit of the entire facility to include resident□s rooms, hallways, and under resident□s bed to ensure the facility was maintained in a clean, sanitary, and orderly manner. The nursing home administrator provide oversight and ensure housekeeping cleaned all areas with identified concerns.</p> <p>On 1/21/22, the Corporate Director of Special Projects began educating 100% of the facility and agency staff on the Emergency Preparedness Plan. The education included reporting to work during inclement weather and sleep pay policy which ensures there is adequate staffing to provide basic goods and services, including basic housekeeping, resident assessments, medications, and nourishment to meet the needs of the residents during inclement weather. The education will be completed on 3/22/22.</p> <p>Any staff that has not worked and completed the inservice will complete upon their next scheduled shift. The Mobile Director of Nursing, Director of Nursing, Housekeeping Supervisor, or Clinical Support Staff will ensure all newly hired housekeepers will complete the inservice during orientation.</p> <p>On 2/18/22 the Corporate Clinical Director</p>		

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F 584	<p>Continued From page 44</p> <p>he had been asked for permission for the police taking photographs of the facility as part of their investigation and he declined. Administrator #3 then stated the police informed him they would obtain a search warrant from the District Attorney (DA) to take pictures and gather other materials as part of their organization and he stated he still refused. The police officer then instructed him until a search warrant to not touch any part of what was being investigated, such as trash on the floor and in order to make sure none of the evidence was disturbed a police officer was placed at the top of each hall, he stated. He said the initial request for photographs was made at 2:00 AM and at 4:30 AM the police officers returned with a warrant and started taking photographs.</p> <p>During a meeting with the city police department and State Bureau of Investigation (SBI) an observation was conducted of the photographs taken by the police department after the search warrant had been served on during the late night and early morning of 1/17/22. Observation of the photographs revealed numerous pictures of garbage bags piled up in various halls of the facility, liquids spills on floors, and photographic evidence of garbage, spilled liquids, and other matter on the floor under and around the bed by the door in room 207.</p> <p>An observation conducted on 1/17/22 at 11:37 AM of the bed by the door in room 207 revealed a garbage overflowing out of a garbage can, multiple spills on the floor from cartons, cups, and mugs which remained on the floor, 2 night gowns on the floor, multiple items under the bread, to go insulated foam food containers overflowing out of</p>	F 584	<p>initiated an inservice with all housekeeping staff on maintaining a clean environment. The inservice included scheduled cleaning of hallway, garbage removal, cleaning under beds, and floor cleaning. The inservice will be completed on 3/22/22. Any housekeeper that has not worked and completed the inservice will complete upon their next scheduled shift. The Mobile Director of Nursing, Director of Nursing, Clinical Support Staff, or Housekeeping Manager will ensure all newly hired housekeepers will complete the Inservice during orientation.</p> <p>On 2/28/22 the Interim Administrator contacted the Quality Improvement Organization to discuss the plan of correction and for further recommendations to the action plans.</p> <p>How the facility plans to monitor its performance to make sure that solutions are sustained:</p> <p>Beginning 3/22/22, the Interim Administrator, Human Resource Support Staff, and/or the Interim Director of Nursing will conduct staffing meetings to ensure there is enough of staff, on each shift, in each department, to provide care and provide supervision to prevent accidents to all residents in accordance with the resident care plans. Supplemental staffing will be utilized to fill openings identified. During the staffing meeting, plans will be made to address staff spending the night if inclement weather is forecasted. The</p>		

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F 584	Continued From page 45 the garbage, multiple items on the over the bed table next to the bed with spills and food, the overall appearance of the room, the floor, and the area surrounding the bed was extremely disheveled. The resident was not interviewable and displayed cognitive impairment when asked basic questions such as what happened to your room. During an interview conducted on 2/2/22 at 1:23 PM with the Administrator #3 he stated it was his expectation for the facility have a sufficient level of staff for a standard of cleanliness. He stated he was attempting to assist with cleaning the facility after he arrived on 1/16/22 but was unable to because he was directed by the police to not touch anything in the facility related to what was being investigated.	F 584	staffing meetings will occur five days a week x 8 weeks with review and discussion of schedules for the clinical, dietary, and housekeeping departments and documented on a staffing audit tool. Beginning 3/22/22, the Mobile Director of Nursing, Director of Nursing, treatment nurse, Nursing Home Administrator, or Clinical Support Staff will make rounds to ensure basic housekeeping is completed to maintain a clean, sanitary, and orderly environment. The rounds will be made weekly x 8 weeks utilizing an environmental rounds audit tool. The Nursing Home Administrator will ensure all areas are cleaned with oversight from corporate staff and housekeeping staff is retrained to address any identified areas of concern. The Administrator will be responsible for forwarding the audits to the Quality Assurance Committee. The facility's Quality Assurance Performance Improvement (QAPI) committee will review the staffing audit tools and environmental rounds audit tools monthly x 2 months to identify trends and determine need for further frequency of monitoring.		
F 600 SS=L	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal	F 600		3/22/22	

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F 600	<p>Continued From page 46</p> <p>punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff, first responders, and resident interviews, the facility neglected to provide basic goods and services, including, but not limited to incontinent care, resident assessments, medications, nourishment, and basic housekeeping to meet the needs of 98 of 98 residents residing in the facility during a winter weather storm on 1/16/22. Neglecting to meet the needs of the residents had the high likelihood of causing severe psychological and physical harm to all 98 residents.</p> <p>Immediate Jeopardy began on 01/16/2022 when the facility neglected to provide basic care and services to meet the needs of the residents during a winter weather storm. The immediate jeopardy was removed on 1/18/22 when the facility provided an acceptable credible allegation of Immediate Jeopardy removal plan. The facility will remain out of compliance at a lower scope and severity of F (no actual harm with a potential for minimum harm that is not Immediate Jeopardy) to ensure the monitoring of the systems put into place and to complete facility employee and agency in-services, orientation and training.</p> <p>Findings included:</p>	F 600	<p>Pine Ridge Health and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents and to meet requirements established by state and federal law. The Plan of Correction is submitted as a written allegation of compliance.</p> <p>Pine Ridge Health and Rehabilitation Center's response to this Statement of Deficiencies and Pine Ridge Health and Rehabilitation Center's earlier submitted credible allegation of immediate jeopardy removal does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate or that any individual resident suffered or was likely to suffer actual harm or a serious adverse outcome. Further, Pine Ridge Health and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal</p>		

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F 600	<p>Continued From page 47</p> <p>Review of Resident #13 most recent Minimum Data Set (MDS) was coded as an annual assessment with an Assessment Reference Date (ARD) of 1/9/22 revealed the resident was coded as being cognitively intact.</p> <p>An interview at 11:47 AM on 1/17/22 with Resident # 13 was conducted. During the interview she stated that there were only 2 people working on 1/16/22 and she didn't receive lunch or supper yesterday. She explained that she was given a sandwich for each meal and that she didn't consider the sandwich as an actual meal. Additionally, she added that she only saw one nursing assistant going back and forth between 2:00 AM -3:00 AM.</p> <p>Review of Resident #15 most recent MDS was coded as an admission assessment with an ARD of 11/09/21 revealed the resident was coded as being cognitively intact.</p> <p>During an interview at 11:54 AM on 1/17/22, Resident # 15 stated lunch was provided at 2:30 PM yesterday and that she did not get dinner except for a few snacks. She stated she didn't know what was going on, the police, firemen, and EMS was here at the facility.</p> <p>Review of Resident #7's most recent Minimum Data Set (MDS) was coded as an admission assessment with an ARD of 11/4/21 revealed the resident was coded as being cognitively intact.</p> <p>During an interview with Resident #7 on 1/17/22 at 12:19 PM the resident stated on 1/16/22 there was</p>	F 600	<p>Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.</p> <p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>On 1/16/22 at 11:30 PM, the Director of Nursing (DON) arrived at the facility and began providing medications and direct care to residents as needed.</p> <p>On 1/17/22 at 1:23 AM, the Assistant Regional Vice President (ARVP) arrived at the facility, assumed charge of the facility, and initiated the Emergency Preparedness Plan. Initiation of the Emergency Preparedness Plan included calling in additional facility staff, additional agency staff, and additional corporate support staff to assist in providing basic goods and services to include but not limited to incontinent care, resident assessments, medications, nourishment, and basic housekeeping.</p> <p>On 1/17/22 the facility implemented the Emergency Preparedness Plan and the residents received medications and meals in a timely manner and received necessary goods and services.</p> <p>On 1/17/22 at 11:30 AM, the supporting RN facility consultant arrived to assist with direct resident care, including but not limited to incontinent care, resident</p>		

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F 600	<p>Continued From page 48</p> <p>only one nurse and two nursing assistants for the entire facility. She said she had turned her call light on during the day on 1/16/22 because her brief needed to be changed and she needed incontinent care and it wasn't until 11:00 PM the call light was answered, and she received incontinent care. She further explained she did not receive incontinent care again until 3:00 AM. She then stated after 3:00 AM, it wasn't until 10:15 AM on 1/17/22 she had received incontinent care. She said she had put her call light on at 7:15 AM on 1/17/22 and it was not answered until 9:20 AM when breakfast was brought in, and she said the staff who delivered her breakfast were unable to provide incontinent care. She stated she had to eat breakfast while sitting in her incontinent brief and she felt uncomfortable about it. She said they had only received a bag of chips and a sandwich for supper at 9:45 PM on 1/16/22, so she wanted to eat breakfast and did not want to skip breakfast. She explained by 10:15 AM on 1/17/22 the urine had soaked through the brief and soaked through the incontinent pad she was on to the point her bed was wet. She described how she had to sit with her brief full of urine for many hours between 1/16/22 and 1/17/22 and how she felt defeated and was not being treated with dignity due to having to wait so long for receiving basic care.</p> <p>Review of Resident #11's most recent Minimum Data Set (MDS) was coded as an admission assessment with an Assessment Reference Date (ARD) of 12/21/21 revealed the resident was coded as being cognitively intact.</p> <p>During an interview with Resident #11 on 1/17/22 at 12:57 PM the resident spoke about the events that occurred on 1/16/22 and asked if the facility</p>	F 600	<p>assessments, medications, nourishment, and basic housekeeping. At 12:00 noon, the assigned RN facility consultant arrived to assist with direct resident care, including but not limited to, incontinent care, resident assessments, medications, nourishment, and basic housekeeping. At 1:00 PM, an additional RN consultant arrived to assist with direct resident care, including but not limited to incontinent care, resident assessments, medications, nourishment, and basic housekeeping.</p> <p>Beginning on 1/17/22-1/20/22 the Physician or Nurse Practitioner assessed all residents for changes in condition. Orders were written and carried out for all identified areas of concern.</p> <p>Beginning on 1/30/22, the social worker talked with 100% of alert and oriented residents to provide psycho-social support.</p> <p>On 1/17/22, the Interim Administrator and Human Resource Support Staff reviewed the staffing schedule for the upcoming 7 days to ensure sufficient number of staff to provide care for all residents. The Interim Administrator, Divisional Vice President, and Human Resource Support Staff ensured there was enough staff, on each shift, in each department, to provide care to all residents in accordance with the resident plan of care.</p> <p>How the facility identified other residents</p>	

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F 600	<p>Continued From page 49</p> <p>had some type of disaster plan that should have been followed? She stated the facility was short of help, she felt neglected, and expressed no one seemed to care. She further stated there were only two Nursing Assistants (NAs) to cover the whole building from 7:00 AM until 11:00 PM. She said there was only one nurse to cover the whole building. She said NA # 2 had told her she hadn't even had an opportunity to go to the bathroom while she was working. Resident #11 stated she was in pain on 1/16/22 and didn't receive her afternoon meds until 8:00 PM-8:30 PM. She further stated the staff refused to help her out of bed on 1/16/22 and that had upset her because she likes to get out of bed because her leg hurts her, and it feels better to get out of bed and change position. She said when she was wet, she had to wait a very long time for someone to come and change her on 1/16/22 and into the morning of 1/17/22. She said the staff who were there did not even have the opportunity to offer her a bedpan so she would not have to be incontinent. On 1/16/22 she received incontinence care twice, for the whole day she stated. She further stated she had to lay in her own pee or poop for many hours and at the time of the interview her bottom felt uncomfortable. She explained while this was happening, she felt dirty, mad, sad, and helpless. She said she received incontinence care at 10:00 PM on 1/16/22 and did not receive incontinence care again until 6:00 AM on 1/17/22.</p> <p>Review of a quarterly MDS with an ARD of 10/21/21 revealed Resident #1 was coded as being cognitively intact.</p> <p>On 1/17/22 at 12:46 PM an interview was</p>	F 600	<p>having the potential to be affected by the same deficient practice:</p> <p>As set forth above, a corrective action plan was put in place and implemented for all residents.</p> <p>Measures put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>On 1/21/22, the Corporate Director of Special Projects began educating 100% of the facility and agency staff on the Emergency Preparedness plan. The education included: 1) the Emergency Preparedness Program, 2) incident management staff chain of command, 3) evacuation, shelter in place, 4) fire response plan, 5) disaster, 6) infectious disease, 7) power outages/interruptions, 8) workplace violence and active shooter, 9) missing resident, 10) reporting to work during inclement weather, and 11) sleep pay policy. The education was completed on 3/22/22. Any staff that has not worked and completed the Inservice will complete upon their next scheduled shift. The Mobile Director of Nursing, Director of Nursing, or Clinical Support Staff will ensure all newly hired staff and newly scheduled agency staff will complete the Inservice during orientation.</p> <p>From 1/17/22 through 2/22/22, the corporate support staff provided seven days</p>		

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F 600	<p>Continued From page 50</p> <p>conducted with Resident #1. During the interview, Resident #1 revealed he assisted the facility staff with handing out sandwiches and went on all halls except the COVID hall and the dementia unit between 6:00 PM-7:30 PM. He stated he volunteered to help because there were only 3 people working and didn't believe the 3 could provide care for the facility. He further added he helped at lunch and passed ice. Resident #1 added around 7:30 PM the police and fire department showed up and "helped out a whole lot".</p> <p>A phone interview was conducted with Nurse #7 on 1/18/22 at 3:41 PM. She said she worked on 1/16/22 and started at 7:00 AM and worked until 7:00 AM 1/17/22. She explained she had worked from 7:00 AM to 7:00 PM on 1/15/22 and it was a normal day. She explained she was aware of the potential for inclement weather, but there was no one from management who had discussed inclement weather with her, or preparations for inclement weather on 1/15/22. She said the employees of the facility were joking about it and making statements such as pack your bags and be prepared to stay in case it snows on 1/15/22. She said when she left her house on 1/16/22 it was just starting to snow. When she arrived at the facility, she explained she was unable to find the schedule, and she did not know who was supposed to work, or who was supposed to be there without the schedule, and without the schedule, she did not know how to make assignments or who would be assigned to what halls. She said she called DON #1 at around 7:30 AM to let her know she was the only nurse who had arrived for the day shift, she couldn't find the</p>	F 600	<p>per week supervision in the facility. The supervision included monitoring to ensure the facility staff and agency staff provided goods and services, to offer guidance and support, and to ensure residents were offered quality care and services.</p> <p>On 2/21/22, the corporate RN support staff initiated a proactive in-service regarding neglect. The in-service covered the importance of providing timely incontinent care, accurate assessments, medications and treatments, nourishment, and housekeeping services. The education will be completed on 3/22/22. Any staff that has not worked and completed the Inservice will complete upon their next scheduled shift. The Mobile Director of Nursing, Director of Nursing, or Clinical Support Staff will ensure all newly hired staff and newly scheduled agency will complete the Inservice during orientation.</p> <p>On 2/28/22 the Interim Administrator contacted the Quality Improvement Organization to discuss the plan of correction and for further recommendations to the action plans.</p> <p>How the facility plans to monitor its performance to make sure that solutions are sustained:</p> <p>Beginning 3/22/22 providing basic goods and services audits will be completed weekly x 8 weeks by the interim</p>		

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F 600	Continued From page 51 schedule, and the night nurse was going to only stay until 11:00 AM. She further explained there were only 2 Nursing Assistants (NAs) who had arrived to work day shift, and typically there would have been 2 medication aides, 3 nurses, and 8-10 NAs. She said she had talked to the DON and the Administrator #2 multiple times throughout the day, but on one occasion when she talked to her the DON had told her she had just gotten back into her driveway after trying to get to the facility, she didn't know anyone who had a truck who could come get her, and she would try to find some staff to come to the facility to help her. She said when she had talked to Administrator #2 she told her she was sorry, and she was going to call DON #1. The nurse described the residents received a hot breakfast, but at lunch time, bagged lunches were pushed out onto the hallway by the dietary staff, and her and the 2 NAs passed out the bagged lunches, which were actually lunch and dinner combined into one bag. She added there was a medication aide (MA) (NA #3) who had come in at 7:00 AM and left at 2:00 PM and there were 2 NAs who had stayed over to help from night shift, but they had left before lunch time. She explained the NA shifts go from 7:00 AM to 3:00 PM, and no NAs arrived at the facility at 3:00 PM. She further explained the nurses work 12 hour shifts from 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM, and no nurses arrived at the facility at 7:00 PM. The nurse described the day as chaotic, residents were asking for their medications, she was trying to prioritize medications such as antibiotics and insulin to ensure residents received them timely, she and the other staff were unable to answer the facility phone, she was communicating with DON #1 and the Administrator #2 via her	F 600	administrator, interim DON, treatment nurse, corporate support staff, and/or clinical support staff utilizing a Providing Basic Goods and Services Audit Tool. The audits will include monitoring of medication administration, treatments, resident care observations, and conducting interviews with alert and oriented resident regarding providing basic goods and services. The Administrator will ensure that any concern or investigation of neglect will also include the procedure for completing a report to be submitted to the Health Care Personnel Investigation site The Administrator will be responsible for forwarding the audit tools to the Quality Assurance Committee. The facility's Quality Assurance Performance Improvement (QAPI) committee will review the audit tools monthly x 2 months to identify trends and to determine the need for further frequency of monitoring.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 600	<p>Continued From page 52</p> <p>personal cell phone which she was carrying with her, she was making periodic rounds on the dementia unit because there was not enough staff to have someone on that unit at all times, at about 4:30 PM one of the NAs was crying, asking if anyone else was going to come to help, and had a panic attack to the point where she felt like she was going to have to call 911 for the NA. The nurse further stated at one point during a conversation with the DON, the DON told her she had too much responsibility in the building and to go lay down for a while and she responded to the DON she was there to take care of the residents and that was her main priority. She said she did not know how long it had been, but at one point there were two police officers behind her, and they had informed her they had received 911 calls regarding the situation at the facility. She said through discussion with the police officers they had asked her who was in charge of the facility, and she responded she was, she was in the only nurse in the facility, there were two NAs, and they were providing care for all of the residents. She explained shortly after that the facility was "swarming" with police, EMS, and firemen. She said they sat her down and were asking questions, seemed concerned about her and well-being, and she felt relieved to know she was going to get some help for caring for the residents. She further stated at 11:00 PM when the night shift NAs were supposed to arrive, no NAs arrived at the facility and the 2 NAs who had been there since 7:00 AM remained at the facility with her. She explained she did not know who the interim administrator was.</p> <p>During an interview conducted on 1/19/22 at 10:29</p>	F 600			

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F 600	<p>Continued From page 53</p> <p>AM with Emergency Responder Nurse #1 he stated he and Emergency Responder Nurse #2 administered medications and provided treatments to multiple residents between when he arrived at 11:30 PM on 1/16/22 and then left at 7:00 AM on 1/17/22. He stated amongst the medications he and the other nurse administered included intravenous (IV) Vancomycin (a strong antibiotic) to Resident #6. He stated that due to being the only nurse, Nurse #7 was unable to administer all of the prescribed medications for the residents of the facility. He stated there was no supervision for the dementia unit because there were only three staff members for the facility. He further stated the Director of Nursing (DON) did arrive to the facility and she was also assisting in the administration of the backlogged medications which were overdue. He further explained it was not just medications which hadn't been administered but ordered treatments had also not been completed as ordered. He explained there was a resident who had edema in her leg and her legs were weeping (a condition in which fluid builds up under the skin and then escapes through the skin and pores). He said the resident wanted to the bandages on her legs changed, but they were unable to get to re-wrapping her legs.</p> <p>Medication Aide (MA) #1 was interviewed via phone on 01/24/2022 at 2:00 PM and she confirmed that she reported to work about 6:45 AM on 01/16/2022 as scheduled by the agency and that she had been assigned to administer medications to the residents on the 200 and 300 halls. MA #1 also reported that while administering medications to her assigned area she had assisted to provide care, answer call lights and to</p>	F 600			

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F 600	<p>Continued From page 54</p> <p>make random checks on the secured dementia unit (also referred to as the SPARKS unit and/or 500 hall). MA #1 reported that she knew that some of the medications were administered late to residents and that the care given was not the best, but they worked as hard as they could. She further stated that she had never experienced a situation like she did on 01/16/2022. MA #1 reported she received permission to leave the facility at 2:00 PM due to the weather.</p> <p>An interview was conducted with NA #2 on 01/19/2022 at 10:28 AM. NA #2 revealed that on 01/16/2022 that only 4 nursing staff members arrived for work at 7:00 AM. The four nursing staff members consisted of 2 nursing assistants, 1 medication aide, and 1 LPN. NA #2 described the entire day as extremely busy and that many residents voiced complaints about not enough staff, not receiving care, call lights not being answered sometimes for 2 or more hours and not adequate food for dinner. NA #2 explained that with only 4 and then 3 staff that there was no staff assigned to the secure dementia unit and that the 3 of them were concerned for the residents on the secured unit. She further stated they gave some care to those residents and tried to check on their safety as they could. NA#2 stated she experienced a panic attack when she realized that no staff came to help them at 3:00 PM. NA #2 explained she overheard some residents talking and they had decided to call 911 because there wasn't enough staff in the facility to take care of them. She further explained the three staff members in the facility (including herself) had to make the residents sandwiches to for dinner which angered the resident's as well. NA #2 stated that</p>	F 600			

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F 600	<p>Continued From page 55</p> <p>the three staff worked with no breaks and that when the police and EMS arrived later that evening, she was very glad to have help to provide care. NA #2 stated that she had never experienced a situation like that and had never been so upset about the lack of resident care.</p> <p>On 01/20/2022 at 1:55 PM an interview was conducted with NA #1, and he revealed that he arrived for work at about 7:15 AM on 01/16/2022. He explained he was a few minutes late due to the snow and having to drive slower. NA #1 revealed in part that he and NA #2 tried as hard as they could to provide care to all the residents at the facility. He stated in the 20 years he had been employed, he had never experienced such a lack of staff to give care to the residents and had never heard residents as angry about the lack of care received on 01/16/2022. He said he felt numb and overwhelmed about the experience he had on 1/16/22 while there were just the 2 NAs to care for all of the residents. He said he felt bad for the residents having to wait so long for care and was disappointed because it seemed like no one was making an effort to get other staff in to help the residents.</p> <p>On 01/18/2022 at 12:05 PM an interview was conducted with DON #1. The DON explained that she had received multiple calls from Nurse #7 and the previous NHA on 01/16/2022 and that she had told Nurse #7 that she tried to get to the facility, but the roads were to snowy and icy but that she had been making calls to facility staff and agency and that she did not get any response that staff would going to the facility. The DON stated that she told Nurse #7 to prioritize care and to do the</p>	F 600			

