MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44MM	A. BUILDING: _____ B. WING _____	C 06/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINEYARD COURT NURSING CENTER	2002 5TH STREET NORTH COLUMBUS, MS 39705

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M 000	Initial Comments The State Agency (SA) conducted a complaint investigation (CI) for MS #17831 from 6/17/21 to 6/21/21. The SA determined the facility was not in compliance with the Minimum Standards of Operation for Instuitions of the Aged or Infirm. The SA substantiated MS #17831 for Resident Rights and identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 6/18/21, which began on 6/7/21 when Registered Nurse (RN) #5 instructed Certified Nursing Assistant (CNA) #4 to place a linen cart in front of Resident #1's door to prevent him from exiting his room, causing mental anguish and the likelihood of physical harm to Resident #1. The facility failed to suspend RN #5 and allowed her to remain in the facility caring for residents until the end of her shift. This placed Resident #1 and other residents in a situation that was likely to cause serious injury, harm, impairment, or death. The SA notified the facility of the IJ and SQC on 6/18/21 at 5:30 PM.. The IJ and SQC existed at: Rule 45.17.2 Resident Rights M 500 Level IV Isolated The facility submitted an acceptable Removal Plan on 6/19/21 in which the facility alleged all corrective actions were completed 6/18/21 and the IJ was removed on 6/19/21. The SA validated the Removal Plan on 6/21/21 and determined the IJ was removed on 6/19/21. Therefore, the scope were lowered to a scope and severity was lowered to Level II while the facility develops and implements a plan of correction and monitors for the effectiveness of	M 000		

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M 000	Continued From page 1 the systemic changes to ensure the facility sustains compliance with regulatory requirements. The facility held a license for 60 beds with a census of 43.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance	M 500		8/1/21

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M 500	Continued From page 2 with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;	M 500		

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M 500	Continued From page 3 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);	M 500		

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M 500	Continued From page 4 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level IV Based on resident interview, staff interview, record review, and facility policy review, the facility failed to ensure a resident was free from involuntary seclusion for one (1) of five (5) residents reviewed for involuntary seclusion. Resident #1 On 6/7/21, at approximately 4:00 PM, the	M 500	• The Administrator was notified by Employee #1 that a dirty linen cart and a Hoyer lift was in front of the door of Resident #1's room. Employee #2 removed the objects from the doorway @ 3:52 pm on June 7, 2021. Certified Nurse Assistant #4 was put on investigative leave on June 7, 2021 and terminated June 8, 2021 by the Administrator. An in-service on June 7, 2021 by	

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M 500	Continued From page 5 Administrator was notified by Employee #1 that a dirty linen cart and a Hoyer lift was in front of the door of Resident #1's room. The cart and lift were blocking the door preventing Resident #1's exit from the room. Employee #2 removed the objects from the doorway. The Administrator viewed camera footage and noted at 3:45 PM Registered Nurse (RN) #5 assisted Resident #1 to his room due to him being naked in the hallway. RN #5 immediately exited Resident #1's room and talked with Certified Nursing Assistant (CNA) #4. RN #5 then returned to her medication cart. CNA #4 pushed a linen/laundry cart into the doorway of Resident #1. Resident #1 pushed the cart away from the door and CNA # 4 put the cart back in front of Resident #1's door and pushed a total lift in front of the laundry cart to hold it in place. Employee #1 and Employee #2 exited the therapy department, which is next door to Resident #1's door and saw the door blocked. Employee #2 removed the cart and lift to allow Resident #1 to exit the room. RN #5 then helped Resident #1 back to his room to get dressed. The Administrator did not suspend RN #5 pending investigation. RN #5 was allowed to complete her scheduled shift on 6/7/21. RN #5 also worked in the facility on 6/8/21, 6/9/21, 6/10/21, 6/13/21, 6/14/21, and 6/15/21. The facility's failure to protect Resident #1 from involuntary seclusion and allow a staff member to work in the facility following an incident of witnessed involuntary seclusion placed Resident #1 and other residents at risk in a situation that was likely to cause serious injury, harm, impairment or death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care which began on 6/7/21 when the involuntary	M 500	Administrator on resident's rights, abuse, neglect, and involuntary seclusion of vulnerable adults was conducted for all employees at facility. Registered Nurse #5 was terminated June 18, 2021 by the Director of Nursing. Resident #1 was assessed on June 7, 2021 for any physical or mental anguish or bodily injury by Employee #3. None were noted. Resident #1 was provided a staff member to monitor him during waking hours on June 18, 2021, and to keep him engaged in an activity to help reduce the behavior of disrobing in public. Frequent well checks were also initiated on June 7, 2021, by Director of Nursing. Resident #1 was discharged home with father on June 25, 2021. • All residents have the potential to be affected by this when an allegation is made against an employee and they are not placed on investigative leave. • Frequent well checks for Resident #1 were continued through June 18, 2021, by Director of Nursing. On June 18, 2021, Staff Development Nurse in-serviced all available staff on resident rights, abuse, neglect, involuntary seclusion and reporting of such. In-services will be conducted by Ombudsman on July 29, 2021 on her job duties, how to interact with residents and how she can do be of assistance for residents. • In-services on resident rights, abuse, neglect, involuntary seclusion, and reporting will be conducted by Administrator, Director of Nursing or Staff Development Nurse monthly at all staff in-service beginning June 29, 2021. Social Services will interview five residents	

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M 500	Continued From page 6 seclusion occurred. The facility's Administrator was notified of the IJ and SQC on 6/18/21 at 5:30 PM and provided with the IJ templates. A credible Removal Plan was provided by the facility on 6/19/21, in which the facility alleged all corrective actions were completed as of 6/18/21, and the IJ was removed on 6/19/21. The State Agency (SA) validated the Removal Plan on 6/21/21 and determined the IJ was removed on 6/19/21. Therefore, the scope and severity for Rule 45.17.2 Resident Rights, (M500) was lowered from a Level IV to a Level II while the facility develops and implements a plan of correction and monitors for the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Review of the facility's policy titled, "Abuse Program", revised May 23, 2017, revealed,"It is the policy of this facility to take all steps necessary to maintain an environment free of abuse and neglect. Each resident has the right to be free from verbal, sexual, physical, and mental abuse, neglect, exploitation, misappropriation of resident property, and involuntary seclusion. The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, consultants, volunteers, sponsors, visitors, surrogates, friends, and other caregivers who provide care and services on behalf of the facility... Involuntary Seclusion is defined as separation of a resident from other residents or from her/his room or confinement to his/her room (with or without roommates) against the residents will, or	M 500	weekly for three months for reporting of any type of abuse, neglect, involuntary seclusion and reporting of such to begin July 14, 2021. This will be monitored through the review of in-service sign in sheets monthly for six months by the Administrator or Director of Nursing. Any negative finding through either in-services, interviews, or investigations will be brought to the Quality Assurance Committee by the Administrator quarterly for review beginning July 28, 2021 for six months. Negative outcomes will be addressed with an action place through the Quality Assurance Committee beginning July 28, 2021.	

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the will of the resident's legal representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs".

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