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F 600	<p>Continued From page 56</p> <p>best that they could until more staff arrived to work.</p> <p>An interview was conducted on 1/19/22 at 9:30 PM with Emergency Medical Technician (EMT) #2. He said he and another EMT arrived at the facility at 9:30 PM. He stated he felt like the residents had been neglected due to observing residents who hadn't been fed or received food, residents who hadn't received incontinent care, he had discovered a resident who was lying in her own vomit, and he felt it was all related to the facility only having one nurse and 2 NAs to care for all of the residents. He stated when he and the other EMT arrived they had started a mass triage of all of the residents to determine if there were any residents who were in an acute condition through a general assessment and getting vital signs (temperature, pulse, respiration, blood pressure if needed). He said there were residents who said they hadn't received their medications and were genuinely concerned about their health. He said he stayed at the facility until 7:00 AM on 1/17/22. He said he did not see an NA the whole time he was there. He said there was such a lack of staff that there was no one at the facility to help them identify who the residents were and were putting name labels on residents, so they knew who the residents were. He said it was difficult to figure out what had been done for some residents and what hadn't been done for other residents.</p> <p>A phone interview was conducted on 1/20/22 at 12:49 PM with Police Officer #1. She stated she and 2 other police officers arrived at Pine Ridge Nursing Home at about 8:09 PM on 1/16/22. The police officer stated she there were residents out</p>	F 600			

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F 600	<p>Continued From page 57</p> <p>and rolling around in the general facility area when they arrived inside of the building and there were several call lights on throughout the facility. She described when she went back to the dementia unit, there were no staff back there, the residents were observed to have been wandering throughout the unit, in and out of rooms, residents were behind the nurses' station, and there were residents observed behind the nurses' station putting items into their mouths.</p> <p>A phone interview was conducted on 1/20/22 at 3:09 PM with Police Officer #3. He stated he and 2 other police officers arrived at Pine Ridge Nursing Home at about 8:09 PM on 1/16/22. The police officer stated there was a nurse and 2 NAs at the facility and none of them were in the dementia unit when he rounded through the building. He said as he was approaching the dementia unit, which is a locked unit, he could see an elderly woman through the window on the door banging on the door. He then said when he entered the dementia unit, he could see residents wandering throughout the dementia unit with no supervision. He described the residents as wandering behind the nurses' station desk, some of the residents who were behind the nurses' station desk were going through the drawers. He said he had also observed a resident pushing an empty intravenous (IV) pole around the nurses' station and dementia unit; there was nothing hanging on it, just an empty IV pole. He described the observation of the dementia unit as "shocking."</p> <p>During an interview conducted on 1/17/22 at 11:32 AM with Housekeeper #1 she stated she had worked on 1/16/22 from 5:30 AM to 10:00 AM and</p>	F 600			

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F 600	<p>Continued From page 58</p> <p>she was the only housekeeper at the facility. She said after she left there was no other housekeeping staff at the facility. She said that was not the time she would have normally gone home later in the day, but she said she had to leave at 10:00 AM because it had started sleeting. She stated she was the only housekeeper who was at the facility on 1/16/22 and there were no housekeepers at the facility after she left. She said there were two Nursing Assistants (NAs) at the facility. She further stated there were very few staff members in the facility. She also stated no one had come to the facility to do laundry on 1/16/22.</p> <p>During a phone interview conducted on 1/20/22 at 12:49 PM with Police Officer #1 she stated he arrived at the facility at 8:10 PM. She stated there were rooms where there was a strong smell of urine and feces. She further stated there were some rooms which had garbage on the floor, spilled liquids on the floor, and the rooms just appeared like no one had cleaned them for a while.</p> <p>A phone interview was conducted on 1/20/22 at 1:14 PM with Police Officer #2. He stated he and 2 other officers arrived at Pine Ridge Nursing Home at about 8:09 PM on 1/16/22. The police officer stated there was an odor of feces when he entered into the facility. He explained the smell continued to only get stronger as he went through the building and described the smell as horrible and as "pure raw sh*t" at one point.</p> <p>A phone interview was conducted on 1/20/22 at 3:09 PM with Police Officer #3. He stated there was garbage laying around "everywhere" inside of</p>	F 600			

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F 600	<p>Continued From page 59</p> <p>the facility. He also said there was an odor of stool and urine in the hallways, especially on the 200 hall outside of room 207 where there was visible feces below the bed. He further stated down another hall there was a line of reddish fluid on the hallway floor. He said the conditions were of concern enough the detective applied for a search warrant to obtain photographs of the unsanitary conditions.</p> <p>Administrator #3 was notified of immediate Jeopardy on 01/21/ 2022 at 12:31 PM.</p> <p>The facility provided the following credible allegation of immediate jeopardy removal.</p> <p>Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance;</p> <p>At 8:09 PM, after a resident called 911, local law enforcement arrived at the facility for a wellness check. It was determined that there was 1 licensed practical nurse (LPN) and 2 nursing assistants (NAs) on site and there were 97 residents which were in need of care and services. Emergency Management personnel gave the residents sandwiches, assessed residents, and got staff to the building during the night and for the next day to provide care. It was determined that the facility was non-compliant with Tag F600 based on a failure of the Administrator to enact an emergency preparedness plan, resulting in residents not receiving medications or meals in a timely manner, and not receiving other necessary goods and services. As set forth in the immediate jeopardy preliminary findings, all residents were</p>	F 600			

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F 600	<p>Continued From page 60</p> <p>likely to suffer a serious adverse outcome based on the non-compliance with emergency preparedness.</p> <p>Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.</p> <p>On 1/16/22 at 9:20 PM the Administrator informed the Assistant Regional Vice President (ARVP) that the fire and police personnel were at the facility. On 1/16/22 at 9:52 PM, the ARVP updated the Divisional Vice President (DVP) and the DVP initiated a Quality Assurance and Performance Improvement (QAPI) conference call with corporate support staff verbalize assignments of duties upon arrival to the facility. The AVRVP and Corporate staff put in place the Emergency Preparedness Plan to obtain additional staff and address the issues at the facility impacting residents. On 1/16/2022, the DON arrived at the facility approximately 11:30 PM, and provided medications and direct care. At 11:45 PM, a call was held with the Administrator and Corporate support staff to implement Emergency Preparedness Plan.</p> <p>On 1/17/2022 at 1:23 AM, the ARVP arrived at the facility and assumed charge of the facility.</p> <p>At 8:02 AM, the Mobile Certified Dietary Manager arrived in the kitchen, and the dietary department provided breakfast as scheduled, and subsequent meals as scheduled.</p> <p>At 10:47 AM, the Corporate Clinical Director</p>	F 600			

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F 600	<p>Continued From page 61</p> <p>arrived in the facility and provided direct care.</p> <p>At 10:50 AM, the Divisional Vice President arrived at the facility and assisted in securing staff, passing out meal trays.</p> <p>At 11:00 AM, Corporate Employee Experience personnel arrived at the facility, to assist with securing staff on the schedule.</p> <p>At 11:10 AM, the Regional RN MDS Consultant arrived at the facility to provide direct resident care.</p> <p>At 11:30 AM, the supporting RN facility consultant arrived to assist with direct resident care. At 12:00 noon, the assigned RN facility consultant arrived to assist with direct resident care. At 1:00 PM, an additional RN consultant arrived to assist with direct resident care.</p> <p>On 1/17/22, all residents were assessed by clinical staff for acute change of condition and no change in condition were noted.</p> <p>On 1/17/22, the social worker talked with 100% of alert and oriented residents to provide psycho-social support.</p> <p>On 1/17/22, the Interim Administrator and Human Resource Support Staff reviewed the staffing schedule for the upcoming 7 days to ensure sufficient number of staff to provide care for the residents. The Interim Administrator, Divisional Vice President, and Human Resource Support Staff ensured there was enough staff, on each shift, in each department, to provide care to all residents in accordance with the resident plan of</p>	F 600			

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F 600	Continued From page 62 care. Date of alleged Immediate Jeopardy removal: 1/18/2022. The facility's credible allegation of compliance was validated through an on-site review process which included record review, observations, interviews with facility staff, corporate staff and residents. Date of IJ removal was validated as 1/18/22	F 600			
F 677 SS=L	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, police, Emergency Medical Technicians (EMTs), resident, and staff interviews, the facility failed to provide Activities of Daily Living (ADL) Care, including incontinence care. The failure occurred on 1/16/22 during a period when there was just one Licensed Practical Nurse (LPN) and two Nursing Assistants in the facility to provide care for 98 residents. Two interviewed residents (Resident #7 and Resident #11) stated they did not receive incontinent care for an extended period of time and Resident #11 stated she had physical discomfort from having had to wait an extended period of time for incontinent care. Interviews with first responders who arrived at the facility described multiple residents in need of care and a strong smell of urine and feces in the facility. Due to the facility 's failure to sufficiently staff the facility to provide necessary ADL care on 1/16/22, every resident of	F 677	Pine Ridge Health and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents and to meet requirements established by state and federal law. The Plan of Correction is submitted as a written allegation of compliance. Pine Ridge Health and Rehabilitation Center's response to this Statement of Deficiencies and Pine Ridge Health and Rehabilitation Center's earlier submitted credible allegation of immediate jeopardy removal does not denote agreement with the Statement of Deficiencies nor does it	3/22/22	

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F 677	<p>Continued From page 63</p> <p>the facility was placed at risk of severe harm.</p> <p>During interviews with the three police officers who arrived to the facility at 8:09 PM on 1/16/22 they stated there was a foul odor of urine and feces, there were multiple call lights on, and after interviewing the LPN on site she stated she was the only nurse in the facility and she and the 2 NAs were unable to supply the medical care the residents needed which included timely incontinent care, assisting with toileting, delivery of nutrition and hydration, answering call lights, and other facets of basic care for the residents. The police officers stated it was determined by them, and the LPN, the residents of the facility were in need of immediate ADL care which the three staff members were unable to provide. In order to meet the needs of ADL care to the residents and the police officers reached out to community resources, including Emergency Medical Services (EMS) and firefighters, to immediately assess all residents of the facility, and to provide care to the residents of the facility.</p> <p>Immediate Jeopardy began on 01/16/22 when the facility failed to have adequate nursing staff during a winter storm on 01/16/22 to provide ADL care for the residents. Nurse #7, Nurse Assistant (NA) #1, and NA #2 were the only staff at the facility after 2:00 PM to provide all ADL care for the 98 residents at the facility. The immediate jeopardy was removed on 01/18/22 when the facility implemented an acceptable credible allegation for immediate jeopardy removal. The facility remains out of compliance at scope and severity level F (potential for actual harm that is not immediate jeopardy) to ensure systems are put in place are</p>	F 677	<p>constitute an admission that any deficiency is accurate or that any individual resident suffered or was likely to suffer actual harm or a serious adverse outcome. Further, Pine Ridge Health and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.</p> <p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice</p> <p>On 1/16/22 at 11:30 PM, the Director of Nursing (DON) arrived at the facility and provided direct activities of daily living (ADL) care, to include incontinent care, to residents including resident #7 and #11.</p> <p>On 1/17/22 at 1:23 AM, the Assistant Regional Vice President (ARVP) arrived at the facility, assumed charge of the facility, and initiated the Emergency Preparedness Plan. Initiation of the Emergency Preparedness Plan included calling in additional facility staff, additional agency staff, and additional corporate support staff to assist in providing basic goods and services to include but not limited to incontinent care.</p> <p>On 1/17/22 at 11:30 AM, the supporting RN facility consultant arrived to assist with direct ADL care to include incontinent care</p>		

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F 677	<p>Continued From page 64 effective.</p> <p>The findings included:</p> <p>1. Resident #7 was admitted to the facility on 10/28/21 and the resident ' s diagnoses included: Heart failure, generalized weakness, and lack of coordination.</p> <p>Review of Resident #7 ' s most recent Minimum Data Set (MDS) revealed an admission comprehensive assessment with an Assessment Reference Date (ARD) of 11/4/21. The resident was coded as cognitively intact. The resident was coded as having had no hallucinations or delusions and the resident was coded as requiring extensive assistance of one to two people for bed mobility, transfer (such as transfer from the bed to the wheelchair), dressing, toileting, and personal hygiene. The resident was coded as always continent of both bowel and bladder.</p> <p>The care plan for Resident #7, most recently revised on 12/7/21, specified the resident had "Focus" areas which included: The resident needed assistance with ADLs/Personal care and the interventions included the resident having been continent of bowel and bladder. Further review revealed a focus area about the resident having the potential for urinary incontinence related to physical immobility and the interventions included encouraging the resident to call for assistance for toileting, praise and encourage attempts to comply with toileting. The resident also had a focus area for her being at risk for skin breakdown, or development of further pressure ulcers related to: Immobility.</p>	F 677	<p>to residents, including resident #7 and #11.</p> <p>On 1/17/22 at 12:00 noon, the assigned RN facility consultant arrived to assist with direct ADL care, to include incontinent care to residents, including resident #7 and #11. At 1:00 PM, an additional RN consultant arrived to assist with direct ADL care to include incontinent care to residents including resident #7 and #11.</p> <p>Resident #7 and #11 received incontinent care and other services in a manner to promote maintenance of residents #7 and #11 quality of life</p> <p>On 1/17/22, 100% head to toe skin assessment were completed of residents to include resident #7 and # 11 by clinical support staff to ensure they are being treated with dignity and respect. During the skin assessments incontinent care was provided by the clinical staff when needed.</p> <p>On 1/17/22, the social worker talked with 100% of alert and oriented residents to provide psycho-social support.</p> <p>On 1/17/22, the Interim Administrator and Human Resource Support Staff reviewed the staffing schedule for the upcoming 7 days to make certain a sufficient number of staff were scheduled to ensure residents to include #7 and # 11 are treated in a dignified manner and receive direct ADL care including providing incontinent care.</p>		

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F 677	<p>Continued From page 65</p> <p>During an interview with Resident #7 on 1/17/22 at 12:19 PM the resident stated on 1/16/22 there was only one nurse and two nursing assistants for the entire facility. She said she had turned her call light on during the day on 1/16/22 because her brief needed to be changed and she needed incontinent care and it wasn't until 11:00 PM the call light was answered, and she received incontinent care. She further explained she did not receive incontinent care again until 3:00 AM.</p> <p>2. Resident #11 was admitted to the facility on 12/14/21 and the resident's diagnoses included: Diabetes, dysphagia (difficulty swallowing), chronic kidney disease, depression, lack of coordination, anxiety, and fibromyalgia.</p> <p>Review of Resident #11's most recent Minimum Data Set (MDS) revealed an admission comprehensive assessment with an Assessment Reference Date (ARD) of 12/21/21. The resident was coded as cognitively intact. The resident was coded as having had no hallucinations or delusions and the resident was coded as requiring total or extensive assistance of one to two people for bed mobility, transfer (such as transfer from the bed to the wheelchair), dressing, toileting, and personal hygiene. The resident was coded as always continent of both bowel and bladder.</p> <p>The care plan for Resident #11, most recently revised on 12/14/21, specified the resident had "Focus" areas which included: The resident needed assistance with ADLs/Personal care and the interventions included the resident having occasional incontinence and requiring assistance</p>	F 677	<p>The Interim Administrator and Human Resource Support Staff ensured there was enough staff, on each shift, in each department, to provide care to all residents to include #7 and # 11 in accordance with the resident plan of care.</p> <p>How the facility identified other residents having the potential to be affected by the same deficient practice</p> <p>As set forth above, on 1/17/22 100% head to toe skin assessment were completed of all residents by clinical support staff to ensure they are being treated with dignity and respect. During the skin assessments incontinent care was provided by the clinical staff when needed.</p> <p>Measures put into place or systemic changes made to ensure that the deficient practice will not recur</p> <p>On 2/18/22 the Corporate Clinical Director initiated an inservice with nurses and nursing assistants on providing direct ADL care including incontinent care so residents receive services to maintain good nutrition, grooming and personal and oral hygiene. The education was completed on 3/22/22. Any staff that has not worked and completed the Inservice will complete the inservice upon their next scheduled shift. The Mobile Director of Nursing, Director of</p>		

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F 677	<p>Continued From page 66 with toileting.</p> <p>During an interview with Resident #7 on 1/17/22 at 12:19 PM the resident spoke about the events that occurred on 1/16/22 and asked if the facility had some type of disaster plan that should have been followed? She stated the facility was short of help, she felt neglected, and expressed no one seemed to care. She further stated there were only two Nursing Assistants (NAs) to cover the whole building from 7:00 AM until 11:00 PM. She said there was only one nurse to cover the whole building. She said NA # 2 had told her she hadn ' t even had an opportunity to go to the bathroom while she was working. She said the staff refused to help her out of bed on 1/16/22 and that had upset her because she likes to get out of bed because her leg hurts her, and it feels better to get out of bed and change position. She said when she was wet, she had to wait a very long time for someone to come and change her on 1/16/22 and into the morning of 1/17/22. She said the staff who were there did not even have the opportunity to offer her a bedpan so she would not have to be incontinent. On 1/16/22 she received incontinence care twice, for the whole day she stated. She further stated she had to lay in her own pee or poop for many hours and at the time of the interview her bottom felt uncomfortable.</p> <p>During a phone interview conducted on 1/19/22 at 10:28 AM with NA #2 she stated she arrived at 7:00 AM on 1/16/22 and they were unable to find the schedule. She and NA #1 had no idea about who else was supposed to work. She explained her and the only other NA split the halls of the facility to provide care for the residents. She said</p>	F 677	<p>Nursing, or Clinical Support Staff will ensure all newly hired staff and newly scheduled agency will complete the Inservice during orientation.</p> <p>On 2/28/22 the Interim Administrator contacted the Quality Improvement Organization to discuss the plan of correction and for further recommendations to the action plans.</p> <p>How the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>Beginning 3/22/22, the Interim Administrator, Human Resource Support Staff, and/or the Interim Director of Nursing will conduct staffing meetings ensuring there was enough of staff, on each shift, in each department, to provide care and provide direct ADL care to include incontinent care in accordance with the resident care plans. During the staffing meeting, plans will be made to address staff spending the night if inclement weather is forecasted. The staffing meetings will occur five days a week x 8 weeks with review and discussion of schedules for the clinical, dietary, and housekeeping departments and documented on a staffing audit tool.</p> <p>Beginning 3/22/22, the Mobile Director of</p>		

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F 677	Continued From page 67 most of the staff who were assigned to leave at 7:00 AM (the end of night shift) did not wait for someone to take their place and left because it was starting to snow. She said 2 nurses from night shift stayed in the morning to assist with morning care and help with breakfast. She explained the two nurses helped a lot with covering the dementia unit, which was a locked unit. She said after the 2 nurses left, it was just her and the other NA to provide care for 98 residents. She further stated her, and the other NA provided as much care as they could to each resident. She said the residents who were alert and oriented were upset and they knew what was going on and she had a discussion with one resident who informed her she was going to call 911 regarding the situation at the facility, lack of care, and her current state. She said it was after 3:00 PM when she realized the other NAs who were scheduled at 3:00 PM had not arrived, and most likely were not going to arrive, which made her and the nurse very mad and upset. She said the phones were often ringing, they did not have time to answer the phones, and the receptionist who would usually answer the phone at the front desk had also not come to work. She said there was no other staff at the facility at that time, no dietary staff, no receptionist, no housekeeping, and no laundry staff. She explained at one point she became very angry and upset and the nurse was concerned for her health and considered sending her to the hospital, but she said she eventually got moving again and just went back to work. She said it was unreal, she was so busy, and had never had an experience like that before. She said she just kept working and at some point, she didn ' t even remember when, she saw the police officers in the	F 677	Nursing, Director of Nursing, treatment nurse, or clinical support staff will complete 10 ADL audits to include providing timely incontinent care weekly x 8 weeks documented on a Resident Care Audit Tool. Staff will be retrained by the interim administrator, interim DON, ADON, treatment nurse, and corporate support staff during the audit for any identified areas of concerns noted with timely incontinent care not being completed. The Administrator will be responsible for forwarding the audit tools to the Quality Assurance Committee. The facility's Quality Assurance Performance Improvement (QAPI) committee will review the audit tools monthly x 2 months to determine need for further frequency of monitoring.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 677	<p>Continued From page 68</p> <p>building, then more police officers, then the fire department and Emergency Medical Services.</p> <p>A phone interview was conducted on 1/19/22 at 10:29 AM with Emergency Responder Nurse #1 (male) and Emergency Responder Nurse #2 (female). He explained they arrived at 11:30 PM on 1/16/22 and there were only 2 Nursing Assistants to care for all of the residents at the facility and they had been at the facility for about 16 hours and needed to go home. He said there were no NA 's who had had arrived for the 11:00 PM to 7:00 AM shift when they had arrived. He explained the nurse and the 2 NAs who were at the facility couldn ' t think beyond the emergency situation. He said the residents expressed frustration over the lack of care, not receiving incontinent care, how they shouldn ' t be treated like that, upset about the condition of the care, and some had informed him they had received candies instead of a meal. She stated a lot of the residents were wet, to the point the urine had gone through the brief the resident was wearing, through an incontinent pad, and on the sheets of the bed. She explained the NAs were doing their best to try and keep up, and keep the patients dry, but it was just not possible for 2 NAs to care for so many residents. She also stated there was no one providing any care or supervision to the residents in the dementia unit.</p> <p>A phone interview was conducted with Emergency Medical Technician (EMT) #1 on 1/19/22 at 8:27 PM. He stated there was only one nurse and two NAs providing care for all of the residents at the facility. He said while they were triaging residents to determine if there were any urgent and acute</p>	F 677			

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F 677	<p>Continued From page 69</p> <p>medical needs of any of the residents one resident had yelled at him that she needed a brief and needed to be changed. He further stated the nurse who was working at the facility told him, the Director of Nursing (DON) told the nurse to find an empty room at midnight, go lie down, and to get some rest, despite her being the only nurse. The conversation between the nurse and the DON had occurred prior to the police arriving at the facility and the subsequent emergency response. The EMT stated the nurse told him she knew that wasn ' t the right thing to do, she was the only nurse there, and the residents were depending on her.</p> <p>A phone interview was conducted with EMT #2 on 1/19/22 at 9:30 PM. He explained he had arrived at the facility at 9:30 PM on 1/16/22. He stated the residents of the facility had been neglected as evidenced by the lack of care they had received. He said many residents were left incontinent and residents were asking how come they were being treated like that. He said he saw multiple residents lying in their own feces. He said the facility had a COVID unit and one resident on the COVID unit told him he had not seen a staff member of the facility since early in the day. He stated he was appalled by the situation he discovered the residents in.</p> <p>During a phone interview conducted on 1/20/22 at 12:49 PM with Police Officer #1 she stated he arrived at the facility at 8:10 PM and the only staff discovered at the facility by himself, and the other two responding officers were one nurse and two Nursing Assistant ' s to care for all of the residents. She stated there were multiple call</p>	F 677			

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F 677	<p>Continued From page 70</p> <p>lights on in each hallway he went down, and she did not see anyone answering the call lights. She stated there were rooms where there was a strong smell of urine and feces, and it was obvious the residents hadn ' t been changed in a long time. The police officer stated Nurse #7 told her this was one of the worst things she had ever seen, and she seemed to be in shock.</p> <p>A phone interview was conducted on 1/20/22 at 1:14 PM with Police Officer #2. He stated he and 2 other officers arrived at Pine Ridge Nursing Home at about 8:09 PM on 1/16/22. The police officer stated there was an odor of feces when he entered into the facility. He explained the smell continued to only get stronger as he went through the building and described the smell as horrible and as "pure raw sh*t" at one point. He said there were residents who were crying and had told him and the other officers they had not seen a nurse all day. He said he had been in the building many times and had never seen the building in a state like he had found it on 1/16/22. He said the experience was a very sad, disturbing, and emotional ordeal for him.</p> <p>A phone interview was conducted on 1/20/22 at 1:14 PM with Police Officer #3. He stated when he and the other officers arrived at the facility they discovered three staff members, one nurse and two NAs. He said the three of them were doing what they could for the residents, but it was obvious three people could not provide care for all of the residents of the facility. He stated there was a room he had observed which had feces under the bed and there was a strong odor. He said during several interviews with residents they</p>	F 677		

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F 677	<p>Continued From page 71</p> <p>told him they had not seen nurses or NAs for several hours, or since breakfast, and some said they hadn ' t eaten since breakfast.</p> <p>During an interview conducted on 2/2/22 at 1:23 PM with Administrator #3 (Who was the Assistant Regional Vice President prior to assuming the administrator role) he stated it was his expectation to have a level of staffing to provide the needed care for residents. He further stated there needed to be oversight through the Administrator and the Director of Nursing to provide that level of staffing to allow residents to feel like they were getting timely and appropriate care.</p> <p>Administrator #3 was made aware of the Immediate Jeopardy (IJ) on 1/22/22 at 1:23 PM.</p> <p>The facility shared the following plan to address the incident which alleged the facility had put into place measures to lower the scope and severity of the IJ as of 1/18/22.</p> <p>The Removal Plan: F677- Activities of Daily Living (ADLs)</p> <p>The entity ' s removal plan must include the following:</p> <p>Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance;</p> <p>On 1/16/22, at 8:09 PM, after a resident called 911, local law enforcement arrived at the facility for a wellness check. It was determined that there</p>	F 677			

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F 677	<p>Continued From page 72</p> <p>was 1 licensed practical nurse (LPN) and 2 nursing assistants (NAs) on site and there were 97 residents which were in need of care and services, including assistance with activities of daily living, (ADL) care. Emergency Management personnel assessed residents, and got staff to the building during the night and for the next day to provide care. It was determined that the facility was non-compliant with Tag F677 based on a failure of the Administrator to enact an emergency preparedness plan, resulting in residents not receiving ADL care. As set forth in the immediate jeopardy preliminary findings, all residents who needed ADL care during the time period where there was only 1 LPN and 2 NAs on site were likely to suffer a serious adverse outcome based on the non-compliance with emergency preparedness.</p> <p>Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.</p> <p>On 1/16/22 at 9:20 PM the Administrator informed the Assistant Regional Vice President (ARVP) that the fire and police personnel were at the facility and that there was only 1 LPN and 2 NAs at the facility. The ARVP began driving to the facility in order to assist with coordinating care of residents and provision of ADL services to residents while getting additional staff to the facility. The AVRVP and Corporate staff put in place the Emergency Preparedness Plan to obtain additional staff and address the issues at the facility impacting residents, including the provision of ADL care.</p>	F 677			

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F 677	<p>Continued From page 73</p> <p>On 1/16/22, the DON arrived at the facility at approximately 11:30 PM, and provided direct activities of daily living (ADL) care, including incontinent care.</p> <p>On 1/16/22, at 11:45 PM, a call was held with the Administrator and Corporate support staff to implement Emergency Preparedness Plan and get sufficient staff to the facility to provide direct ADL care, including incontinent care.</p> <p>On 1/17/22 at 1:23 AM, the ARVP arrived at the facility and assumed charge of the facility, which included coordinating care of residents and provision of direct ADL care, including incontinent care.</p> <p>On 1/17/22 at 10:47 AM, the Corporate Clinical Director arrived in the facility and provided direct resident ADL care, including as needed, incontinent care, toileting, bed-mobility, positioning, assisting residents of the dementia unit, and answering call bell lights.</p> <p>On 1/17/22 at 11:00 AM, Corporate Employee Experience personnel arrived at the facility, to assist with securing staff on the schedule.</p> <p>On 1/17/22 at 11:10 AM, the Regional RN MDS Consultant arrived at the facility to provide direct resident ADL care, including as needed, incontinent care, toileting, bed-mobility, positioning, assisting residents of the dementia unit, and answering call bell lights.</p> <p>On 1/17/22 at 11:30 AM, the supporting RN facility consultant arrived to assist with direct resident</p>	F 677			

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F 677	<p>Continued From page 74</p> <p>ADL care, including as needed, incontinent care, toileting, bed-mobility, positioning, assisting residents of the dementia unit, and answering call bell lights, and assessed residents for acute change in condition, no changes noted.</p> <p>On 1/17/22, at 12:00 noon, the assigned RN facility consultant arrived to assist with direct resident ADL care, including as needed, incontinent care, toileting, bed-mobility, positioning, assisting residents of the dementia unit, and answering call bell lights, and assessed residents for acute change in condition, no changes noted.</p> <p>At 1:00 PM, an additional RN consultant arrived to assist with direct resident ADL care, including as needed, incontinent care, toileting, bed-mobility, positioning, assisting residents of the dementia unit, and answering call bell lights.</p> <p>On 1/17/22, the Interim Administrator and Human Resource Support Staff reviewed the staffing schedule for the upcoming 7 days to ensure sufficient number of staff to provide ADL care for the residents, including timely incontinent care, toileting, bed-mobility, positioning, assisting residents of the dementia unit, and answering call bell lights timely. The Interim Administrator, Divisional Vice President, and Human Resource Support Staff ensured there was enough staff, on each shift, in each department, to provide ADL care to all residents in accordance with the resident plan of care.</p> <p>Date of alleged Immediate Jeopardy removal: 1/18/2022</p>	F 677			

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F 677	Continued From page 75	F 677			
F 684 SS=H	<p>The facility ' s credible allegation of compliance was validated through an on-site review process which included record review, observations, staff, corporate, and resident interviews. Date of IJ removal was validated as 1/18/22.</p> <p>Quality of Care CFR(s): 483.25</p> <p>§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Family Member, staff and Physician the facility failed to provide necessary care and services for a surgical incision; failed to start an antibiotic that was ordered for the right hip incision; and failed to identify signs and symptoms of infection to a right hip incision for 1 of 1 residents, Resident #8, reviewed for an infection. Resident #8 discharged to the hospital on 11/24/2021 with a fractured right hip and she returned to the facility on 11/30/2021 with an incision after surgical repair of a right hip fracture. On 1/1/2022 Resident #8 was sent to the hospital Emergency Department for a fall and an infection was identified to her right hip incision.</p> <p>Findings included:</p> <p>A review of Resident #8's medical record revealed</p>	F 684	<p>This plan of correction constitutes Pine Ridge Health and Rehabilitation Center's written allegation of compliance for the deficiency cited. However, preparation and execution of the plan of correction is not an admission by Pine Ridge Health and Rehabilitation Center of the truth of the facts alleged, conclusions set forth in the statement of deficiencies, or that any individual resident suffered or had the potential to suffer minimal harm or actual harm. This plan of correction is prepared and executed to meet requirements established by state and federal law.</p> <p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p>	3/22/22	

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F 684	<p>Continued From page 76</p> <p>she originally admitted to the facility 11/3/2020 and readmitted after repair of a right hip incision on 11/30/2021. Her diagnoses included osteoarthritis and dementia.</p> <p>Resident #8's Care Plan initiated on 9/21/2021 stated she was at risk for skin breakdown, but no interventions were found for the right hip surgical incision.</p> <p>A review of the Discharge Instruction when Resident #8 was discharged from the hospital with a right hip incision due to surgical repair of a right hip fracture indicated Resident #8 had a dressing to her right hip incision but there were no instructions regarding changing the dressing. The Discharge Instructions stated Resident #8's right hip dressing was a Xeroform (petroleum blend dressing) . A review of the manufacturer's directions for Xeroform dressing indicated the dressing should be changed according to the health provider instructions but is usually changed daily to keep the wound moist and prevent the dressing from sticking to the wound.</p> <p>Physician's Orders for Resident #8 for 11/30/2021 were reviewed and no orders were found for surgical incision.</p> <p>During a review of Resident #8's Medication Administration Records (MAR) and Treatment Administration Records (TAR) for 11/2021 no treatments were found for 11/30/2021 when Resident #8 returned from the hospital with surgical repair of her right hip fracture until an order was written for an antibiotic and dressing on 12/14/2021.</p>	F 684	<p>Resident did not return after being admitted to the hospital on 1/1/22. Resident #8 no longer resides at the facility.</p> <p>How the facility identified other residents having the potential to be affected by the same deficient practice:</p> <p>On 1/17/22-1/18/22 the Director of Nursing completed head to toe assessments on 100% of all residents to identify all wounds including surgical incisions. On 2/28/22-3/1/22 the Director of Nursing assessed all identified wounds for signs and symptoms of infections and to ensure a treatment order was in place with documentation on a wound assessment audit tool. There were no identified areas of concern.</p> <p>On 2/28/22 the RN facility consultant completed an audit of all ordered antibiotics from 1/31/22 to 2/28/22 for current residents to ensure the antibiotic was started when ordered. There were no identified areas of concern during the audit.</p> <p>Measures put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>On 2/18/22 the Corporate Clinical Director initiated an in-service with 100% of all nurses to include agency on the wound care process and following physician's orders to include antibiotics. The in-service</p>		

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F 684	<p>Continued From page 77</p> <p>Review of a Skin Check on 11/30/2021 by Nurse #11 indicated there were no skin integrity issues present and there was no mention of the right hip incision.</p> <p>A Minimum Data Set (MDS) significant change assessment dated 12/2/2021 indicated Resident #8 was severely cognitively impaired and had a history of falls.</p> <p>A Skin Check completed by the Wound Care Nurse/Assistant Director of Nursing on 12/7/2021 indicated there was no skin integrity issues present and the right hip incision was not indicated on the skin check.</p> <p>A Wound Flowsheet dated 12/8/2021 completed by the Wound Care Nurse/Assistant Director of Nursing on 12/8/2021 stated Resident #8 had a right hip incision measuring 11 centimeters by 0.2 centimeters and there was redness and bruising at the incision site. The Flowsheet further stated the current treatment was to monitor for signs of infection.</p> <p>Review of Resident #8's Physician's Orders revealed an order for Ciprofloxacin 500 milligrams twice a day for 7 days and the area may be covered by a dressing which was ordered on 12/9/2021 and written by Nurse #5 due to cellulitis of the right hip</p> <p>On 1/26/2022 at 4:34 pm an interview was conducted with Nurse #5, and she stated she called the Physician on 12/9/2021 and obtained the order for an antibiotic, Ciprofloxacin 500 milligrams twice a day for 7 days, because</p>	F 684	<p>addressed (1) obtaining treatment orders for all identified wounds to include surgical wounds and (2) signs and symptoms of wound infections (3) starting medications when ordered by the physician. The Inservice will be completed on 3/22/22. Any nurse that has not worked and completed the Inservice will complete upon their next scheduled shift. The Mobile Director of Nursing, Director of Nursing, or Clinical Support Staff will ensure all newly hired nurses and newly scheduled agency nurses will complete the Inservice during orientation.</p> <p>On 2/28/22 the Interim Administrator contacted the Quality Improvement Organization to discuss the plan of correction and for further recommendations to the action plans.</p> <p>How the facility plans to monitor its performance to make sure that solutions are sustained:</p> <p>Beginning 3/22/22 the Mobile Director of Nursing, Director of Nursing, or clinical support staff will complete head to toe assessments of residents weekly. The audit is to identify wounds to include surgical incisions, for signs and symptoms of infection, and to ensure a treatment is in place. The Mobile Director of Nursing, Director of Nursing, assigned hall nurse, treatment nurse, or clinical support staff will ensure that the MD is notified with documentation in the clinical record for all</p>		

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F 684	<p>Continued From page 78</p> <p>Resident #8's right hip incision was red, swollen, and draining a pinkish, yellow drainage. Nurse #5 stated there was an area on the incision where a staple had torn loose, and the inside of the wound was protruding. Nurse #5 stated she had questioned the Wound Care Nurse/ADON about how long Resident #8's incision had been infected because the wound looked so bad.</p> <p>A Physician's Progress Note dated 12/13/2021 written by the Orthopedic Surgeon indicated Resident #8 could begin weight bearing as tolerated to the right lower extremity, daily dressing change to incision, and follow up in one month or sooner if worsening drainage. The Physician's Progress Note written by the Orthopedic Surgeon dated 12/13/2021 did not indicate the condition of Resident #8's incision.</p> <p>Physician's Orders dated 12/14/2021 for Resident #8 for a dressing change daily to the incision site due to increased drainage was written by the Physician after Resident #8 was seen by the Orthopedic Surgeon on 12/13/2021.</p> <p>Resident #8's Medication Administration Record (MAR) for 12/2021 indicated she received an antibiotic, Ciprofloxacin 500 milligrams twice a day for 7 days, from 12/14/2021 to 12/20/2021 for cellulitis of her right hip. The 12/2021 MAR also indicated Resident #8 had a dressing to her right hip incision daily beginning 12/14/2021 and ended 12/29/2021.</p> <p>A Wound Flowsheet dated 12/22/2021 written by the Assistant Director of Nursing/Wound Care Nurse stated Resident #8 had a right hip surgical</p>	F 684	<p>identified areas of concern. 100% of head to toe assessments will be completed weekly x 4 weeks then 10% weekly x 4 weeks utilizing a Census/Wound Audit tool. The nurse will be retrained by the Mobile Director of Nursing, Director of Nursing, or clinical support staff for all identified areas of concern identified based on a review of the audit tool.</p> <p>Beginning 3/22/22 the Mobile Director of Nursing, Director of Nursing, or clinical support will review physician orders weekly x 8 weeks to identify all residents who were ordered antibiotics. The Mobile Director of Nursing, Director of Nursing, or clinical support will check the Medication Administration records of all resident□s with newly ordered antibiotics to ensure the medication was started when it was ordered. The audit will be documented on an Orders Audit Tool. The Mobile Director of Nursing, Director of Nursing, or clinical support will contact the physician, complete a medication error report, and retrain the nurse for all identified areas of concern. The Administrator or Director of Nursing will review and initial the audit tools weekly x 8 weeks for compliance and to ensure all areas of concern were addressed.</p> <p>The Administrator will be responsible for forwarding the audit tools to the Quality Assurance Committee. The facility□s Quality Assurance Performance Improvement (QAPI) committee will review the Notification Audit Tool and Orders Audit</p>	

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F 684	<p>Continued From page 79</p> <p>incision with a small amount of drainage.</p> <p>A Wound Flowsheet dated 12/29/2021 written by the Assistant Director of Nursing/Wound Care Nurse indicated Resident #8 had a right hip surgical incision with no drainage.</p> <p>A Skin Check dated 1/1/2022 by Nurse #1 indicated Resident #8 had an incision to the right thigh but did not give a description of the incision.</p> <p>Review of the Emergency Department to Hospital Discharge Summary with an admission dated of 1/2/2022 indicated Resident #8 was seen in the Emergency Department for a fall and drainage was noted from her right hip incision. A Computed Tomography (CT) Scan revealed she had an abscess of the right hip incision and right hip joint. The Emergency Department to Hospital Discharge Summary further indicated on 1/3/2022 she was sent to the operating room for irrigation and drainage and hardware removal of the right hip due to the infection.</p> <p>An interview was conducted on 1/20/2022 at 2:40 pm with the Family Member who stated Resident #8 returned to the facility on 11/30/2021 after having a surgical repair of a right hip fracture which occurred in the facility. The Family Member stated Resident #8 fell again on 1/1/2022 and was not able to move her leg and she requested the staff send Resident #8 to the hospital. The Family Member stated the Emergency Room Physician indicated Resident #8's right hip incision was infected, and the infection had spread to the hip joint, and she would require surgery to remove the right hip prosthesis. The Family Member stated</p>	F 684	Tools monthly x 2 months to identify trends and determine need for further frequency of monitoring.		

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F 684	<p>Continued From page 80</p> <p>she did not understand how Resident #8 had an infection to her right hip incision and the nurses did not know about it if they were changing the dressing daily.</p> <p>The Assistant Director of Nursing (ADON) was interviewed on 1/25/2022 at 10:38 am and she stated she had been the Wound Care Nurse when Resident #8 returned from the hospital on 11/30/2021 but her position changed to ADON on 12/28/2021. The ADON stated when Resident #8 returned from the hospital on 11/30/2021 she had an order for the incision to be open to air. The ADON stated when she assessed the incision on 12/29 it did not appear to be infected. The ADON stated Resident #8 was picking at her right hip incision and the order was changed to a dry dressing. The ADON stated there was more drainage from Resident #8's right hip incision when she went back out to the hospital on 1/1/2022. An attempt was made to reinterview the ADON but she did not return my call.</p> <p>On 1/25/2022 at 3:54 pm an interview was conducted with Nurse #3, and she stated she was employed by agency staffing but worked at the facility regularly. She stated the wound dressing changes were completed by the Wound Care Nurse during the weekdays and by the Nurses on the weekend days. Nurse #3 stated she had observed Resident #8's wound after she finished the antibiotics ordered on 12/14/2021 and completed on 12/20/2021 and the incision had a large amount of bloody drainage that would come through the dressing if it had remained on more than 24 hours. Nurse #3 stated Resident #8's right hip incision looked infected when she was</p>	F 684			

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F 684	<p>Continued From page 81</p> <p>taking the antibiotic and when the antibiotic was completed on 12/20/2021. Nurse #3 stated she did not notify the physician of the condition of Resident #8's wound.</p> <p>An interview was conducted with Nurse #2 on 1/26/2022 at 9:05 am and she stated when Resident #8 returned to the facility after the hospitalization to repair her right hip fracture on 11/30/2021 she transcribed the Medication Administration Record from the Physician's orders. Nurse #2 stated she did not remember if Resident #8 had a treatment to her right hip incision and she stated the Wound Care Nurse would have assessed the incision site and obtain orders for the dressing changes.</p> <p>During an interview with Nurse #1 on 1/26/2022 at 9:32 am she stated she had not cared for Resident #8 until the end of December. Nurse #1 stated the Wound Care Nurse did the dressing changes through the week. She stated she did remember seeing the wound during the week before Resident #8 discharged back to the hospital and it was red and inflamed, there was a staple that had come loose, and there was a lot of drainage. Nurse #1 stated the wound looked infected and she had told the Wound Nurse she should look at the wound.</p> <p>Resident #8's Physician was interviewed on 1/26/2022 at 11:08 am and stated he remembered Resident #8 had an infection to her right hip incision and he had ordered the antibiotic. The Physician stated he was aware Resident #8's incision was inflamed when the antibiotic was ordered on 12/9/2021 but he had not been notified the incision continued to be red and draining after</p>	F 684			

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F 684	Continued From page 82 the antibiotic was completed. The Physician stated the condition of Resident #8's wound should have been reported to either him or the Orthopedic Surgeon if it continued to be inflamed and showed signs of infection. An attempt was made to reach Resident #8's Orthopedic Surgeon on 1/28/2022 at 12:08 pm and the Office Manager stated the Orthopedic Surgeon said the medical records from the hospital would speak to Resident #8's care and he would not be returning my call. During an interview with Administrator #3 on 1/31/2022 at 11:00 am he stated he had not been Administrator #3 during Resident #8's stay but nursing should have monitored Resident #8's right hip incision for any signs of infection and reported any signs of infection to the Physician.	F 684			
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, first responder, resident, physician, family member, and staff interviews, the facility failed to provide an environment without severe risk of harm through not providing supervision of the residents in the locked dementia unit for several hours. This occurred during a	F 689	Pine Ridge Health and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with	3/22/22	

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F 689	<p>Continued From page 83</p> <p>period when there was just one Licensed Practical Nurse (LPN) and two Nursing Assistants in the facility to provide care for 98 residents. As reported by Police Officer #2 who went into the dementia unit after arriving to the facility at 8:10 PM on 1/16/22 she discovered no staff supervising the dementia unit, residents wandering throughout the unit, residents behind the nurses' station desk, and residents placing items in their mouths. This deficient practice impacted all residents of the locked dementia unit, 25 of 25 residents. This resulted in the residents on the dementia unit being at severe risk for harm.</p> <p>During interviews with the three police officers who arrived at the facility at 8:09 PM on 1/16/22 they stated there was no staff member within the locked dementia unit. The three staff who were in the building were in the main part of the facility and were unable to supervise the cognitively impaired residents. The police officers stated it was determined the three staff members were in need of immediate assistance to provide appropriate staffing to ensure the safety of the residents of the facility, including the residents of the dementia unit. In order to meet safety needs the residents, the police officers reached out to community resources, including Emergency Medical Services (EMS) and firefighters, to immediately assess all residents of the facility, provide supervision, and assist as need, all residents of the facility.</p> <p>Immediate Jeopardy began on 01/16/22 when the facility failed to have adequate nursing staff during a winter storm on 01/16/22 to provide supervision of the dementia care unit to minimize the risk of accidents or severe harm to the 25 residents who</p>	F 689	<p>applicable rules and provisions of quality of care of residents and to meet requirements established by state and federal law. The Plan of Correction is submitted as a written allegation of compliance.</p> <p>Pine Ridge Health and Rehabilitation Center's response to this Statement of Deficiencies and Pine Ridge Health and Rehabilitation Center's earlier submitted credible allegation of immediate jeopardy removal does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate or that any individual resident suffered or was likely to suffer actual harm or a serious adverse outcome. Further, Pine Ridge Health and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.</p> <p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice</p> <p>On 1/16/22 at 11:45 PM the administrator, with the assistance from the ARVP, initiated the Emergency Preparedness Plan due to the inclement weather. This was to ensure residents in the dementia unit received adequate supervision and assistive devices to prevent accidents. On 1/16/22 at approximately 11:30 PM, the</p>		

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F 689	<p>Continued From page 84</p> <p>were residing in the dementia unit. Nurse #7, Nurse Assistant (NA) #1, and NA #2 were the only staff at the facility after 2:00 PM and were unable to provide a continuous presence on the dementia unit for resident supervision, which many had cognitive loss and required supervision for resident safety. The immediate jeopardy was removed on 01/18/22 when the facility implemented an acceptable credible allegation for immediate jeopardy removal. The facility remains out of compliance at scope and severity level H (actual harm that is not immediate jeopardy) for example #2 and to ensure systems put in place are effective.</p> <p>Based on record review and staff, Physician and Family Member interviews the facility failed to provide the recommended 1 on 1 supervision to prevent falls for 1 of 1 resident reviewed for accidents (Resident #8).</p> <p>The findings included:</p> <p>1. Review of the SPARC Manual, which was dated July 2019, documented dementia unit, or Specialized Programming for Alzheimer 's and Related Care (SPARC), is a unit which is designed and staff to provide care and services to people living with dementia (PLWD). On page A-10, the section was titled, "Safety." The seventh bullet point of the page documented staff assignments had specific responsibilities to assure that residents can be supervised adequately. Further review revealed on page D-1, titled "Environment," the first paragraph read in part, the purpose of the environment was to provide a safe and enriched space to promote well-being of PLWD, their care</p>	F 689	<p>DON arrived at the facility and provided supervision and direct resident care, including in the locked dementia unit, to minimize the potential risk for resident accidents.</p> <p>On 1/17/22 at 10:47 AM, the Corporate Clinical Director arrived at the facility and provided supervision and direct care, including in the locked dementia unit, to minimize the potential risk for resident accidents.</p> <p>On 1/17/22 at 11:30 AM, the supporting RN facility consultant arrived at the facility and provided direct resident care, including in the locked dementia unit, to minimize the potential risk for resident accidents.</p> <p>On 1/17/22 at 12:00 noon, the assigned RN facility consultant arrived at the facility and provided direct resident care, including in the locked dementia unit, to minimize the potential risk for resident accidents.</p> <p>On 1/17/22 at 1:00 PM, an additional RN consultant arrived at the facility and provided direct resident care, including in the locked dementia unit, to minimize the potential risk for resident accidents.</p> <p>On 1/17/22 at 2:30 PM, the nursing facility staff and agency nursing staff were able to make it to the facility and many came prepared to spend the night, including those who made longer term commitments to stay in the facility until the weather</p>		

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F 689	<p>Continued From page 85</p> <p>partners and families, and staff. Critical to this purpose is shared responsibility of all who work in the space. Additionally, it documented PLWD often have reduced safety awareness. There was a section (G) Behaviors which documented behaviors are understood as communication and approached as efforts to communicate and common unmet needs might include: Physical: hunger, thirst, need for elimination, fatigue, pain, sex; Sensory; too hot/too cold, too loud or noisy, too empty; Emotional: anger, frustration, sadness, enthusiastic; Social: lonely or crowded; and Cognitive: overwhelmed, confused.</p> <p>During a phone interview conducted on 1/19/22 at 10:28 AM with NA #2 she stated she arrived at 7:00 AM on 1/16/22 and they were unable to find the schedule. She and NA #1 had no idea about who else was supposed to work. She explained she and the only other NA split the halls of the facility to provide care for the residents. She said most of the staff who were assigned to leave at 7:00 AM (the end of night shift) did not wait for someone to take their place and left because it was starting to snow. She said 2 nurses from night shift stayed in the morning to assist with morning care and help with breakfast. She explained the two nurses helped a lot with covering the dementia unit, which was a locked unit. She said after the 2 nurses left, it was just her and the other NA to provide care for 98 residents. She explained because there were only 3 staff for the whole facility after 2:00 PM, there was not enough staff for one person to stay in the dementia at all times. She further stated her, and the other NA provided as much care as they could to each resident. She said she went back to the dementia</p>	F 689	<p>cleared up. While working, the staff provided supervision of residents to prevent potential risk of accidents, including in the locked dementia unit.</p> <p>How the facility identified other residents having the potential to be affected by the same deficient practice</p> <p>Between 1/17/22-1/20/22 the Physician or Nurse Practitioner assessed all residents to include residents in the dementia unit for changes in condition to include new or worsening pain and/or gait. Orders were written and carried out for all identified areas of concern.</p> <p>On 1/17/22 the Interim Administrator and Human Resource Support Staff reviewed the staffing schedule for the upcoming 7 days. This review was to ensure a sufficient number of staff was scheduled to provide supervision and an environment without severe risk of harm and to prevent accidents. Supplemental staffing was utilized to include agency staff and corporate support staff to fill all vacant positions identified.</p> <p>On 2/28/22 the RN facility consultant reviewed falls from 1/16/22-2/18/22 to ensure no falls results from not providing supervision of residents. There were no identified areas of concern.</p> <p>Measures put into place or systemic changes made to ensure that the deficient</p>		

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F 689	Continued From page 86 unit from time to time to check on the residents, but she could not stay on the dementia unit because she was covering 2 other halls. She explained there was another resident who was helping to pass the bagged sandwiches, but she did not allow him to go into the dementia unit to pass the bagged sandwiches to the residents. She said there was no one to help her with the residents on the halls she was working on, including the dementia residents, except for the nurse, and she was covering three halls by herself, including the dementia unit. She said it was after 3:00 PM when she realized the other NAs who were scheduled at 3:00 PM had not arrived, and most likely were not going to arrive, which made her and the nurse very mad and upset. She said the phones were often ringing, they did not have time to answer the phones, and the receptionist who would usually answer the phone at the front desk had also not come to work. She said there was no other staff at the facility at that time, no dietary staff, no receptionist, no housekeeping, and no laundry staff. She explained at one point she became very angry and upset and the nurse was concerned for her health and considered sending her to the hospital, but she said she eventually got moving again and just went back to work. She said it was unreal, she was so busy, and had never had an experience like that before. She said she had passed out some food for supper to the residents in the dementia unit, which she and the nurse was able to find in the kitchen, and then after that she saw the police officer in the facility, and then more help arrived with Emergency Medical Services and firefighters. She said she went home at midnight when an agency NA came into help, and she was exhausted.	F 689	practice will not recur As of 1/17/22, the interim administrator brought in a team of consultants to assist the facility seven days per week. The consultant team included registered nurses, certified dietary manager, registered dietician, maintenance supervisor, human resources, and office support. The consultant team worked along-side facility staff to assist with and provide resident care to include supervision to prevent accidents. The consultant team provided training, in-services, and competency training. The consultant team also assisted with scheduling agency staff and hiring new staff. As of 1/17/22, the interim administrator initiated staffing meetings to ensure adequate staffing in all departments including nursing to provide supervision to prevent accidents. Agency staff was scheduled to supplement facility staff when necessary. On 2/18/22 the Corporate Clinical Director initiated an inservice with all staff on supervision for the residents in the locked dementia unit and throughout the facility and providing an environment free of accidents. The inservice will be completed by 3/22/22. Any staff that has not worked and completed the inservice will complete the inservice upon their next scheduled shift. The Mobile Director of Nursing, Director of Nursing, or Clinical Support		

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F 689	<p>Continued From page 87</p> <p>An interview was conducted on 1/20/22 at 1:55 PM with NA #1. He stated on 1/16/22 he and NA #2 were the only two NAs at the facility providing care for the residents, and there was only one nurse, after the night shift staff left after lunch time. After lunch he said the nurse and NA #2 made a plan that the 2 NAs would take the 300 hall, the 400 hall, and try to help with the dementia unit. He said there was no one assigned to stay back on the dementia unit and one of them would go back there from time to time. He explained from about 2:00 PM to when the police arrived, he had only gone back there "a couple of times." He said NA #2 was going back there and checking on things, maybe every few hours. He further explained at one point when there were only the two of them as NAs in the building a resident had expired, and he and the other NA provided post-mortem care for the resident and during that time neither of them were able to assist other residents or check in the dementia unit. He said he, nor the other two staff members at the facility had time to answer the phone. He said he wasn't scared during the period when it was just the three of them, just kind of disappointed, he said it felt like no one was making an effort to get other staff into the facility to help the residents and help them care for the residents. He explained the worst part of it was the residents having to wait such a long time to receive assistance and care.</p> <p>A phone interview was conducted on 1/18/22 with Nurse #7 on 1/18/22 at 3:41 PM. She said she worked on 1/16/22 and started at 7:00 AM and worked until 7:00 AM 1/17/22. She explained she had worked from 7:00 AM to 7:00 PM on 1/15/22</p>	F 689	<p>Staff will ensure all newly hired staff and newly scheduled agency will complete the inservice during orientation.</p> <p>On 2/28/22 the Interim Administrator contacted the Quality Improvement Organization to discuss the plan of correction and for further recommendations to the action plans.</p> <p>How the facility plans to monitor its performance to make sure that solutions are sustained</p> <p>Beginning 3/22/22, the Interim Administrator, Human Resource Support Staff, and/or the Interim Director of Nursing will conduct staffing meetings ensuring there was enough staff, on each shift, in each department, to provide care and provide supervision to prevent accidents to all residents in accordance with the resident care plans. During the staffing meeting, plans will be made to address staff spending the night if inclement weather is forecasted. The staffing meetings will occur five days a week x 8 weeks with review and discussion of schedules for the clinical, dietary, and housekeeping departments and documented on a staffing audit tool.</p> <p>On 2/15/22, the interim administrator resumed Cardinal Interdisciplinary Team (IDT) meetings five times weekly x 8 weeks. The purpose of the meeting is to review resident concerns, resident needs</p>		

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F 689	Continued From page 88 and it was a normal day. She explained she was aware of the potential for inclement weather, but there was no one from management who had discussed inclement weather with her, or preparations for inclement weather on 1/15/22. She said the employees of the facility were joking about it and making statements such as pack your bags and be prepared to stay in case it snows on 1/15/22. She said when she left her house on 1/16/22 it was just starting to snow. When she arrived at the facility, she explained she was unable to find the schedule, and she did not know who was supposed to work, or who was supposed to be there without the schedule, and without the schedule, she did not know how to make assignments or who would be assigned to what halls. She said she called DON #1 at around 7:30 AM to let her know she was the only nurse who had arrived for the day shift, she couldn't find the schedule, and the night nurse was going to only stay until 11:00 AM. She further explained there were only 2 Nursing Assistants (NAs) who had arrived to work day shift, and typically there would have been 2 medication aides, 3 nurses, and 8-10 NAs. She said she had talked to the DON and the Administrator #2 multiple times throughout the day, but on one occasion when she talked to her the DON had told her she had just gotten back into her driveway after trying to get to the facility, she didn't know anyone who had a truck who could come get her, and she would try to find some staff to come to the facility to help her. She said when she had talked to the former administrator, she told her she was sorry, and she was going to call DON #1. She added there was a medication aide (MA) (NA #3) who had come in at 7:00 AM and left at 2:00 PM and there were 2 NAs	F 689	and preferences, ensure basic goods and services are provided to the residents, and review reported accidents. All falls will be reviewed and discussed during the meeting by the Director of Nursing, Assistant Director of Nursing, Supervisors, and/or Administrator to ensure no fall resulted from lack of supervision. Interventions will be implemented to include increasing supervision as warranted for any identified areas of concern. The falls review will be documented on a fall audit tool. The Administrator or Director of Nursing will review and initial the audit tools weekly x 8 weeks for compliance and to ensure all areas of concern were addressed. The Administrator will be responsible for forwarding the audit tools to the Quality Assurance Committee. The facility's Quality Assurance Performance Improvement (QAPI) committee will review the audit tools monthly x 2 months to identify trends and determine the need for further frequency of monitoring.		

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F 689	Continued From page 89 who had stayed over to help from night shift, but they had left before lunch time. She explained the NA shifts go from 7:00 AM to 3:00 PM, and no NAs arrived at the facility at 3:00 PM. She further explained the nurses work 12 hour shifts from 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM, and no nurses arrived at the facility at 7:00 PM. The nurse described the day as chaotic, residents were asking for their medications, she was trying to prioritize medications such as antibiotics and insulin to ensure residents received them timely, she and the other staff were unable to answer the facility phone, she was communicating with DON #1 and the former administrator via her personal cell phone which she was carrying with her, she was making periodic rounds on the dementia unit because there was not enough staff to have someone on that unit at all times, at about 4:30 PM one of the NAs was crying, asking if anyone else was going to come to help, and had a panic attack to the point where she felt like she was going to have to call 911 for the NA. The nurse further stated at one point during a conversation with the DON, the DON told her she had too much responsibility in the building and to go lay down for a while and she responded to the DON she was there to take care of the residents and that was her main priority. She said she did not know how long it had been, but at one point there were two police officers behind her, and they had informed her they had received 911 calls regarding the situation at the facility. She said through discussion with the police officers they had asked her who was in charge of the facility, and she responded she was, she was in the only nurse in the facility, there were two NAs, and they were providing care for all of the residents. She	F 689			

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F 689	<p>Continued From page 90</p> <p>explained shortly after that the facility was "swarming" with police, EMS, and firemen. She said they sat her down and were asking questions, seemed concerned about her and well-being, and she felt relieved to know she was going to get some help for caring for the residents. She further stated at 11:00 PM when the night shift NAs were supposed to arrive, no NAs arrived at the facility and the 2 NAs who had been there since 7:00 AM remained at the facility with her. She explained she did not know who the interim administrator was.</p> <p>A phone interview was conducted on 1/20/22 at 12:49 PM with Police Officer #1. She stated she and 2 other police officers arrived at Pine Ridge Nursing Home at about 8:09 PM on 1/16/22. The police officer stated she there were residents out and rolling around in the general facility area when they arrived inside of the building and there were several call lights on throughout the facility. She described when she went back to the dementia unit, there were no staff back there, the residents were observed to have been wandering throughout the unit, in and out of rooms, residents were behind the nurses ' station, and there were residents observed behind the nurses ' station putting items into their mouths.</p> <p>A phone interview was conducted on 1/20/22 at 3:09 PM with Police Officer #3. He stated he and 2 other police officers arrived at Pine Ridge Nursing Home at about 8:09 PM on 1/16/22. The police officer stated there was a nurse and 2 NAs at the facility and none of them were in the dementia unit when he rounded through the building. He said as he was approaching the</p>	F 689			

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F 689	<p>Continued From page 91</p> <p>dementia unit, which is a locked unit, he could see an elderly woman through the window on the door banging on the door. He then said when he entered the dementia unit, he could see residents wandering throughout the dementia unit with no supervision. He described the residents as wandering behind the nurses ' station desk, some of the residents who were behind the nurses ' station desk were going through the drawers. He said he had also observed a resident pushing an empty intravenous (IV) pole around the nurses ' station and dementia unit; there was nothing hanging on it, just an empty IV pole. He described the observation of the dementia unit as "shocking."</p> <p>During a round of the facility conducted on 1/17/22, which started at 11:07 AM, the dementia, or SPARC, unit was observed to have had two access points, one from the 100 hall and the other from the 200 hall. Both access points had magnetically locked double doors which could only be released by entering a code into a keypad located near the door. A code would have to be entered to either enter or exit the dementia unit. The observation of the unit revealed residents resting in bed, and residents up out of bed wandering about the unit. Several staff members were observed in the unit, some were assisting residents, and some staff members were located behind the desk at the nurses ' station. Attempts to interview residents were unsuccessful due to the cognitive loss of the residents. When questioned even with simple questions such as, how are you doing? Would illicit no response and the resident would look at you, but was unable to speak, or acknowledge an answer.</p>	F 689			

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F 689	<p>Continued From page 92</p> <p>During an interview conducted on 2/2/22 at 1:23 AM with Administrator #3 (who was the Assistant Regional Vice President prior to assuming the administrator role) he stated it was his expectation to follow the policy for the dementia unit and there should be staff in the dementia unit to supervise the residents, and care for their needs.</p> <p>Administrator #3 was made aware of the Immediate Jeopardy (IJ) on 1/22/22 at 1:23 PM.</p> <p>The facility shared the following plan to address the incident which alleged the facility had put into place measures to lower the scope and severity of the IJ as of 1/18/22.</p> <p>Removal Plan F689-Accidents</p> <p>Recipients who have suffered or are likely to suffer, a serious adverse outcome as a result of the non-compliance</p> <p>At 8:09 PM, after a resident called 911, local law enforcement arrived at the facility for a wellness check. It was determined that there was 1 Licensed Practical Nurse (LPN) and 2 Nursing Assistants on site and there were 25 residents on the special care dementia unit. Additional assistance was immediately provided at the facility by a County Emergency Medical Services individuals, including two nurses, directed by the County Emergency Management Director.</p> <p>As set forth in the immediate jeopardy preliminary findings, twenty-five dementia unit residents, were likely to suffer a serious adverse outcome based</p>	F 689			

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F 689	<p>Continued From page 93 on the non-compliance.</p> <p>Actions taken to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring</p> <p>On 1/16/22 at 9:20 PM the Administrator informed the Assistant Regional Vice President (ARVP) that the fire and police personnel were at the facility.</p> <p>Action steps taken were as follows:</p> <p>January 16, 2022:</p> <p>(1) 11:30 PM the Director of Nursing (DON) arrived at the facility to provide direct care and medications to residents in the special care dementia unit.</p> <p>(2) 11:45 PM, a call was held with the Administrator and Corporate support staff to implement Emergency Preparedness - inclement weather staffing plan.</p> <p>January 17, 2022</p> <p>At 12:35 AM, the corporate Registered Nurse (RN) facility consultants started contacting their local law enforcement to request transportation to the facility of staff for the special care dementia unit during the inclement weather.</p> <p>(1) The ARVP instructed corporate support staff to contact additional staffing agencies to request assisting the facility with staffing needs, for the special care dementia unit. The other staffing agency companies were able to provide assistance with the 7 AM-3PM shift on 1/17/22.</p> <p>(2) At 7:00 AM, the nurse unit manager arrived at</p>	F 689			

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F 689	<p>Continued From page 94</p> <p>the facility to assist the DON and other staff nurses with resident care in the special care dementia unit.</p> <p>(3) At 10:47 AM, the Corporate Clinical Director arrived in the facility, to provide direct resident care, in the special care dementia unit.</p> <p>(4) 11:30 AM, the supporting RN facility consultant arrived to assist with direct resident care in the special care dementia unit.</p> <p>(5) 12:00 noon, the assigned RN facility consultant arrived to assist with direct resident care in the special care dementia unit.</p> <p>(6) 1:00 PM, an additional RN consultant arrived to assist with direct resident care in the special care dementia unit.</p> <p>(7) By 2:30 PM, the nursing facility staff and agency nursing staff were able to make it to the facility and many came prepared to spend the night, including those who made longer term commitments to stay in the facility until weather cleared up. They provided care in the special care dementia unit.</p> <p>(8) At approximately 5:30 PM, the Assistant Regional Vice President (ARVP) suspended the Administrator for failure to implement the Emergency Preparedness Plan, sleep pay benefit. The ARVP assigned himself as the Interim Administrator during the investigation.</p> <p>As of 1/17/2022 at 2:30 PM sufficient staff were in the facility providing care for the residents in the special care dementia unit, including but not limited to incontinent care, medications as ordered, treatments as ordered, call lights answered timely, assessment of changes in condition, and supervision.</p>	F 689			

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F 689	<p>Continued From page 95</p> <p>On 1/17/22, the Interim Administrator and Human Resource Support Staff reviewed the staffing schedule for the upcoming 7 days to ensure sufficient number of staff to provide care for the residents in the special care dementia unit.</p> <p>Over the course of the next 7 days, the Interim Administrator, Divisional Vice President, and Human Resource Support Staff ensured there was enough of staff, on each shift, in each department, to provide care to residents in the special care dementia unit, in accordance with the resident care plans, plans were also made to address who would be spending the night if staff could not get into the facility and possible transportation options to get staff to the facility. After securing staffing for the special care dementia unit on 1/17/22, the facility implemented staffing meetings to review sufficient staffing for the special care dementia unit shifts going forward.</p> <p>Alleged Immediate jeopardy removal: 1/18/22</p> <p>Date of alleged Immediate Jeopardy removal: 1/18/2022</p> <p>The facility ' s credible allegation of compliance was validated through an on-site review process which included record review, observations, staff, corporate, and resident interviews. Date of IJ removal was validated as 1/18/22.</p> <p>2. A review of the medical record revealed Resident #8 admitted to the facility on 11/3/2020 and discharged to the hospital on 11/24/2021 after she developed a limp and pain to her right hip and an x-ray obtained in the facility indicated she had a right hip fracture. She returned to the facility on</p>	F 689			

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F 689	<p>Continued From page 96</p> <p>11/30/2021 after surgical repair of a right hip fracture. Resident #8 had diagnoses of osteoarthritis and dementia.</p> <p>Resident #8's Care Plan initiated 11/3/2022 stated she was at risk for fractures due to osteoarthritis and a Care plan initiated on 11/3/2021 stated she was at risk for falls due to a history of falls and impaired cognition.</p> <p>On 11/24/2021 an intervention to provide supervision as needed was added to Resident #8's Care Plan for Potential for Falls.</p> <p>Interventions of monitor for effectiveness and side effects of psychotropic drugs; rehabilitation therapy referral; and observe and interview for factors causing falls was added to Resident #8's Care Plan for Potential for Falls on 11/30/2021.</p> <p>A Significant Change Minimum Data Set (MDS) assessment dated 12/2/2021 indicated Resident #8 was severely cognitively impaired and had a history of falls.</p> <p>A Nurse's Progress Note written by Nurse #12 dated 12/12/2021 at 8:03 am stated Resident #8 was found on the floor in the hallway. The Nurse's Progress Note further stated the Nurse was alerted by Resident #8's roommate yelling for help.</p> <p>Attempts were made to contact Nurse #12 without success and the Director of Nursing #1 stated Nurse #12 was out of the country.</p> <p>An intervention of observe and intervene for factors causing falls, ie., bowel and bladder needs and</p>	F 689			

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F 689	<p>Continued From page 97</p> <p>mobility was added to the Potential for Falls Care Plan on 12/12/2021.</p> <p>On 12/26/2021 at 10:58 am Nurse #4's Nurse's Progress Note stated Resident #8 was noted on the floor in the hallway by staff. The note further stated Resident #8 slid to the floor from her wheelchair. Nurse #4's note stated Resident #8 was assessed and no injuries were noted.</p> <p>During a telephone interview on 1/25/2022 at 4:01 pm with Nurse #4 she stated Resident #8 was found on the floor when she fell on 12/26/2021. Nurse #4 stated Resident #8 was supposed to be monitored one to one but there was not enough staff. Nurse #4 stated she assessed Resident #8 after the fall on 12/26/2021 and she was not injured.</p> <p>A Nurse's Progress Note written by Nurse #1 and dated 1/1/2022 at 6:12 pm indicated Resident #8 fell at the Nurses Station from a standing position. The note stated staff were not able to get to Resident #8 before she fell.</p> <p>During a telephone interview with Nurse #1 on 1/24/2022 at 8:25 am she stated Resident #8 fell often and an intervention was put into place after she returned from the hospital on 11/30/2021 for her to have a staff member with her one to one to prevent further falls but there was not enough staff to assign a staff member to her. Nurse #1 stated the staff would try to watch Resident #8 as close as they could. Nurse #1 stated on 1/1/2022 when Resident #8 fell at the Nurse's Station she did not have a staff member assigned one to one with her, but the staff were trying to keep a close watch on</p>	F 689			

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F 689	Continued From page 98 her and do their assignment, which is why she was at the Nurse's Station when she fell. On 1/20/2022 at 2:40 pm a phone interview was conducted with the Family Member. The Family Member stated Resident #8 had fallen multiple times in the facility and she had been assured a staff member would be always with Resident #8 to prevent her from falling after she returned from the hospital on 11/30/2021. An interview was conducted with Director of Nursing #1 on 1/26/2022 at 8:16 am . Director of Nursing #1 stated she told the staff before and after Resident #8 was sent to the hospital with a fracture on 11/24/2021 she required one on one monitoring. Director of Nursing #1 further stated the facility was having staffing issues they could not always assign someone to Resident #8. During an interview with the Physician on 1/26/2022 at 11:08 am he stated Resident #8's history of dementia and osteoarthritis made her high risk for an injury, and he felt the facility had done the best they could to prevent an injury.	F 689			
F 725 SS=L	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses	F 725		3/22/22	

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F 725	<p>Continued From page 99</p> <p>of the facility's resident population in accordance with the facility assessment required at §483.70(e).</p> <p>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>(i) Except when waived under paragraph (e) of this section, licensed nurses; and</p> <p>(ii) Other nursing personnel, including but not limited to nurse aides.</p> <p>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record reviews, first responder, staff and interviews, the facility failed to provide adequate staffing to provide care and supervise resident safety during inclement weather (a winter storm) on 01/16/22. Nurse #1, Medication Aide (MA) #1 and two Nursing Assistants (NAs) (NA #1 and NA #2) reported to work on the morning of 01/16/22. MA #1 left the facility at 2:00 PM after she received permission to leave the facility from the Director of Nurses (DON) #1. The nurse and the 2 NAs remained as the only staff to provide resident care and services for 98 residents in the facility. Nurse #7 communicated the staffing situation of the facility to Administrator #2 and her concerns regarding the lack of care and quality of care the three of them could provide for the residents. Administrator #2 told the Nurse #7 that she was sorry about the situation and the staff needed to</p>	F 725	<p>Pine Ridge Health and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents and to meet requirements established by state and federal law. The Plan of Correction is submitted as a written allegation of compliance.</p> <p>Pine Ridge Health and Rehabilitation Center's response to this Statement of Deficiencies and Pine Ridge Health and Rehabilitation Center's earlier submitted credible allegation of immediate jeopardy removal does not denote agreement with</p>		

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F 725	<p>Continued From page 100</p> <p>do the best that they could. Police Officers arrived at the facility at 8:09 PM on 01/16/22 for a wellness check after 911 calls from a resident and after attempted calls to the facility from 911 dispatch went unanswered. This situation affected 98 of 98 residents.</p> <p>Immediate Jeopardy began on 01/16/22 when the facility failed to have adequate nursing staff scheduled during a winter storm on 01/16/22. Nurse #7, Nurse Assistant (NA) #1 and NA #2 were the only staff at the facility after 2:00 PM making all nursing care decisions and providing resident supervision for all 98 residents at the facility. The immediate jeopardy was removed on 01/18/22 when the facility implemented an acceptable credible allegation for immediate jeopardy removal. The facility remains out of compliance at scope and severity level F (potential for actual harm that is not immediate jeopardy) to ensure systems are put in place are effective.</p> <p>Findings included:</p> <p>A phone interview conducted with Nurse #9 and Nurse #10 on 01/26/22 at 4:23 PM revealed they were both agency nurses and worked from 7:00 PM on 01/15/22 until 7:00 AM on 01/16/22. Nurse #9 stated at about 6:30 AM on 01/16/22 Nurse #7 reported to work followed by MA #1 and NA #1 and NA #2. Nurse #7 asked where the nurse schedule or assignment sheet was for 01/16/22 and the nurses were not able to find the schedule or the list of nurse staff names and contact information (phone numbers). Nurse #9 and Nurse #10 informed Nurse #7 that no staff had called during the night to report the were not coming to work on</p>	F 725	<p>the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate or that any individual resident suffered or was likely to suffer actual harm or a serious adverse outcome. Further, Pine Ridge Health and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.</p> <p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>On 1/16/22 at 11:45 PM the administrator, with the assistance from the assistant regional vice president (ARVP), initiated the Emergency Preparedness Plan to ensure there was adequate staffing to provide care and supervise resident safety during inclement weather. The initiation of the Emergency Preparedness Plan included bringing in corporate support staff and additional agency staff to assist in providing basic goods and services to include but not limited to incontinent care, resident assessments, medications, nourishment, and basic housekeeping. On 1/17/22, the Regional RN MDS Consultant, supporting RN facility consultant, additional RN Consultant, facility staff and agency staff arrived at facility to provide direct resident care, including but not limited to incontinent</p>		

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F 725	<p>Continued From page 101</p> <p>01/16/22. Nurse #9 and Nurse #10 gave a report to Nurse #7 and MA #1 received the medication cart keys for the 200 hall and the 300 hall while Nurse #7 received medication cart keys for the 100 hall, 400 hall and 500 hall. Nurse #9 and Nurse #10 revealed at about 7:30 AM no other staff reported to work, and the night shift staff had left or was about to leave the facility. Nurse #7 called DON #1 and placed the call on speaker for Nurse #9 and Nurse #10 to hear. When Nurse #7 asked if she knew where the schedule was for 01/16/22 or if any staff had called out for work the DON told her she did not know where the schedule was, and she had not received any calls from staff during the night to report they were not able to get to work. Nurse #7 informed the DON that only four staff had reported to work. Nurse #9 and Nurse #10 told the DON that they would stay through breakfast to assist with breakfast and resident care but needed to leave at 12:00 PM because they were tired, but they would leave earlier if more staff arrived. Nurse #9 and Nurse #10 went to the secure dementia unit to give care and assist with breakfast because there was always one staff assigned to remain on that unit at all times. Nurse #9 revealed when she and Nurse #10 left at 12:00 PM no other staff had reported to work and the remaining four nursing staff would only be able to make rounds on the secure dementia unit.</p> <p>A phone interview conducted with Nurse #7 on 01/18/2022 at 3:39 PM revealed in part that on the morning of 01/16/22 when she arrived at work on 01/16/22 at 6:30 AM it had already started to snow. But, she explained, she packed extra clothes in case she was needed to stay at the facility past her shift that ended at 7:00 PM.</p>	F 725	<p>care, resident assessments, medications, and nourishment to all residents. As of 1/17/22, the interim administrator brought in a team of consultants to assist the facility. On 1/17/22, a consultant team including registered nurses, certified dietary manager, registered dietician, maintenance supervisor, human resources, and office support worked along-side facility staff to assist with and provide resident care. The consultant team assisted with supervision and resident safety.</p> <p>How the facility identified other residents having the potential to be affected by the same deficient practice:</p> <p>As set forth above, a corrective action plan was put in place and implemented for all residents. Measures put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>As of 1/17/22, the administrator is no longer working at the facility. The ARVP assigned himself as the interim administrator.</p> <p>As of 1/17/22, the interim administrator brought in a team of consultants to assist the facility seven days per week. The consultant team included registered nurses, certified dietary manager, registered dietician, maintenance supervisor, human resources, and office support. The consultant team assisted with and provided resident care. The</p>		

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F 725	Continued From page 102 Nurse #7 revealed she phoned DON #1 at about 7:30 to 8:00 AM and the DON was not aware of any staff not reporting to work and the DON had not received calls from staff about not being able to get to work on 01/16/22. Nurse #7 revealed the DON told her the staff needed to do the best they could and to focus on medication administration making insulin injections the biggest priority because blood sugar changes could cause residents a lot of harm. The DON also told Nurse #7 that she would notify Administrator #2, start to call staff and agencies to get extra help, and she had attempted to drive to the facility, but the ice and snow made the drive impossible which made her return home. Nurse #7 revealed that she had left a message for Administrator #2 but was not certain of the time except it was in the morning of 01/16/22, but when Administrator #2 returned the call to Nurse #7, Administrator #2 told Nurse #7 that she was sorry about the staffing situation. Nurse #7 revealed Nurse #9 and Nurse #10 left the facility at 12:00 PM. She said MA #1 left at 2:00 PM but had been scheduled until 7:00 PM. Nurse #7 revealed that she called the DON a little after 3:00 PM and reported that no staff arrived at 3:00 PM and the remaining staff was Nurse #7, NA #1 and NA #2. The DON told Nurse #7 to continue to do the best that they could. Nurse #7 explained it was very chaotic and the staff present had all worked together to give care, answer call lights, and Nurse #7's focus was on medication administration. Nurse #7 revealed sometime near 5:00 or 6:00 PM there was no prepared dinner for residents and there was no dietary staff was in the building. Nurse #7 and NA #2 were not able to find and sandwiches or other prepared dinner items for residents and decided to make peanut butter and	F 725	consultant team assisted with supervision and resident safety. The consultant team provided training, in-services, and competency training. The consultant team also assisted with scheduling agency staff and hiring new staff. As of 1/17/22, the interim administrator worked closely with the human resources department to review current applications, post on-line open positions, recruit new employees, and interview applicants. Multiple vacant positions have been filled including housekeeping/laundry supervisor, dietary manager, and nursing positions. On 1/17/22, the Interim Administrator and Human Resource Support Staff reviewed the staffing schedule for the upcoming 7 days to ensure sufficient number of staff to ensure residents are treated in a dignified manner to include providing incontinence care. The Interim Administrator and Human Resource Support Staff ensured there was enough staff, on each shift, in each department, to provide care to all residents in accordance with the resident plan of care. Agency staff was scheduled to supplement facility staff when necessary. Starting 2/15/22 the ARVP has employed a new Interim Administrator. On 2/15/22, the Interim Administrator was educated by the ARVP regarding how and when to enact the emergency preparedness plan, how and when to utilize resources to provide care for residents during inclement weather, how and when to communicate the urgency and potential impact of pending inclement weather to all		

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F 725	<p>Continued From page 103</p> <p>jelly sandwiches for the resident ' s dinner. Nurse #7 revealed she also had carried her cell phone with her because they were not able to answer the facility phone. Nurse #7 indicated that normally the facility was staffed with at least 3 nurses, 2 to 3 MAs and about 8 - 10 NAs. She further explained at least 1 NA and either 1 MA or 1 nurse was always assigned to the secure dementia unit. Nurse #7 revealed the staff was only able to make walking rounds to the secure unit and provide care at those times. Nurse #7 revealed she was aware some residents were angry about the lack of care and said they were going to call 911 because the care was late, or they did not receive care. Nurse #7 revealed she did not know that the Police Department came to the facility around 8:00 PM on 01/16/22 until one police officer walked up to her and asked her what was going on at the facility. Nurse #7 revealed she almost started to cry when she told the police officer, she was the only nurse at the facility along with NA #1 and NA #2. Nurse #7 explained to the police officer about the lack of care. She said after she explained what had happened to the police officer, he was able to get assistance, and she was so glad to see those Police Officers, Fire Department and Emergency Medical Services (EMS) enter the facility because they had come to help take care of the residents.</p> <p>MA #1 was interviewed via phone on 01/24/22 at 2:00 PM and she confirmed she worked from 7:00 AM until 2:00 PM o 01/16/22. She explained there was only one nurse and two NAs who came to work at 7:00 AM, but when they could not find a schedule to validate who was actually scheduled. MA #1 revealed she began to administer</p>	F 725	<p>administrative staff, how and when to communicate a potential crisis situation to all staff, and how and when to communicate a dangerously low staffing situation to the ARVP.</p> <p>As of 1/21/22, the Director of nursing is no longer working at the facility. The Interim Administrator designated an Interim Director of Nursing, start date 1/22/22. On 1/22/22, the Interim Director of nursing was educated by the ARVP on the emergency preparedness plan to include: how to manage facility staff during inclement weather by developing a plan in coordination with the Administrator to house staff at the facility, transport staff, arrange transport, and utilize community resources to provide transportation to the facility nurses and Nursing Assistants. On 2/7/22, the Housekeeping/laundry supervisor began working at the facility. The housekeeping/laundry supervisor was educated by the Administrator, regarding how and when to enact the emergency preparedness plan, how and when to utilize resources to provide services during inclement weather, how and when to communicate the urgency and potential impact of pending inclement weather to housekeeping/laundry staff, and how and when to communicate a dangerously low staffing situation to the Administrator. On 2/21/22, the Dietary manager joined the dietary team. The dietary manager was educated by the Administrator, regarding how and when to enact the emergency preparedness plan, how and when to utilize</p>		

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F 725	<p>Continued From page 104</p> <p>medications the residents on the 200 hall and 300 hall while answering call lights, giving as much resident care as she could, passing breakfast trays, passing bagged lunch meals, and assisting to feed residents. MA #1 revealed she received permission from DON #1 to leave the facility at 2:00 PM because of the winter storm. She explained no other staff came to the facility, so when she left only Nurse #7, NA #1 and NA #2 were the only staff to care for the residents at the facility. MA #1 explained usually there were at least three nurses scheduled, two or three MAs, and at least 10 NAs scheduled to work a typical day shift. MA #1 also explained that she had never experienced such a shortage of staff at the facility prior to that date, and she believed that residents received basic care, but they also lacked a lot of care.</p> <p>An interview was conducted with NA #2 on 01/19/22 at 10:28 AM. NA #2 revealed she was scheduled to work from 7:00 AM until 3:00 PM on 01/16/22 and when she arrived there was no schedule to check what staff was scheduled to work that day. She explained only she, Nurse #7, MA #1 and NA #1 reported to work that morning. NA #1 and NA #2 decided to just split the halls between the two of them and make frequent rounds to the secured dementia unit where normally at least two staff were assigned. She said it never happened before that staff was not able to remain on the on the dementia unit at all times. NA #2 revealed the night shift NAs had already left the facility when she arrived and that was unusual because in the past they had always stayed until they had relief. NA #1 revealed it sometimes took over 2 hours for resident call</p>	F 725	<p>resources to provide services during inclement weather, how and when to communicate the urgency and potential impact of pending inclement weather to dietary staff, and how and when to communicate a dangerously low staffing situation to the Administrator.</p> <p>On 2/28/22 the Interim Administrator contacted the Quality Improvement Organization to discuss the plan of correction and for further recommendations to the action plans.</p> <p>How the facility plans to monitor its performance to make sure that solutions are sustained</p> <p>Beginning 3/22/22, the Interim Administrator, Human Resource Support Staff, and/or the Interim Director of Nursing will conduct staffing meetings to ensure there is enough of staff, on each shift, in each department, to provide care and provide supervision to prevent accidents to all residents in accordance with the resident care plans. Supplemental staffing will be utilized to fill openings identified. During the staffing meeting, plans will be made to address staff spending the night if inclement weather is forecasted. The staffing meetings will occur five days a week x 8 weeks with review and discussion of schedules for the clinical, dietary, and housekeeping departments and documented on a staffing audit tool.</p>		

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F 725	<p>Continued From page 105</p> <p>lights to get answered or for residents to receive care. She said on 01/16/22 the dinner meal was late, and residents were unhappy and complained about the lack of staff and lack of care. NA #2 revealed when no staff came to work at 3:00 PM, the start of the next shift when typically, more staff would arrive, she had a panic attack because she was so tired and felt compelled to stay and keep working, even though had no breaks and no meals. NA #2 explained that she did not leave the facility until after 11:00 PM when Police Officers and EMS were in the facility and assisted with care.</p> <p>On 01/20/22 at 1:55 PM an interview was conducted with NA #1, and he revealed that he arrived for work at about 7:15 AM on 01/16/2022. He explained the snow slowed him down a little bit and that was how come he had not arrived at or prior to 7:00 AM and he was scheduled to work from 7:00 AM until 3:00 PM. NA #1 said that when he arrived at the facility, he did not see many cars in the parking lot and when he entered the facility, he went to the nurse station to find his assignment Nurse #7 told him there was not an assignment because it was just him and NA #1 and she could not find the schedule. He and NA #1 decided to split the halls and start making resident care rounds, answering call lights, delivering breakfast, and eventually passed out lunch. When it came time for supper, NA #1 Revealed he, NA #1, and Nurse #7 had to make sandwiches for the residents because they had not found any prepared meals for dinner on 01/16/22. NA #1 explained he worked as quick as possible and tried to get to each resident timely to provide care but that was not possible, and residents were unhappy. He said the residents</p>	F 725	The Administrator will be responsible for forwarding the audit tools to the Quality Assurance Committee. The facility's Quality Assurance Performance Improvement (QAPI) committee will review the staffing audit tools monthly x 2 months to identify trends and to determine the need for further frequency of monitoring.		

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F 725	<p>Continued From page 106</p> <p>were complaining because they had to wait for care and for food, but they thanked him for all that he was able to do for them. NA #1 revealed that he was upset and felt overwhelmed that the facility had no arrangements to get staff to the facility during the storm as they always had for past storms. NA #1 revealed he never heard about any preparations for the pending winter storm on 01/16/22 from anyone at the facility which also disappointed him. NA #1 explained the worst part was that on 01/16/22 he had to make the residents wait for care, and he felt the residents had to suffer for other people ' s decisions and poor planning.</p> <p>During an interview conducted with Administrator #2 at 2:08 PM on 01/17/22 she stated according to the schedules for 01/16/22 the facility to be fully staffed, but the scheduled staff had not shown up for work as scheduled. Administrator #2 revealed she was in constant contact with the (Director of Nursing) DON #1 and Nurse #7 and she attempted to call all of the transport services she knew of to try to get staff, the DON and herself to the facility but had no success.</p> <p>01/18/2022 at 12:50 PM an interview with DON #1 revealed she had been made aware earlier in the previous week about the possibility of a winter weather storm, she believed Administrator #2 was aware of the pending winter storm, but she had not discussed any of the preparations with the DON. The DON revealed on 01/16/22 she received a phone call from Nurse #7 and was informed of the poor staffing at the facility. The DON added she tried to drive to the facility after Nurse #7 called her, she thought it was shortly after 7:00 AM, but</p>	F 725			

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F 725	<p>Continued From page 107</p> <p>the roads were icy, and she turned around and went home. The DON revealed she had not received calls from any staff about not reporting to work because staff knew they had to call her or a nurse manager at least 2 hours before their scheduled start time. The DON said she called Administrator #2 and made her aware of the staffing; administrator #2 told the DON she had tried to get to work but her car got stuck and she was trying to find a ride to the facility. The DON admitted that she gave permission for MA #1 to leave the facility at 2:00 PM because of the winter weather, even though she was scheduled to stay at work until 7:00 PM. The DON explained she had attempted to call staff to come work at the facility, but no one answered their phone, or told the DON they could not drive to work because of the weather and road conditions. The DON knew that Nurse #7 was very busy and not able to document on all residents. The DON stated they did not have staff assigned to the secure dementia unit as they normally did but that Nurse #7, NA #1 and NA #2 worked very hard and did the best that they could.</p> <p>A phone interview was conducted on 1/20/22 at 12:49 PM with Police Officer #1. He stated he and two other two police officers arrived at the facility on 01/16/22 at 8:09 PM and only 1 nurse (Nurse #7) and two NAs were working at the facility. Police Officer #2 interviewed Nurse #7 and was told she had been in contact with DON #1 and Administrator #2 many times, but no more staff came to the facility. She further explained to the police officer the three staff were exhausted and this was "one of the worst things she had ever seen." She said that she was not able to answer</p>	F 725			

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F 725	<p>Continued From page 108</p> <p>the phone because she was busy administering medications. Police Officer #1 described five to six call lights were on in the hallway he was on, multiple residents complained they were hungry, a few rooms had strong smells of urine and feces, and some resident rooms had garbage on the floors. Police Officer #1 revealed he had seen some residents in the secure dementia unit behind the nurse station, putting items in their mouths, and were wandering around the unit.</p> <p>Police Officer #2 was interviewed on 01/20/22 at 1:14 PM via phone. Officer #2 explained he was one of three Police Officers that arrived at the facility at 8:09 PM on 01/16/22 and when he made contact with Nurse #7, she almost started to cry. Nurse #7 explained that only two NAs were at the facility with her. Police Officer #2 stated it was a very emotional ordeal at the facility. Police Officer #2 revealed Nurse #1 reported that some residents had not received lunch or dinner. He observed residents crying that they had not received medications or food that day and the facility smelled horribly of urine and feces. Police Officer #2 revealed that Emergency Medical Services (EMS), the Fire Department, Public Health Director and County Emergency Management were all notified of the status at the facility and responded by sending support staff to the facility.</p> <p>A phone interview conducted with Emergency Medical Technician (EMT) #2 on 01/19/22 at 9:30 PM revealed that he arrived at the facility about 9:30 PM on 01/16/22 and to assist Police Officers and the Fire Department. Emergency Medical Services (EMS) began a mass triage of all residents and he described residents were</p>	F 725			

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F 725	<p>Continued From page 109</p> <p>incontinent, spilled liquids in resident rooms, and spills in the hallway. He revealed they obtained vital signs, provided incontinent care, assisted with meals, and answered call lights.</p> <p>A phone interview conducted on 01/19/22 at 10:29 AM with Emergency Response Team Nurse (ERTN) #1 revealed that he and ERTN #2 were part of the County Emergency Response Team that were dispatched to the facility at 11:30 PM on 01/16/22. He revealed that Nurse #7 provided him with resident information and he and the other ERTN began obtaining resident vital signs, familiarizing themselves with the medication carts and Medication Administration Records (MARs) for medications that needed to be administered. He further stated they reviewed the Treatment Administrations Records (TARS) for treatments that needed to be performed.</p> <p>A phone interview conducted on 01/26/22 with the DON #1 revealed the facility had been short staffed since the summer and Administrator #2 was made aware but never addressed staffing. The DON revealed that the facility never experienced a staffing shortage like they did on 01/16/22 even with staff from agencies. The DON revealed she and Administrator #2 never spoke about plans for staffing or plans for staff transportation prior to the winter storm on 01/16/22.</p> <p>On 02/02/22 at 1:23 PM Administrator #3 was interviewed and stated he expected all vacant positions be posted. He further stated he expected for the facility continue to work with agencies to provide staff and arrangements were to be in place to transport staff to work as scheduled.</p>	F 725			

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F 725	<p>Continued From page 110</p> <p>Administrator #3 was notified of Immediate Jeopardy on 01/21/22 at 12:31PM.</p> <p>The facility shared the following credible allegation of immediate jeopardy removal. Residents who have suffered or are likely to suffer, a serious adverse outcome as a result of the non-compliance</p> <p>Prior to 8:09 PM, the administrator identified there was inadequate staffing in the facility due to the administrator not planning for or making arrangements for adequate staffing prior to inclement weather.</p> <p>At 8:09 PM, after a resident called 911, local law enforcement arrived at the facility for a wellness check. It was determined that there was 1 LPN and 2 Nursing Assistant on site and there were 98 residents which were in need of care and services. It was determined that the facility was non-compliant with Tag 725 based on the staffing at the facility on 1/16/2022. Additional assistance was immediately provided at the facility by a County Emergency Medical Services individuals, including two nurses, directed by the County Emergency Management Director.</p> <p>As set forth in the immediate jeopardy preliminary findings, all residents were likely to suffer a serious adverse outcome based on the non-compliance. Actions taken to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring</p>	F 725			

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F 725	<p>Continued From page 111</p> <p>On 1/16/22 at 9:20 PM the Administrator informed the Assistant Regional Vice President (ARVP) that the fire and police personnel were at the facility. On 1/16/22 at 9:52 PM, the ARVP updated the Divisional Vice President (DVP) about sufficient staffing at the facility. The DVP initiated a conference call with corporate support staff and Corporate staff put in place the Emergency Preparedness Plan to obtain additional staff and address the issues at the facility impacting residents.</p> <p>Action steps taken were as follows:</p> <p>January 16, 2022:</p> <p>(1) 11:30 PM the DON arrived at the facility to provide direct care and medications to the residents.</p> <p>(2) 11:45 PM, a call was held with the Administrator and Corporate support staff to implement Emergency Preparedness - inclement weather staffing plan.</p> <p>January 17, 2022</p> <p>At 12:35 AM, the corporate RN facility consultants started contacting their local law enforcement to request transportation to the facility during the inclement weather.</p> <p>(1) The ARVP instructed corporate support staff to contact additional staffing agencies to request assistance the facility with staffing needs. The other staffing agency companies were able to provide assistance with the 7 AM-3PM shift on</p>	F 725		

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F 725	Continued From page 112 1/17/22. (2) At 7:00 AM, the nurse unit manager arrived at the facility to assist the DON and other staff nurses with resident care. (3) At 8:02 AM, the Mobile Certified Dietary Manager arrived in the kitchen, to assist in meal preparation and delivery. (4) At 10:47 AM, the Corporate Clinical Director arrived in the facility, to provide direct resident care. (5) 10:50 AM, the Divisional Vice President arrived at the facility to assist in obtaining additional staff and meal delivery. (6) 11:00 AM, Corporate Employee Experience personnel arrived at the facility, to obtain additional staff. (7) 11:30 AM, the supporting RN facility consultant arrived to assist with direct resident care. (8) 12:00 noon, the assigned RN facility consultant arrived to assist with direct resident care. (9) 1:00 PM, an additional RN consultant arrived to assist with direct resident care. (10) By 2:30 PM, the nursing facility staff and agency nursing staff were able to make it to the facility and many came prepared to spend the night, including those who made longer term	F 725			

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F 725	<p>Continued From page 113</p> <p>commitments to stay in the facility until weather cleared up.</p> <p>(11) At approximately 5:30 PM, the Assistant Regional Vice President (ARVP) suspended the Administrator for failure to implement the Emergency Preparedness Plan, sleep pay benefit. The ARVP assigned himself as the Interim Administrator during the investigation.</p> <p>As of 1/17/2022 at 2:30 PM sufficient staff were in the facility providing care for the residents, including but not limited to incontinent care, medications as ordered, treatments as ordered, call lights answered timely, assessment of changes in condition, and supervision of the dementia unit and COVID unit.</p> <p>On 1/17/22, the Interim Administrator and Human Resource Support Staff reviewed the staffing schedule for the upcoming 7 days to ensure sufficient number of staff to provide care for the residents. Over the course of the next 7 days, the Interim Administrator, Divisional Vice President, and Human Resource Support Staff ensured there was enough of staff, on each shift, in each department, to provide care to all residents in accordance with the resident care plans, plans were also made to address who would be spending the night if staff could not get into the facility and possible transportation options to get staff to the facility. After securing staffing for 1/17/22, the facility implemented staffing meetings to review sufficient staffing for shifts going forward.</p> <p>Alleged Immediate jeopardy removal: 1/18/22.</p>	F 725			

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F 725	Continued From page 114 The facility ' s credible allegation of compliance was validated through an on-site review process which included record review, observations and interviews with staff and residents. Date of IJ removal was validated as 01/18/22.	F 725			
F 802 SS=L	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2) (ii). This REQUIREMENT is not met as evidenced by: Based on staff, resident, police interviews, Emergency Medical Services (EMS) interviews and record reviews, the facility failed to provide dietary staff who were competent to carry out food and nutrition services during a winter weather storm on 01/16/22. Dietary staff made the decision without consultation with the Mobile Certified Dietary Manager (MCDM) or the Consulting Registered Dietitian (RD) to prepare	F 802	Pine Ridge Health and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents and to meet requirements established by state and federal law. The	3/22/22	

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F 802	<p>Continued From page 115</p> <p>bags of food to be consumed for lunch and dinner and then leave the building at around 1:00 PM in the afternoon. This left no dietary staff in the building after lunch. The decision was authorized by Administrator #2. There was no communication with the nursing staff about the intent of the bagged lunch to last for lunch and dinner, how the potentially hazardous food was to be kept safe between the time of distribution to the residents at lunch until the dinner meal, where additional prepared sandwiches were stored or when dietary staff left the building. When it was dinner time, residents became unhappy that there was no food delivery. Nursing staff responded by preparing sandwiches as they made rounds. Police arrived on the scene and found residents hungry. Emergency Medical Staff (EMS) were alerted and assisted in food preparation and feeding of residents. This situation affected 97 of 98 residents.</p> <p>Immediate Jeopardy began on 01/16/22 when the facility failed to have any dietary staff on duty to prepare and distribute a dinner meal on 01/16/22. Nurse #7, Nurse Aide (NA) #1 and NA #2 had to try and prepare food in addition to provide nursing care to the residents of the facility. The immediate jeopardy was removed on 01/18/22 when the facility implemented an acceptable credible allegation for immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of an F (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure systems put in place are effective.</p> <p>Findings included:</p>	F 802	<p>Plan of Correction is submitted as a written allegation of compliance.</p> <p>Pine Ridge Health and Rehabilitation Center's response to this Statement of Deficiencies and Pine Ridge Health and Rehabilitation Center's earlier submitted credible allegation of immediate jeopardy removal does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate or that any individual resident suffered or was likely to suffer actual harm or a serious adverse outcome. Further, Pine Ridge Health and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.</p> <p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 1/17/22, the assistant regional vice president (ARVP) assisted the administrator in ensuring the facility had dietary staff who were competent to carry out food and nutrition services. The second ARVP provided transportation to dietary staff needing transport to work. Second, the Corporate Dietary Consultant and mobile certified dietary manager (MCDM) provided supervision in the dietary department. Third, on 1/21/22 the facility</p>		

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F 802	Continued From page 116 Timecards were reviewed for Dietary staff for 1/16/22. Cook #1's time was from 5:20 AM - 1:03 PM. Dietary Aide (DA) #1's time was from 6:39 AM - 9:37 AM. Prep Cook #1's time was from 7:54 AM - 11:35 AM and Cook #2's time was from 9:41 AM - 6:20 PM. The ending time stamp did not match the time Cook #2 actually left the building according to Cook #2's interview. An interview was conducted with Cook #1 on 01/20/22 at 10:13 AM. Cook #1 revealed he arrived at the facility at 5:20 AM on 01/16/22 as scheduled and Dietary Aide #1 arrived at 6:30 AM. The scheduled Prep Cook #1 arrived at 8:00 AM or very close to that time. Cook #1 revealed they prepared a hot breakfast meal for the residents and those meals were delivered to the halls as normally scheduled at 8:00 AM. Cook #1 reported he had a phone conversation with Administrator #2 on 01/16/22 and informed her that because of the weather he was allowing both Dietary Aide #1 and Prep Cook #1 to leave the facility earlier than scheduled and he explained that he would like to provide the residents with bagged lunches for the lunch and dinner meals. He said each resident would have their own bag and attached to the outside would be each resident's individual meal tray ticket so that they would be easily identified by the nurse staff. Cook #1 stated that Administrator #2 gave him permission and he did not contact the Registered Dietitian (RD) and did not contact the MCDM to review the plan for the bagged meals. Cook #1 explained Prep Cook #1 began to make a cold bean salad and Prep Cook #1 pureed the salad to place in individual bags for residents that required a mechanically altered or	F 802	provided education to all staff to include dietary staff on the emergency preparedness plan during inclement weather which included contact phone numbers to utilize in case of low staffing or assistance with providing meals. How the facility identified other residents having the potential to be affected by the deficient practice: On 1/17/22, the Mobile Certified Dietary Manager (MCDM) and registered dietitians reviewed residents' electronic health records to assess negative outcomes due to lack of dietary staff on 1/16/22. On 1/17/22, dietary staff met with residents and ensured that all residents received their three scheduled meals and any requested snacks or additional food. There were no additional identified areas of concern. On 1/17/22, the MCDM checked the facility's emergency food supply and ensured disaster menus and plans are in place at the facility as outlined in the dietary manual. There were no identified areas of concern. Measures put into place or systemic changes made to ensure the deficient practice will not recur: On 1/17/22, the MCDM educated the dietary staff on the emergency preparedness plan during inclement weather. Such education and training to include sleep pay for staying at the facility during inclement weather and expectations regarding leaving facility during an		

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F 802	Continued From page 117 puree meal. Cook #1 also included that he and Prep Cook #1 made chicken salad and that was also pureed for those residents that required a mechanically altered or puree meal and that all the pureed foods were placed in separate bowls and placed in the bags for those residents along with apple sauce, puddings and thickened liquids as ordered. Cook #1 reported he and the other dietary staff also stocked the nourishment rooms on the units with all forms of snacks that included sugar free foods, extra liquid thickener, chips and crackers and they also stocked the nourishment room and dining room refrigerators and freezers with ice cream, pudding, apple sauce, pre thickened liquids and a multiple variety of foods and snacks prior to leaving the facility. Cook #1 stated he then gave permission for Dietary Aide #1 and Prep Cook #1 permission to leave early. Cook #1 contacted Cook #2 to come to the facility to assist with the bagged lunch and dinner meal. When Cook #2 arrived he explained the bagged meal plans to her and both of them prepared a bagged meal for each resident. They placed 2 sandwiches in the bags for the residents who did not require mechanically altered diets. Cok #1 stated that he spoke to Nurse #7 and explained to her the plan was for residents to receive meals in bags, that he would bring them to the nurse stations on rolling metal carts at lunch time. He also told Nurse #7 he spoke to Administrator #2 and had received her permission to use the bags on that day. Cook #1 revealed he and Cook #2 made a bagged meal for each resident and took them to the nurse stations along with extra drinks on ice in metal bins. Cook #1 and Cook #2 left the facility at about 1:00 PM. Cook #1 did not notify Nurse #7 nor the two nurse assistants (NAs) that	F 802	emergency including inclement weather. The education was completed on 3/22/22. Any dietary staff that has not worked and completed the Inservice will complete upon their next scheduled shift. The Mobile Director of Nursing, Director of Nursing, Clinical Support Staff, or dietary manager will ensure all newly hired staff and newly scheduled agency will complete the Inservice during orientation. On 1/17/22, Interim Administrator and MCDM reviewed the Dietary Staffing Schedule with the Dietary Manager for the next 7 days to ensure sufficient dietary staff were scheduled to provide adequate meals during each meal service. There were no identified areas of concern. On 2/28/22 the Interim Administrator contacted the Quality Improvement Organization to discuss the plan of correction and for further recommendations to the action plans. How the facility plans to monitor its performance to make sure that solutions are sustained: Beginning 3/22/22, the Interim Administrator, Human Resource Support Staff, and/or the Interim Director of Nursing will conduct staffing meetings to ensure there is enough of staff, on each shift, in each department to include dietary. The Dietary Manager attend or review the staffing meetings to discuss staffing in the dietary department. Supplemental staffing will be utilized to fill open dietary positions identified. During the staffing meeting,		

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F 802	<p>Continued From page 118</p> <p>the dietary staff would be gone from the facility at 1:00 and would not return that day.</p> <p>On 01/17/22 at 11:07 AM an interview was conducted with Cook #1. Cook #1 revealed that he did not work the previous night (01/16/22) and that no dietary staff worked after 1:00 PM on 01/16/22.</p> <p>A phone interview with Cook #2 was conducted on 01/21/22 at 9:19 AM. Cook #2 revealed on 01/16/22 she received a call from Cook #1 and was asked to report to the facility as soon as she could that morning prior to her scheduled time which was at 1:00 PM. Cook #2 revealed she arrived at the facility near 9:30 AM and that she observed Dietary Aide #1 leaving the facility at that time. Cook #2 revealed that when she entered the kitchen, she observed Cook #1 and Prep Cook #1 making cold bean salad and chicken salad sandwiches, Prep Cook #1 was mechanically pureeing those items and scooping them into small individual sized bowls. Cook #2 revealed Cook #1 explained he had talked to Administrator #2 and had received the approval to make a bagged meal for all the residents that contained each resident's specific diet. Cook #2 further explained that for residents who required any type of mechanically altered foods, a bagged lunch with bowls in them with each item was placed in a bag for the resident along with the type of drink required for each specific resident. Residents who were able to eat a regular diet were packed two sandwiches along with a drink and a variety of other snacks like cookies, crackers and chips. Cook #2 revealed that they stapled each bag with each tray label on the outside of each bag and there was one bag for each resident. Then Cook</p>	F 802	<p>plans will be made to address staff spending the night if inclement weather is forecasted. The staffing meetings will occur five days a week x 8 weeks with review and discussion of schedules for the clinical, dietary, and housekeeping departments and documented on a staffing audit tool. The Administrator will be responsible for forwarding the audit tools to the Quality Assurance Committee. The facility's Quality Assurance Performance Improvement (QAPI) committee will review the staffing audit tools monthly x 2 months to identify trends and to determine the need for further frequency of monitoring.</p>		

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F 802	<p>Continued From page 119</p> <p>#2 rolled the bags along with a bin of ice and extra drinks to the nurse stations at about 12:00 PM which was the scheduled lunch time. Cook #2 revealed she left the facility with Cook #1 at about 1:00 PM and she did not return to the facility on 01/16/22.</p> <p>A phone interview with Prep Cook #1 conducted on 01/24/22 at 2:29 PM revealed he arrived at the facility as scheduled the morning of 01/16/22 but he had been later than usual because of the ice and snow. Prep Cook #1 revealed he made the cold bean salad that was scheduled for the dinner meal and he made chicken salad. He pureed both of those items as directed by Cook #1 and the pureed items were scooped into individual serving sized bowls. He assisted to make chicken salad sandwiches and some other sandwiches. Prep Cook #1 assisted wrapping the sandwiches individually. Cook #1 told him to leave the facility early at around 1:30 PM because of the snowstorm. Prep Cook #1 revealed he did not know any details about the bagged meals or what happened after he left for the day.</p> <p>An interview conducted with the Mobile Certified Dietary Manager (MCDM) conducted at 9:54 AM on 01/20/22 revealed she had not been contacted by Cook #1, Cook #2, the Director of Nurses (DON) or Administrator #2 about the emergency meal menu or other dietary concerns at the facility on 01/16/22. The MCDM also revealed she did not know that bagged meals were part of the emergency meal preparations for the facility.</p> <p>On 01/18/22 at 11:45 AM the Registered Dietitian (RD) was interviewed and revealed. The RD</p>	F 802			

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F 802	<p>Continued From page 120</p> <p>revealed she did not have any role in the kitchen staff or their schedules.</p> <p>An interview conducted with Resident #7 on 01/17/22 at 9:20 AM revealed on 01/16/22 her breakfast tray was delivered at 9:20 AM and she did not receive anything but a sandwich for lunch. At about 9:45 PM on 01/16/22 she received another sandwich and a bag of chips for dinner. Resident #7's most recent Minimum Data Set (MDS) with an assessment date of 11/04/21 included that Resident #7 had no cognitive impairment.</p> <p>During an interview with Resident #11 on 01/17/22 at 12:19 PM she revealed she had received her breakfast tray about 9:25 AM on 01/16/22 and the lunch meal was only a sandwich or two delivered in a paper bag. Dinner was also a sandwich that the two Nursing Assistants had to scavenge to make. A review of the most recent MDS for Resident # 11 dated 12/21/21 revealed Resident #11 had no cognitive impairment, had diabetes mellitus and received a therapeutic diet.</p> <p>On 01/19/2022 at 10:28 AM an interview with NA #2 revealed on 01/16/2022 they had been given bagged lunches labeled with meal tickets for each resident and that almost every bag contained 2 sandwiches and a bunch of snack items that the nurse staff delivered to the residents and there were pureed foods in bowls for the residents that required them. NA #2 revealed at the time she was not aware one of the two sandwiches was meant to be saved for dinner and about 5:00 PM NA #2 and Nurse #7 went into the kitchen to look for more bagged items but were not able to find any,</p>	F 802			

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F 802	<p>Continued From page 121</p> <p>so they agreed to make sandwiches for the residents. They were still making sandwiches and passing them out to residents when EMS arrived at the facility. EMS assisted making more sandwiches, passing them out and assisted to feed residents as needed. NA #2 stated she had not seen any dietary staff since about 1:00 PM on 01/16/22 and there had always been dietary staff in the facility through dinner.</p> <p>An interview conducted with NA #1 on 01/20/22 at 1:55 PM revealed on 01/16/22 around the dinner meal he was told by Nurse #7 that there was no prepared dinner meal for the residents. He explained that Nurse #7 and NA #2 went into the kitchen and returned with bread, peanut butter, and jelly and the three of them would need to make sandwiches for the residents as they continued to make rounds. NA #1 also explained he had not seen any dietary staff in the facility after about 1:00 PM. NA #1 revealed the facility had never used paper bags to serve meals to residents before and he was glad when EMS came to the facility with the police and assisted to make sandwiches, serve them and assisted residents to eat.</p> <p>Nurse #7 was interviewed via phone on 01/18/22 at 3:39 PM. Nurse #7 revealed on 01/16/22, Cook #1 approached her and explained that residents would be served bagged meals for both lunch and dinner and that he would bring the bagged meals to the nurse stations in time for lunch. Nurse #7 revealed when the nurse staff began to pass the bagged meals to residents at lunch they discovered the nurse discovered that some of the bags contained two sandwiches along with a drink</p>	F 802			

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F 802	<p>Continued From page 122</p> <p>and other items and that each resident had only one bag. Nurse #7 revealed residents were asking about dinner and she phoned the DON and Administrator #2 to ask about the dinner meal. The DON explained she had no idea about the dinner meal. Administrator #2 said Cook #1 had left more sandwiches in the walk -in cooler in the kitchen and if any residents had received two sandwiches in a bag one of them should have been saved for dinner. Nurse #7 revealed she had not been made aware of that plan. Nurse #7 and NA #2 went into the kitchen. They had no idea where the walk- in cooler was and did not find any made sandwiches. They grabbed some bread, peanut butter and jelly and decided that they would make more sandwiches for residents as they continued to make rounds. Nurse #7 revealed she had never experienced a time when there was no meal prepared by the dietary staff and she had not been aware that there was no kitchen staff at the facility until the DON told her. Nurse #7 also revealed some residents complained of hunger and she said it had been difficult for her and the two NAs to keep up with meals while providing all the care that was needed, but they kept doing as much as they could for the residents. When Emergency Medical Services (EMS) arrived, they assisted her and the two NAs to make and provide meals to the residents.</p> <p>On 01/18/2022 at 12:50 PM (Director of Nursing) DON #1 was interviewed and explained that on 01/16/22 at about 5:20 PM she was informed by Nurse #7 that she and NA #2 went into the kitchen to find resident bagged dinner meals that Nurse #7 believed the dietary staff had prepared. They had not been able to find any prepared bag</p>	F 802			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 802	<p>Continued From page 123</p> <p>meals or premade sandwiches. The DON told Nurse #7 she would call Administrator #2 and find out the status of the dinner meal. The DON revealed that she spoke to Administrator #2 and then called Nurse #7 and reported that Cook #1 had left premade sandwiches in the kitchen's walk-in cooler and that Nurse #7 was instructed to go back to the kitchen and look again.</p> <p>Administrator #2 was interviewed on 01/17/22 at 2:08 PM and revealed she had talked to Cook #1 on 01/16/22 around 12:00 PM. She said Cook #1 explained that he had called Cook #2 and asked her to come to the facility earlier than scheduled to assist in the kitchen. Administrator #2 revealed Cook #1 allowed Dietary Aide #1 and the Cook Prep #1 to leave earlier than scheduled because of the weather. Cook #1 also asked her if it was okay to provide the residents with bagged lunch and dinner meals. Administrator #2 agreed with Cook #1's plan for bagged meals and agreed with his plans to leave extra sandwiches in the walk-in cooler in the kitchen. Administrator #2 reported around dinner time she received phone calls from both the DON and Nurse #7. They asked about dinner for the residents. Administrator #2 explained Cook #1 had left extra sandwiches in the walk-in cooler in the kitchen. Administrator #2 revealed she was not aware that there were still concerns about the dinner meal until about 9:00 PM and 10:00 PM when she received calls from some family members of residents that reported dinner had not been served to residents that evening.</p> <p>A phone interview was conducted on 1/20/22 at 1:14 PM with Police Officer #2. He stated he and</p>	F 802			

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F 802	<p>Continued From page 124</p> <p>two other two police officers arrived at the facility on 01/16/22 at 8:09 PM. There was only 1 nurse (Nurse #7) along with two NAs working at the facility. When he interviewed Nurse #7 he asked if the residents had eaten or been fed. Nurse #7 revealed the residents had received breakfast and she believed that all received lunch from a paper bag that had been prepared by the dietary staff. She and the two NAs were trying to give residents sandwiches for dinner that they were making as they went down the hall providing care. Police Officer #2 revealed some of the residents told him they had not received food and they were very hungry. Police Officer #2 revealed EMS arrived shortly after the police arrived and they assisted to provide food and feed residents.</p> <p>A phone interview was conducted on 01/19/22 at 9:30 PM with EMS #1. EMS #1 revealed when he arrived at the facility at 9:30 AM on 01/16/22 multiple residents said they received a bagged lunch but no dinner meal. EMS #1 revealed that the EMS staff and Fire Department looked through the kitchen and nourishment rooms and did find some sandwiches and drinks for the residents, but nothing was labelled and they also found some thickened drinks and applesauce to feed the residents.</p> <p>Administrator #3 was interviewed on 02/02/22 at 1:23 PM and he stated it was expected the facility maintain the appropriate staff to work as scheduled to ensure that the nutritional need of all residents be maintained.</p> <p>Administrator #3 was notified of Immediate Jeopardy on 01/21/22 at 12:31PM.</p>	F 802			

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F 802	<p>Continued From page 125</p> <p>The facility shared the following credible allegation of immediate jeopardy removal.</p> <p>At 8:09 PM, on 1/16/22 local law enforcement arrived at the facility for a wellness check. It was determined that due to a severe ice storm there was 1 LPN and 2 Nursing Assistants on site and there were 97 residents which were in need of care and services. Residents were provided with bagged meals at lunch time that contained a variety of sandwiches, chips, fruit cups, puddings, cakes, and crackers. Pureed consistency was also provided to include meat, bread, three-bean salad, and pudding. The bags provided at lunch included meals for lunch and dinner which included the tray card for each resident attached to each resident's bag. Each tray card includes the resident's name, room number, allergies, diet consistency, and ordered diet type. Additionally, approximately 100 sandwiches were prepared and accessible. The dietary staff notified the administrator that the sandwiches were in the kitchen's walk-in cooler and the kitchen was unlocked. The nourishment room on the dementia unit, and the nourishment room at the main dining room was stocked with snacks and food to include sugar free chocolate ice cream, milk, soda, sandwiches, pudding, applesauce, and thickened liquids. The last two dietary staff members left the facility at 1:03 PM with approval from the Administrator and notified the administrator where the prepared food could be found. The nurse staff were not informed by the dietary staff that they were leaving or where the prepared food could be found. Emergency Management Services personnel that were on site assisted with providing food delivery to the residents.</p>	F 802			

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F 802	<p>Continued From page 126</p> <p>It was determined that the facility was non-compliant with Tag 802 based on the facility failing to have sufficient nutrition staff to provide dinner during inclement weather. The Administrator did not ensure sufficient dietary staff were present at the facility to appropriately deliver the last meal of the day.</p> <p>As set forth in the immediate jeopardy preliminary findings, all residents were likely to suffer a serious adverse outcome based on this identified non-compliance except for one resident who received tube feedings.</p> <p>Actions taken to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring</p> <p>The facility took the following immediate corrective action to ensure that adequate dietary staff is available to ensure that each meal be prepared as ordered for each resident as prescribed.</p> <ul style="list-style-type: none"> o On 1/17/22, the Mobile Certified Dietary Manager (MCDM) and registered dieticians reviewed residents' electronic health records. The review included diets, weights, and meal intake. Results: no unexpected negative outcomes were identified. o On 1/17/22, the MCDM checked the facility's emergency food supply and ensured disaster menus and plans are in place per the dietary manual. o On 1/17/22, the MCDM educated the dietary 	F 802			

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F 802	Continued From page 127 staff on the emergency preparedness plan during inclement weather which discussed food supply to the facility. Going forward, the Administrator will ensure the emergency preparedness plan is communicated with the dietary manager and dietary staff to ensure sufficient dietary staff are present to prepare and deliver meals during an emergency. o On 1/17/22, the Interim Administrator and MCDM reviewed the Dietary Staffing Schedule with the Dietary Manager for the next 7 days to ensure sufficient dietary staff were scheduled to provide adequate meals during each meal service. Date of alleged Immediate Jeopardy Removal: 1/18/22. The facility ' s credible allegation of compliance was validated through an on-site review process which included record review, observations, interviews with staff and residents. Date of IJ removal was validated as 01/18/22.	F 802			
F 809 SS=F	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse	F 809		3/22/22	

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F 809	<p>Continued From page 128</p> <p>between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.</p> <p>§483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews, resident interviews, and record reviews that facility failed to provide three meals at regular times during a winter storm on 01/16/22. Ninety-seven of ninety-eight residents were affected by the deficient practice.</p> <p>Findings included:</p> <p>Breakfast was served in the main dining room at 8:00 AM and then was served to the halls in the following order the 100 hall, the 500 hall, the 200 hall, the 400 hall and lastly the 300 hall at 8:45 AM. Lunch was served in the same order, but began at 12:00 PM in the main dining room and the last hall was served at 12:45 PM. Dinner was served in the main dining room at 5:45 PM and then served to the halls in the same order as breakfast and lunch with the 300 hall served last at 6:45 PM.</p> <p>On 01/17/22 at 11:07 AM an interview was conducted with Cook #1. Cook #1 revealed on 01/16/22 a hot breakfast meal was served to the residents as per their usual schedule. Cook #1 also revealed he spoke to Administrator #2 before lunch on 01/16/22 and received permission to give all residents a bagged lunch and dinner meal on</p>	F 809	<p>This plan of correction constitutes Pine Ridge Health and Rehabilitation Center's written allegation of compliance for the deficiency cited. However, preparation and execution of the plan of correction is not an admission by Pine Ridge Health and Rehabilitation Center of the truth of the facts alleged, conclusions set forth in the statement of deficiencies, or that any individual resident suffered or had the potential to suffer minimal harm or actual harm. This plan of correction is prepared and executed to meet requirements established by state and federal law.</p> <p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>On 1/16/22 at 11:45 PM the administrator, with the assistance from the ARVP, initiated the Emergency Preparedness Plan to ensure residents received meals in a timely manner, and received other necessary care and services.</p> <p>On 1/17/22 at 8:02 AM, the Mobile</p>		

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F 809	<p>Continued From page 129</p> <p>01/16/22. Cook #1 revealed that he explained the plan with Nurse #7 and that the bagged meals were delivered to the nurse stations prior to 12:00 PM for nursing staff to deliver.</p> <p>On 01/27/22 at 3:39PM Nurse #7 was interviewed and revealed that each resident received a bagged lunch meal on 01/16/22 at the regular lunch time beginning at 12:00 PM. Nurse #7 revealed that at dinner the nursing staff started to serve meals at 5:45 PM until after 9:00 PM.</p> <p>An interview conducted with Resident #7 on 01/17/22 at 9:20 AM revealed on 01/16/22 her breakfast tray was delivered at 9:20 AM and she received a sandwich for lunch. At about 9:45 PM on 01/16/22 she received another sandwich and a bag of chips for dinner. Resident #7's most recent Minimum Data Set (MDS) with an assessment date of 11/04/21 included that Resident #7 had no cognitive impairment.</p> <p>During an interview with Resident #11 on 01/17/22 at 12:19 PM she revealed that she had received her breakfast tray about 9:25 AM on 01/16/22 and the lunch meal was only a sandwich or two delivered in a paper bag. Dinner was also a sandwich that the two Nursing Assistants had to scavenge to make. A review of the most recent MDS for Resident # 11 dated 12/21/21 revealed that Resident #11 had no cognitive impairment, had diabetes mellitus and received a therapeutic diet. Resident # 11 was not able to confirm the time that she received her dinner on 01/16/22 except that it was delivered late and she had been very hungry.</p>	F 809	<p>Certified Dietary Manager arrived in the kitchen, and the dietary department provided breakfast as scheduled.</p> <p>At 11:10 AM, the Regional RN MDS Consultant arrived at the facility to provide direct resident care to include ensuring residents received meals at regular mealtimes.</p> <p>At 11:30 AM, the supporting RN facility consultant arrived to assist with direct resident care. At 12:00 noon, the assigned RN facility consultant arrived to assist with direct resident care to include ensuring residents received meals at regular mealtimes.</p> <p>At 1:00 PM, an additional RN consultant arrived to assist with direct resident care to include ensuring residents received meals at regular mealtimes.</p> <p>On 1/17/22, the Mobile Certified Dietary Manager (MCDM) and registered dieticians reviewed residents' electronic health records. The review included diets, weights, and meal intake. Results: no unexpected negative outcomes were identified.</p> <p>At 2:30 PM, sufficient facility staff were in the facility providing care for the residents to include ensuring residents received meals at regular mealtimes.</p> <p>How the facility identified other residents</p>		

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F 809	<p>Continued From page 130</p> <p>On 01/19/2022 at 10:28 AM an interview with NA #2 revealed that on 01/16/22 the nurse staff had been given bagged lunches for each resident that the nursing staff delivered to the residents about the normal time for lunch at 12:00 PM. NA #2 revealed that the dinner meal was served up to eight or nine hours and many residents were unhappy about not receiving a meal until past the regular dinner time on 01/16/22.</p> <p>An interview conducted with NA #1 on 01/20/22 at 1:55 PM revealed that on 01/16/22 around the dinner meal he was told by Nurse #7 that there was no prepared dinner meal for the residents. NA #1 revealed he was not certain of the usual dinner time, but some residents had not received anything to eat for dinner until after 8:00 PM or 9:00 PM. NA #1 revealed he was glad when EMS came to the facility with the police and assisted to make sandwiches, serve them and assisted residents to eat.</p> <p>Administrator #3 was interviewed on 02/02/22 at 1:23 PM and revealed that he expected all meals be provided to residents as scheduled and that residents receive snacks between meals or at bedtime as requested or as ordered by the physician and that meal menus be provided as posted and preplanned.</p>	F 809	<p>having the potential to be affected by the same deficient practice:</p> <p>As set forth above, a corrective plan was put in place and implemented for all residents.</p> <p>Measures put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>On 1/18/22 the interim administrator posted contact names and phone numbers at the nurse stations, break room, and in the kitchen for staff to use in the event of an emergency such emergency to include insufficient staff to provide at least three meals daily.</p> <p>On 1/17/22, the MCDM checked the facility's emergency food supply and ensured disaster menus and plans are in place as outlined in the dietary manual. There were no identified areas of concern. On 1/21/22, the Corporate Director of Special Projects began educating 100% of the facility to include dietary staff, and agency staff on the Emergency Preparedness plan. The education included: 1) the Emergency Preparedness Program, 2) incident management staff chain of command, 3) evacuation, shelter in place, 4) fire response plan, 5) disaster, 6) infectious disease, 7) power outages/interruptions, 8) workplace violence and active shooter, 9) missing</p>		

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F 809	Continued From page 131	F 809	<p>resident, 10) reporting to work during inclement weather, and 11) sleep pay policy. The education will be completed on 3/22/22. Any dietary staff that has not worked and completed the Inservice will complete upon their next scheduled shift. The Mobile Director of Nursing, Director of Nursing, or Clinical Support Staff will ensure all newly hired staff and newly scheduled agency staff will complete the Inservice during orientation. Going forward, the administrator will ensure the emergency preparedness plan is communicated with the dietary manager and dietary staff to ensure sufficient dietary staff are present to prepare and deliver at least three meals daily during an emergency.</p> <p>On 1/17/22, Interim Administrator and MCDM reviewed the Dietary Staffing Schedule with the Dietary Manager for the next 7 days to ensure sufficient dietary staff were scheduled to provide at least three meals daily. There were no identified areas of concern.</p> <p>On 2/28/22 the Interim Administrator contacted the Quality Improvement Organization to discuss the plan of correction and for further recommendations to the action plans.</p> <p>How the facility plans to monitor its performance to make sure that solutions are sustained:</p> <p>Beginning on 3/22/22 the Mobile Director of</p>		

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F 809	Continued From page 132	F 809	Nursing, Director of Nursing, treatment nurse, Dietary Manager, or clinical support staff will audit meals services 3 x per week x 4 weeks then weekly x 4 weeks utilizing a Meal Observation audit tool. This audit is to ensure residents are receiving three meals a day at regular times. The will retrain the Mobile Director of Nursing, Director of Nursing, treatment nurse, or clinical support staff dietary or nursing staff for any identified areas of concern during the audit. The Administrator will be responsible for forwarding the audit tools to the Quality Assurance Committee. The facility's Quality Assurance Performance Improvement (QAPI) committee will review the Meal Observation audit tools monthly x 2 months to identify trends and to determine the need for further frequency of monitoring.		
F 835 SS=L	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on North Carolina State of Emergency press releases, email review, text message review, record review, resident, emergency/disaster relief staff, Emergency Medical Services (EMS), police, and facility staff interviews Administrator #2 failed	F 835	Pine Ridge Health and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct	3/22/22	

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F 835	<p>Continued From page 133</p> <p>to enact the facility emergency preparedness plan, failed to utilize resources to provide care for the residents of the facility during inclement weather, failed to communicate the urgency and potential impact of pending inclement weather to administrative staff, key staff, and general staff prior to inclement weather, failed to communicate a potential crisis situation to her administrative and key staff, failed to ensure sufficient dietary staff who left the facility at 1:00 PM, and failed to communicate a dangerously low staffing situation to the Assistant Regional Vice President (Administrator #3) in the midst of inclement weather in a staffing crisis. Furthermore, DON #1 failed to manage the facility nursing staff during the inclement weather event through failure to coordinate with Administrator #2 a plan to house staff at the facility, transport staff, arrange for transport, or utilize community resources to provide transportation to the facility for nurses and Nursing Assistants. The result of the failure impacted all residents during a governor declared state of emergency involving inclement weather. The failure to prepare resulted in a severe shortage of staff which resulted in one Licensed Practical Nurse (LPN) and two Nursing Assistants (NAs) to take care of 98 residents at the facility starting at 2:00 PM on 1/16/22.</p> <p>On 1/16/22 at 8:09 PM three police officers arrived at the facility for a wellness check to investigate a 911 call from a resident at the facility who had called and complained of not having seen staff members for a long period of time. When 911 dispatch attempted to call the facility, the calls went unanswered. The police officers who arrived then contacted the city fire department and county</p>	F 835	<p>and in order to maintain compliance with applicable rules and provisions of quality of care of residents and to meet requirements established by state and federal law. The Plan of Correction is submitted as a written allegation of compliance.</p> <p>Pine Ridge Health and Rehabilitation Center's response to this Statement of Deficiencies and Pine Ridge Health and Rehabilitation Center's earlier submitted credible allegation of immediate jeopardy removal does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate or that any individual resident suffered or was likely to suffer actual harm or a serious adverse outcome. Further, Pine Ridge Health and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.</p> <p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 1/17/22 at 1:23 AM, the assistant regional vice president (ARVP) arrived at the facility, assumed charge of the facility, and initiated the Emergency Preparedness Plan. The initiation of the Emergency Preparedness Plan included implementing the shelter-in-place, protocols for staff</p>		

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F 835	<p>Continued From page 134</p> <p>Emergency Medical Services (EMS). Due to the facility administration's (Administrator #2 and DON #1) lack of ability to manage the facility and ensure necessary staffing levels to meet the needs of the residents of the facility, the county Emergency Preparedness Director took over operations of the facility and utilized resources to obtain a combination of skilled individuals to provide care, assess, assist with an evening meal, and other services for the residents of the facility.</p> <p>Immediate Jeopardy began on 1/16/22 when Administrator #2 failed to plan, prepare, and respond for inclement weather (snow/ice). The opportunity to prepare and to involve department heads, key staff, nursing staff, and other facility began on 1/13/22, when the potential for inclement weather was announced by the Governor of the State of North Carolina through his enactment of a state of emergency for the entire state related to the predicted winter storm. Administrator #2 had a sequence of failures which resulted in the immediate jeopardy situation including, but not limited to failure to review, update, and enact the facility emergency preparedness plan, which would have included instituting measures to ensure sufficient staffing, failure to communicate the urgency and potential impact of pending inclement weather to administrative staff, key staff, and general staff prior to inclement weather, failure to communicate a potential crisis situation to her administrative and key staff, failed to ensure sufficient dietary staff who left the facility at 1:00 PM, and failure to communicate a dangerously low staffing situation to the Assistant Regional Vice President (Administrator #3) in the midst of inclement weather. The immediate jeopardy was</p>	F 835	<p>calling for additional support from facility staff, agency staff, and the corporate support team. The corporate support team included registered nurses (RNs) to work with and supervise the director of nursing (DON) and nursing services. Immediate actions were taken to ensure residents received the goods and services needed during an urgent situation arising from inclement weather and that the facility was being administered so as to maintain the highest practicable physical, mental and psycho-social well-being of the residents. The Administrator #2 was suspended on 1/17/22. DON #1 was suspended on 1/21/22.</p> <p>Acting as the Governing Body, the ARVP assigned himself as the Interim Administrator during the Investigation. An Interim DON was hired on 1/22/22.</p> <p>How the facility identified other residents having the potential to be affected by the same deficient practice:</p> <p>As set forth above, a corrective action plan was put in place and implemented for all residents.</p> <p>Measures put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>On 1/17/22 at 1:23 AM, the ARVP arrived at the facility and assumed charge of the facility. Acting as the Governing Body, the ARVP assigned himself as the Interim Administrator during the investigation.</p> <p>On 1/17/22 at 10:47 AM <input type="checkbox"/> 12:00 noon, the corporate RNs arrived to assist in direct resident care, initial audits, staff education,</p>		

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F 835	<p>Continued From page 135</p> <p>removed on 1/18/22 when the facility provided an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity level of F (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put into place are effective. Every resident of the facility was placed at risk of severe harm.</p> <p>Findings included:</p> <p>Cross Refer to E0001: Based on North Carolina State of Emergency press releases, email review, text message review, record review, resident, emergency/disaster relief staff, Emergency Medical Services (EMS), police, and facility staff interviews, the facility failed to enact the facility emergency preparedness plan which impacted all residents during a governor declared state of emergency involving inclement weather. The result of the failure to prepare resulted in one Licensed Practical Nurse (LPN) and two Nursing Assistants (NAs) to take care of 98 residents at the facility starting at 2:00 PM on 1/16/22.</p> <p>Cross Refer to F550: Based on record review, police, resident, and staff interviews, the facility failed to treat residents in a dignified manner, when residents did not receive incontinence care for several hours during a period when there was just one Licensed Practical Nurse (LPN) and two Nursing Assistants in the facility to provide care for 98 residents. Two of five interviewed residents (Resident #7 and Resident</p>	F 835	<p>program monitoring, and nursing services supervision. 1/17/22 through 2/22/22 the corporate RNs continued to provide support services to facility and agency staff on site. Starting 2/15/22 the ARVP employed a new Interim Administrator. On 2/15/22, the Interim Administrator was educated by the ARVP regarding how and when to enact the emergency preparedness plan, how and when to utilize resources to provide care for residents during inclement weather, how and when to communicate the urgency and potential impact of pending inclement weather to administrative all staff, how and when to communicate a potential crisis situation to all staff, and how and when to communicate a dangerously low staffing situation to the ARVP.</p> <p>On 1/22/22, an Interim Director of Nursing was hired. On 1/22/22 the interim Director of Nursing was educated by the ARVP on the emergency preparedness plan to include: how to manage facility staff during inclement weather by developing a plan in coordination with the Administrator to house staff at the facility, arrange transportation for staff, transport staff to the facility, and utilize community resources to provide transportation to the facility nurses and nursing assistants.</p> <p>On 2/28/22 the Interim Administrator contacted the Quality Improvement Organization to discuss the plan of correction and for further recommendations to the action plans.</p>		

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F 835	<p>Continued From page 136</p> <p>#11) stated the lack of incontinent care for an extended period of time made them feel like they were defeated, not treated with dignity, neglected, dirty, mad, and abandoned. This deficient practice had the high likelihood of negatively impacting many residents in the facility.</p> <p>Cross Refer to F584: Based on record review, observations, photographs, police, Emergency Medical Technicians (EMTs) and staff interviews, the facility failed to provide a clean environment for 2 of 2 days investigated for environment. Interviews with first responders who arrived at the facility described and provided photographic evidence bags of garbage in the hallways and an observation on 1/17/22 revealed a room with overflowing garbage, garbage on the floor, garbage under the bed, and spilled fluids.</p> <p>Cross Refer to F600: Based on record review, staff, first responders, and resident interviews, the facility neglected to provide basic goods and services, including, but not limited to incontinent care, resident assessments, medications, nourishment, and basic housekeeping to meet the needs of 98 of 98 residents residing in the facility during a winter weather storm on 1/16/22. Neglecting to meet the needs of the residents had the high likelihood of causing severe psychological and physical harm to all 98 residents.</p> <p>Cross Refer to F677: Based on record review, police, Emergency Medical Technicians (EMTs), resident, and staff interviews, the facility failed to provide Activities of</p>	F 835	<p>How the facility plan to monitor its performance to make sure that solutions are sustained: Beginning on 3/22/22 the ARVP or Corporate support staff will complete an administration monitoring tool weekly for 8 weeks to document reviews of the Plan of Corrections, including the monitoring tools and ensure the facility is compliant for E001, F550, F584, F600, F677, F689, F725, F802, and F809. The Administrator and/or Director of Nursing will be retrained by the ARVP or Corporate Support staff for any identified areas of concern. The ARVP or Corporate support staff will ensure the Administrator forwards the audit tools to the Quality Assurance Committee. The facility's Quality Assurance Performance Improvement (QAPI) committee will review the Administration monitoring tools monthly x 2 months to identify trends and to determine need for further frequency of monitoring.</p>		

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F 835	<p>Continued From page 137</p> <p>Daily Living (ADL) Care, including incontinence care. The failure occurred on 1/16/22 during a period when there was just one Licensed Practical Nurse (LPN) and two Nursing Assistants in the facility to provide care for 98 residents. Two interviewed residents (Resident #7 and Resident #11) stated they did not receive incontinent care for an extended period of time and Resident #11 stated she had physical discomfort from having had to wait an extended period of time for incontinent care. Interviews with first responders who arrived at the facility described multiple residents in need of care and a strong smell of urine and feces in the facility. Due to the facility 's failure to sufficiently staff the facility to provide necessary ADL care on 1/16/22, every resident of the facility was placed at risk of severe harm.</p> <p>Cross Refer to F689: Based on record review, first responder, resident, physician, family member, and staff interviews, the facility failed to provide an environment without severe risk of harm through not providing supervision of the residents in the locked dementia unit for several hours. This occurred during a period when there was just one Licensed Practical Nurse (LPN) and two Nursing Assistants in the facility to provide care for 98 residents. As reported by Police Officer #2 who went into the dementia unit after arriving to the facility at 8:10 PM on 1/16/22 she discovered no staff supervising the dementia unit, residents wandering throughout the unit, residents behind the nurses' station desk, and residents placing items in their mouths. This deficient practice impacted all residents of the locked dementia unit, 25 of 25 residents. This resulted in the residents on the dementia unit</p>	F 835			

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F 835	<p>Continued From page 138 being at severe risk for harm.</p> <p>Based on record review and staff, Physician and Family Member interviews the facility failed to provide the recommended 1 on 1 supervision to prevent falls for 1 of 1 resident reviewed for accidents (Resident #8).</p> <p>Cross Refer to F725: Based on record reviews, first responder, staff and interviews, the facility failed to provide adequate staffing to provide care and supervise resident safety during inclement weather (a winter storm) on 01/16/22. Nurse #1, Medication Aide (MA) #1 and two Nursing Assistants (NAs) (NA #1 and NA #2) reported to work on the morning of 01/16/22. MA #1 left the facility at 2:00 PM after she received permission to leave the facility from the Director of Nurses (DON) #1. The nurse and the 2 NAs remained as the only staff to provide resident care and services for 98 residents in the facility. Nurse #7 communicated the staffing situation of the facility to Administrator #2 and her concerns regarding the lack of care and quality of care the three of them could provide for the residents. Administrator #2 told the Nurse #7 that she was sorry about the situation and the staff needed to do the best that they could. Police Officers arrived at the facility at 8:09 PM on 01/16/22 for a wellness check after 911 calls from a resident and after attempted calls to the facility from 911 dispatch went unanswered. This situation affected 98 of 98 residents.</p> <p>Cross Refer to F802: Based on staff, resident, police interviews, Emergency Medical Services (EMS) interviews</p>	F 835			

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F 835	<p>Continued From page 139</p> <p>and record reviews, the facility failed to provide dietary staff who were competent to carry out food and nutrition services during a winter weather storm on 01/16/22. Dietary staff made the decision without consultation with the Mobile Certified Dietary Manager (MCDM) or the Consulting Registered Dietitian (RD) to prepare bags of food to be consumed for lunch and dinner and then leave the building at around 1:00 PM in the afternoon. This left no dietary staff in the building after lunch. The decision was authorized by Administrator #2. There was no communication with the nursing staff about the intent of the bagged lunch to last for lunch and dinner, how the potentially hazardous food was to be kept safe between the time of distribution to the residents at lunch until the dinner meal, where additional prepared sandwiches were stored or when dietary staff left the building. When it was dinner time, residents became unhappy that there was no food delivery. Nursing staff responded by preparing sandwiches as they made rounds. Police arrived on the scene and found residents hungry. Emergency Medical Staff (EMS) were alerted and assisted in food preparation and feeding of residents. This situation affected 97 of 98 residents.</p> <p>Cross Refer to F809: Based on staff interviews, resident interviews, and record reviews that facility failed to provide three meals at regular times during a winter storm on 01/16/22. Ninety-seven of ninety-eight residents were affected by the deficient practice.</p> <p>An interview was conducted with Administrator #2 on 1/17/22 at 2:08 PM. She stated she had been</p>	F 835			

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F 835	Continued From page 140 the administrator at the facility since August 2021. She explained for 1/16/22 they were fully staffed on paper, but there were one or two call outs, and the scheduled staff did not come in at 7:00 AM on 1/16/22. She explained a majority of the staff from night shift who worked from 11:00 PM on 1/15/22 to 7:00 AM on 1/16/22 had stayed over to help the 7:00 AM staff who arrived on 1/16/22. She said the staff who stayed over included a majority of the Nursing Assistants (NAs), the medication aides (med aides), and 2 nurses. She said she and the Director of Nursing had tried to come into the building, but they were unable to because of the poor road conditions from the inclement weather. She said she talked with Nurse #7 who arrived at the facility at 7:00 AM on 1/16/22 and was assigned to work until 7:00 PM on 1/16/22 and the nurse told her she had packed a bag and was prepared to stay the night if needed. She then stated the staff who was scheduled at 3:00 PM for the NAs and 7:00 PM for the nurses called and told her they were not able to make it to the facility and would not be coming in. She said she talked to Nurse #7 later in the day and the nurse told her it was just her and 2 NA ' s for the whole facility. She stated she started to call her administrative team for them to come in and help, people were trying to come in, but they were unable to get to the facility. She said she was corresponding with the dietary staff at around noon and was aware the first shift cook was there, and the second shift cook had come in early to help out and she thought the second shift cook stayed until 8:00 PM. She stated Nurse #7 told her the residents had sandwiches for a dinner meal on 1/16/22. She explained at some time between 9:00 PM and 10:00 PM Nurse #7 had called her and informed	F 835			

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F 835	Continued From page 141 her Emergency Management was on site, along with the police, fire department, and they had called the state (DHHS). She then stated she had received calls from her supervisors who had informed them they had been contacted by the Nursing Home Section Chief. She said she was also made aware the Davidson County Emergency Management Coordinator had been trying to contact her and was unable to, but she said she had received no calls from him. She explained she had been talking to Nurse #7 several times through the day and administrative and key staff were to come into the facility to provide help and relief. She stated on 1/16/22 she had reached out to staff who had 4x4s but none of them were able to assist with transportation, including the Central Supply Coordinator (SSC). She said the SSC was able to transport staff on 1/17/22, and that was how they were able to get some staff in. She said she had tried to contact different transport services but the response she received the response the transport agencies were not going to put their drivers on the road. She said she had even tried a mobility service provider through an app and there were no transport options at the time. She further stated part of the challenge was that she did not know the addresses of many staff members so she could not arrange transportation for them to come to the facility and for some which she did have addresses for, lived outside of the county. Administrator #2 stated she was not aware contacting the Davidson County Emergency Management Coordinator was an option to provide assistance. Administrator #2 further stated she had not reviewed the Emergency Preparedness Plan prior to the inclement weather but it may have had some information which would have been	F 835			

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F 835	<p>Continued From page 142</p> <p>helpful for the situation. Regarding communication with corporate, her supervisor, Assistant Regional Vice President, Administrator #3, she stated she had let him know there were call outs of first (7:00 AM to 3:00 PM) and second (3:00 PM- 11:00 PM) shifts. She said she had a plan with a 4x4 vehicle to pick people up, but she could not get out of her complex and she said staff were trying to get to the facility between 6:00 AM and 7:00 AM. She explained she did not choose to have one nurse, one medication aide, and one NA, there were more staff scheduled than that.</p> <p>A phone interview was conducted on 1/20/22 at 1:14 PM with the Emergency Management Coordinator of Davidson County. The coordinator stated the facility did not have a very good incident plan regarding the situation with inclement weather. He further stated he had not met, talked to on the phone, or had any type of information exchange with the Administrator #2 of the facility, while he had received communication from other facilities in the area. He explained he felt it was important for the administrators at nursing homes in Davidson County and him to work with each other. He explained it was especially important to meet and discuss emergency preparedness plans to try work with a facility to make sure the residents receive the care and assistance they need in an emergency situation in order to try and prevent a situation like what happened on 1/16/22.</p> <p>During an interview conducted with the Central Supply Coordinator (SSC) on 1/20/22 at 11:07 AM he stated he had not heard from Administrator #2 about coming into the facility or picking up staff for the facility on 1/16/22. He said if he would have</p>	F 835			

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F 835	<p>Continued From page 143</p> <p>received a call, he would have come to the facility to have helped or even stayed overnight if need be. He further during the week prior to the storm, Administrator #2 had not discussed with anything about coming into the facility in case it stormed or transporting staff members to the facility in the event there was inclement weather over the weekend.</p> <p>During an interview conducted on 1/20/22 at 12:26 PM with the Payroll Bookkeeper she stated as far as she was aware Administrator #2 had not reviewed anything with staff regarding disaster preparedness since she had started in August. She stated it seemed unusual to have not have anyone discuss inclement weather preparations and about her and other staff coming into help out prior to the storm. She said she was very surprised to have heard what happened when she returned to work and would have been willing to try to come in and help and felt guilty about not knowing the residents needed help.</p> <p>Interviews were conducted from 1/17/22 through 2/2/22 with several members of the nursing home administration team and key staff members including the two social workers, central supply coordinator, medical records director, and the Assistant Director of Nursing (ADON). The interviews revealed during the daily department head meetings, including the meetings on Friday. The interviews revealed the staff members found the situation to be odd in that there was a pending potential winter storm and there had been little or no preparation for them to come in and help at the facility. The staff members expressed guilt for not having known the situation the staff members were</p>	F 835			

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F 835	<p>Continued From page 144</p> <p>in at the facility and frustration in knowing they could have come into help but were unaware the residents were not receiving the care they needed. Furthermore, the interviews revealed there was no weekend manager duty or Manager on Duty (MOD) for the weekends, which would have utilized a department head or key staff member to come into the facility on weekends as a means to have presence of an administrative person present.</p> <p>Interviews with conducted from 1/17/22 through 2/2/22 with several members of the nursing home administration team and key staff members including the two social workers, central supply coordinator, medical records director, and the Assistant Director of Nursing (ADON). During the interviews it was discovered there were vacancies or absences in several department head and key vacancy positions including the maintenance assistant, dietary manager, housekeeping director, activities director, staffing development coordinator, and the nursing staff scheduler. It was also discovered the Minimum Data Set (MDS) Coordinator position was occupied by a temporary fill in corporate employee who traveled to stay near the facility during the week and returned home on weekends.</p> <p>During an interview conducted on 2/2/22 at 1:23 PM with the Administrator #3 he stated as the Assistant Regional Vice President he had reviewed the upcoming forecasted inclement weather with Administrator #2 on 1/14/22 while he was at the facility. He stated they had discussed preparations for inclement weather such as transportation, getting to work, being a leader and having the building staffed, and asked to have any</p>	F 835			

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F 835	<p>Continued From page 145</p> <p>issues communicated to him which were to arise and require further intervention. He further explained his expectations in the current role of being the administrator were to instill programs such as the sleep pay benefit which pays an hourly wage to employees who stay at the building and sleep rather than returning home, assure to provision people arrive to work on time for their shift, telephone numbers for key administrative and corporate staff are posted, provide transportation in the event of inclement weather, a supervisor key ring has been supplied which contains keys to reach areas of the facility such as the kitchen, as the administrator, be on-site when needed, and anything which the staff would need regarding service provision to the residents. He stated Administrator #2, who was in place from August, was suspended on 1/17/22 and he was acting as the current administrator.</p> <p>Administrator #3 was made aware of Immediate Jeopardy (IJ) on 1/21/22 at 12:31 PM.</p> <p>The facility shared the credible allegation of immediate jeopardy removal.</p> <p>Recipients who have suffered or are likely to suffer, a serious adverse outcome as a result of the non-compliance</p> <p>On 1/16/22 at 8:09 PM, after receiving a call from a resident, local law enforcement arrived at the facility for a wellness check. It was determined that there was 1 LPN and 2 Nursing Assistants on site and there were 97 residents which were in need of care and services. It was determined that the facility was non-compliant with Tag 835 based on the Administrator 's failure to enact the</p>	F 835			

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F 835	<p>Continued From page 146</p> <p>emergency preparedness plan, ensure key supervisory personnel were in place, communicate with facility staff and did not communicate a problem to her supervisor, Assistant Regional Vice President (ARVP). The Administrator failed to communicate to facility staff, the need to be prepared to travel to the facility during or prior to the inclement weather resulting in a staffing shortage in every Department at the Facility. As set forth in the immediate jeopardy preliminary findings, all residents were likely to suffer a serious adverse outcome based on the non-compliance.</p> <p>Actions taken to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring</p> <p>On 1/16/22 at 9:20 PM the Administrator informed the Assistant Regional Vice President (ARVP) that the fire and police personnel were at the facility. On 1/16/22 at 9:52 PM, the ARVP updated the Divisional Vice President (DVP) and the DVP initiated a Quality Assurance and Performance Improvement (QAPI) conference call with corporate support staff verbalize assignments of duties upon arrival to the facility. The AVRVP and Corporate staff put in place the Emergency Preparedness Plan to obtain additional staff and address the issues at the facility impacting residents.</p> <p>The DON arrived at the facility approximately 11:30 PM, and provided medications and direct care. At 11:45 PM, a call was held with the Administrator and Corporate support staff to implement Emergency Preparedness Plan.</p> <p>On 1/17/2022 at 1:23 AM, the ARVP arrived at the facility and assumed leadership of the facility. The corporate staff arriving were directed by the ARVP to work in their assigned areas to ensure care and</p>	F 835			

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F 835	<p>Continued From page 147</p> <p>services were delivered to all residents 8:02 AM, the Mobile Certified Dietary Manager arrived in the kitchen, and the dietary department provided breakfast as scheduled.</p> <p>At 10:47 AM, the Corporate Clinical Director arrived in the facility and provided direct care.</p> <p>At 10:50 AM, the Divisional Vice President arrived at the facility and assisted in securing staff, passing out meal trays.</p> <p>At 11:00 AM, Corporate Employee Experience personnel arrived at the facility, to assist with securing staff on the schedule. After securing staffing for 1/17/22, the facility implemented staffing meetings to review sufficient staffing for shifts going forward.</p> <p>At 11:10 AM, the Regional RN MDS Consultant arrived at the facility to provide direct resident care.</p> <p>At 11:30 AM, the supporting RN facility consultant arrived to assist with direct resident care. At 12:00 noon, the assigned RN facility consultant arrived to assist with direct resident care. At 1:00 PM, an additional RN consultant arrived to assist with direct resident care.</p> <p>At 1/17/22 at 2:30 PM sufficient facility staff were in the facility providing care for the residents. On 1/17/22, all residents were assessed by clinical staff for acute change of condition and no change in condition were noted. On 1/17/22, the social worker talked with 100% of alert and oriented residents to provide psycho-social support.</p> <p>On 1/17/22 at approximately 5:30 PM, the ARVP suspended the Administrator for failure to implement the Emergency Preparedness Plan. Acting as the Governing Body, the ARVP assigned himself as the Interim Administrator during the investigation.</p> <p>Interim Administrator is responsible for</p>	F 835			

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F 835	Continued From page 148 implementing credible allegation of compliance, ARVP is committed to ensuring the facility is administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain regulatory compliance, until such time the ARVP hires a qualified, licensed Administrator to assume this responsibility. Date of alleged Immediate Jeopardy removal: 1/18/22 The facility's credible allegation of compliance was validated through an on-site review process which included record review, observations, interviews with administrative staff, Administrator #2, and corporate staff. Date of IJ removal was validated as 1/18/22.	F 835			
F 837 SS=L	Governing Body CFR(s): 483.70(d)(1)(2) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by: Based on North Carolina State of Emergency press releases, email review, text message review, record review, resident, emergency/disaster relief	F 837	Pine Ridge Health and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes	3/22/22	

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F 837	<p>Continued From page 149</p> <p>staff, Emergency Medical Services (EMS), police, corporate, and facility staff interviews, the Governing Body (GB) (Principle LTC (Long Term Care)) which manages Pine Ridge Health and Rehabilitation Center of Thomasville, failed to review, and prepare Administrator #2 regarding the facility emergency preparedness plan, how to enact the emergency preparedness plan, and how to manage a facility in the midst of a staffing crisis during inclement weather. Furthermore, the GB failed to instruct Administrator #2 to report urgent situations which may arise in the event of an emergency situations, or how to utilize and communicate with corporate support, such as reporting to her Assistant Regional Vice President (Administrator #3). The result of the failure impacted all residents during a governor declared state of emergency involving inclement weather. The failure of the GB to communicate to Administrator #2 the importance of the Emergency Preparedness Plan and reporting urgent situations resulted in a severe shortage of staff which resulted in one Licensed Practical Nurse (LPN) and two Nursing Assistants (NAs) to take care of 98 residents at the facility starting at 2:00 PM on 1/16/22.</p> <p>On 1/16/22 at 8:09 PM three police officers arrived at the facility for a wellness check to investigate a 911 call from a resident at the facility who had called and complained of not having seen staff members for a long period of time. When 911 dispatch attempted to call the facility, the calls went unanswered. The police officers who arrived then contacted the city fire department and county Emergency Medical Services (EMS). Due to the GB ' s failure to support and communicate with</p>	F 837	<p>this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents and to meet requirements established by state and federal law. The Plan of Correction is submitted as a written allegation of compliance.</p> <p>Pine Ridge Health and Rehabilitation Center's response to this Statement of Deficiencies and Pine Ridge Health and Rehabilitation Center's earlier submitted credible allegation of immediate jeopardy removal does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate or that any individual resident suffered or was likely to suffer actual harm or a serious adverse outcome. Further, Pine Ridge Health and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.</p> <p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 1/17/22 at 1:23 AM, the assistant regional vice president (ARVP) arrived at the facility, assumed charge of the facility, and initiated the Emergency Preparedness Plan. The initiation of the Emergency Preparedness Plan included the</p>		

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F 837	<p>Continued From page 150</p> <p>Administrator #2 about the Emergency Preparedness Plan and reporting urgent situations, the county Emergency Preparedness Director took over operations of the facility and utilized resources to obtain a combination of skilled individuals to provide care, assess, assist with an evening meal, and other services for the residents of the facility.</p> <p>Immediate Jeopardy began on 1/16/22 when the GB ' s failure to support and communicate to Administrator #2 about the Emergency Preparedness Plan and reporting urgent situations resulted in the administrator ' s failure to plan, prepare, and respond for inclement weather (snow/ice). The opportunity for the GB to prepare and to involve Administrator #2 began on 1/13/22, when the potential for inclement weather was announced by the Governor of the State of North Carolina through his enactment of a state of emergency for the entire state related to the predicted winter storm. Furthermore, the Assistant Regional Vice President (Administrator #3) was at the facility on 1/14/22 and had met with Administrator #2 but had not reviewed the Emergency Preparedness Plan. The immediate jeopardy was removed on 1/18/22 when the facility provided an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity level of F (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put into place are effective. Every resident of the facility was placed at risk of severe harm.</p>	F 837	<p>implementing shelter-in-place, protocol for staff calling for additional support from facility staff, agency staff, and the corporate support team. Immediate actions were taken to ensure residents received the goods and services needed during an urgent situation arising from inclement weather.</p> <p>Administrator # 2 was suspended on 1/17/22.</p> <p>Acting as the Governing Body, the ARVP assigned himself as the Interim Administrator during the investigation. On 1/22/22 the ARVP was trained by the Corporate Clinical Director acting as the Governing Body on the emergency preparedness process, the responsibilities for managing the facility and the process for reporting to the Governing Body and being accountable to the Governing Body. How the facility identified other residents having the potential to be affected by the same deficient practice:</p> <p>As set forth above, a corrective action plan was put in place and implemented for all residents.</p> <p>Measures put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>Starting 2/15/22 the ARVP has employed a new Interim Administrator. On 2/15/22 the Interim Administrator was educated by the Assistant Regional Vice President, acting as the Governing Body regarding how and when to enact the emergency preparedness plan, how and when to utilize resources to provide care for residents</p>		

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F 837	<p>Continued From page 151</p> <p>Findings included:</p> <p>Cross Refer to E0001: Based on North Carolina State of Emergency press releases, email review, text message review, record review, resident, emergency/disaster relief staff, Emergency Medical Services (EMS), police, and facility staff interviews, the facility failed to enact the facility emergency preparedness plan which impacted all residents during a governor declared state of emergency involving inclement weather. The result of the failure to prepare resulted in one Licensed Practical Nurse (LPN) and two Nursing Assistants (NAs) to take care of 98 residents at the facility starting at 2:00 PM on 1/16/22.</p> <p>On 1/17/22 at 11:06 AM an interview was conducted with the Divisional Vice President, and she stated the Assistant Regional Vice President (Administrator #3) arrived at the facility at 1:00 AM on 1/17/22. She explained she and several other Regional Support Personnel were either at the facility or on their way to the facility to assist facility operations, resident care, and staffing.</p> <p>An interview was conducted with Administrator #2 on 1/17/22 at 2:08 PM. She stated she had been the administrator at the facility since August 2021. Regarding communication with corporate, her supervisor, Assistant Regional Vice President (Administrator #3), she stated she had let him know there were call outs for first (7:00 AM to 3:00 PM) and second (3:00 PM- 11:00 PM) shifts. During the interview she did not state she had communicated to her Administrator #3 the situation with dietary staffing, that the dietary staff</p>	F 837	<p>during inclement weather, how and when to communicate the urgency and potential impact of pending inclement weather to all administrative staff, how and when to communicate a potential crisis situation to all staff, and how and when to communicate low staffing situation to the ARVP. The Interim Administrator was also trained by Assistant Regional Vice President on , the responsibilities for managing the facility and the process for reporting to the Governing Body and being accountable to the Governing Body.</p> <p>The ARVP now provides oversight to the Interim Administrator to ensure responsible management and operation of the facility. The ARVP and Interim Administrator are making rounds, meeting with residents and family members, and continuing with the Emergency Preparedness Plan implementation, including monitoring weather forecasts, staffing projection levels, and quality of resident care. On 2/28/22 the Interim Administrator contacted the Quality Improvement Organization to discuss the plan of correction and for further recommendations to the action plans.</p> <p>How the facility plan to monitor its performance to make sure that solutions are sustained: Beginning on 3/22/22, the ARVP or Corporate support staff will complete an administration monitoring tool weekly for 8 weeks to document reviews of the Plan of Corrections, including the monitoring tools</p>		

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F 837	<p>Continued From page 152</p> <p>was leaving early, and the dietary staff had prepared bagged lunches to take the place of the scheduled menu meals. She explained she received a call from Nurse #7 about the presence of the police, Emergency Medical Service (EMS), the fire department, and the county emergency management services at the facility at some time between 9:00 and 10:00 PM on 1/16/22. She said it was after that she received a call from Administrator #3, Assistant Regional Vice President (Administrator #3) who informed her he had been notified by the Nursing Home Section Chief of the staffing crisis at the facility. During the interview she was unable to provide information as to how come she had not notified her Administrator #3 about the staffing crisis at the facility which was a result of the inclement weather. She said Administrator #3 was able to make it to the facility before she was able to make it to the facility.</p> <p>Review of the police provided phone records between Administrator #2 and Administrator #3 revealed there was a text on 1/16/22 at 9:53 AM from Administrator #3 stating, "OK. Hang in there. You are all a good team." The next communication between the two of them was a phone call at 9:19 PM. A time span of 11 hours and 26 minutes.</p> <p>An interview was conducted on 1/18/22 at 2:30 PM with the Assistant Regional Vice President (Administrator #3). He stated he was the current administrator for the facility and Administrator #2 had been suspended as of 1/17/22. He explained he oversaw, in a regional manager capacity, the operations of three facilities in the central North</p>	F 837	<p>and ensure the facility is compliant for E001, F550, F584, F600, F580, F835, F684, F677, F689, F725, F802, and F809. Revision <input type="checkbox"/>s will be made to the plans to include increasing frequency of monitoring for all identified areas of concern. The Administrator and/or Director of Nursing will be retrained by the ARVP or Corporate Support staff for any identified areas of concern.</p> <p>The ARVP or Corporate support staff will ensure the Administrator forwards the audit tools to the Quality Assurance Committee. The facility <input type="checkbox"/>s Quality Assurance Performance Improvement (QAPI) committee will review the Administration monitoring tools monthly x 2 months to identify trends and to determine need for further frequency of monitoring.</p> <p>Upon hiring of a new Administrator, the QAPI committee will review the training documents to ensure that the new Administrator understands responsibilities related to management of the facility and how to report to the Governing Body.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/11/2022
FORM APPROVED
OMB NO. 0938-0391

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F 837	Continued From page 153 Carolina area. He said he had not heard from Administrator #2 through the day until around 9:20 PM on 1/16/22 about the presence of the police, Emergency Medical Services (EMS), firefighters, county Emergency Management Services, however, Administrator #2 had not explained how come all of the people were in the building. He did not discuss the texts the text exchange he had with her in the morning. He said he received information from the Nursing Home Section Chief and the Director of Special Projects from his corporate office about concerns regarding staffing levels at the facility. He said he had talked with Administrator #2 after he was made aware of the situation, and he had suggested ways for her to get to the facility through the night, but she was unable to make it to the facility. He said he was able to get to the facility at 1:23 AM on 1/17/22 and Administrator #2 arrived at the facility at 8:20 AM. He said to his knowledge there was something in place at the facility to pick people up and bring them to the facility, but he didn ' t know how people would have been picked up. He said the facility did not have a facility identified vehicle for inclement weather. He said the Maintenance Director may have had a truck, but it would have been his personal vehicle, and he believed Administrator #2 had contacted the Maintenance Director. He said he had talked with Administrator #2 in the morning on 1/16/22, and she said they were dealing with the weather, had been making sure everything was covered, and there were no power outages. He further stated he had been at the facility on Friday and had discussions with Administrator #2 regarding preparations for inclement weather, such as making sure the generator was operational for backup power, sleep	F 837			

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F 837	<p>Continued From page 154</p> <p>pay (a program where staff are paid when they sleep at the facility between shifts), transport for staff, Personal Protective Equipment (PPE), all of the information was reviewed verbally, and she verbally affirmed there was a plan in place, but had not reviewed the Emergency Preparedness Plan. He said prior to suspending Administrator #2 he informed her it was his expectation for her to have called him about the situation. He said he told her he could have assisted in utilizing resources to have avoided the crisis situation. He also stated it was not just the Administrator who could have called him, he explained the Director of Nursing, the nurse, could have reached out to him, or other corporate support personnel who could have provided assistance during the situation.</p> <p>A Video conference was conducted on 1/21/22 at 1:00 PM with the President of Principle LTC. During the conference the president stated it was an abject failure of Administrator #2 not to have notified her supervisor (Administrator #3) regarding the staffing situation. She further stated there was no reason Administrator #2 did not call someone from corporate.</p> <p>During a Video conference was conducted on 1/21/22 at 1:00 PM with the Assistant Regional Vice President (Administrator #3) he stated it was unknown when the last time Administrator #2 had reviewed the Emergency Preparedness Plan.</p> <p>During an interview conducted on 2/2/22 at 1:23 PM with the Administrator #3 he stated as the Assistant Regional Vice President he had reviewed the upcoming forecasted inclement weather with Administrator #2 on 1/14/22 while he</p>	F 837			

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F 837	<p>Continued From page 155</p> <p>was at the facility. He stated they had discussed preparations for inclement weather such as transportation, getting to work, being a leader and having the building staffed, and asked to have any issues communicated to him which were to arise and require further intervention. He further explained his expectations in the current role of being the administrator were to instill programs such as the sleep pay benefit which pays an hourly wage to employees who stay at the building and sleep rather than returning home, assure to provision people arrive to work on time for their shift, telephone numbers for key administrative and corporate staff are posted, provide transportation in the event of inclement weather, a supervisor key ring has been supplied which contains keys to reach areas of the facility such as the kitchen, as the administrator, be on-site when needed, and anything which the staff would need regarding service provision to the residents.</p> <p>Administrator #3 was made aware of Immediate Jeopardy (IJ) on 1/21/22 at 12:31 PM.</p> <p>The facility shared the following credible allegation of immediate jeopardy removal.</p> <p>Recipients who have suffered or are likely to suffer, a serious adverse outcome as a result of the non-compliance</p> <p>In August 2021, with oversight of the regional vice president, the previous administrator ensured the oncoming administrator received orientation and training on the facility ' s Emergency Preparedness Plan. The outgoing administrator was a seasoned mobile administrator with approximately 18 years nursing home</p>	F 837		

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F 837	Continued From page 156 administrator experience. The Mobile Administrator also reviewed, prepared, and updated the emergency preparedness plan for this facility on 5/4/2021. The outgoing administrator overlapped with new administrator during the transition period from 8/9/2021 until 8/18/2021. This mobile administrator has demonstrated history of understanding policies and procedures based on her years of experience. While the assistant regional vice president (ARVP) did not go through the hard copy of the Emergency Prepared Plan with the Administrator, on 1/14/22 the ARVP and the human resources consultant reviewed on-site, with the administrator, the procedures and processes to be put in place in the event of an emergency, including ensuring sufficient staffing and meeting resident ' s needs for medication, nutrition and other services in which the Administrator verbalized understanding of the necessary actions to be taken. The review occurred in advance of the 1/16/22 winter storm and in response to the Governor ' s declaration of a state of emergency. Despite this review, the administrator did not implement the Emergency Preparedness Plan, or the processes and procedures that had been discussed on 1/14/22. On 1/12/22, the corporate dietician sent out a communication to the Administrator at the facility reminding the facility to have a three-day emergency supply of food and water. On 1/13/22, an email communication was sent by the Vice President of Operations Support Services to the facility administrator instructing her to prepare for incoming inclement weather over the weekend. This communication included emergency contact numbers and instructions to the Administrator to use those numbers in case of	F 837			

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F 837	<p>Continued From page 157</p> <p>emergency. On 1/14/22 another e-mail was sent to the facility administrator by the Chief Operating Officer notifying the administrator of inclement weather guidance for review with all staff in anticipation for the weekend of 1/15/22 - 1/16/22. On 1/16/22, the facility was non-compliant with Tag 837 due to the Governing Body 's failure to ensure the building was prepared for inclement weather staffing and enact the emergency preparedness plan. As a result, State and County Emergency Management and Law Enforcement took over the building on 1/16/22, 3 PM - 11 PM shift.</p> <p>As set forth in the immediate jeopardy preliminary findings, all residents were likely to suffer a serious adverse outcome based on the non-compliance.</p> <p>Actions taken to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring</p> <p>On 1/16/22 at 9:52 PM, the ARVP, acting as part of the Governing Body, updated the Divisional Vice President (DVP). The DVP initiated a conference call with corporate support staff. The ARVP and Corporate staff put in place the Emergency Preparedness Plan to obtain additional staff and address sheltering the residents in place at the facility. The corporate staff utilized a Call Tree to call in corporate and facility staff and provide transportation to the facility. The corporate and facility staff provided direct care to meet the needs of the resident while sheltering in place during the inclement weather.</p> <p>On 1/17/2022 at 1:23 AM, the ARVP arrived at the facility and assumed charge of the facility.</p> <p>On 1/17/22 at approximately 5:30 PM, the ARVP</p>	F 837			

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NAME OF PROVIDER OR SUPPLIER PINE RIDGE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 706 PINEYWOOD ROAD THOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 837	<p>Continued From page 158</p> <p>suspended the Administrator for failure to implement the Emergency Preparedness Plan. The ARVP ' s experience and knowledge of the Emergency Preparedness plan implementation was that the facility administrator had been trained and emergency preparedness for the upcoming winter storm was in place.</p> <p>Acting as the Governing Body, the ARVP assigned himself as the Interim Administrator during the investigation. The DVP continues to provide oversight to interim Administrator to ensure responsible management and operation of the facility. The ARVP is involved and overseeing the operations by being on-site from approximately 1:23 AM 1/17/22 through 1/25/22. The DVP is on-site 1/17/22 through 1/25/22. The ARVP and DVP are making rounds, meeting with residents and family members, and continuing with the Emergency Preparedness Plan implementation, including monitoring weather forecasts, and staffing projection levels.</p> <p>Date of alleged removal of Immediate Jeopardy: 1/18/2022</p> <p>The facility ' s credible allegation of compliance was validated through an on-site review process which included record review, observations, interviews with Administrator #3 (Assistant Regional Vice President) and the Corporate Clinical Director. Date of IJ removal was validated as 1/18/22.</p>	F 837			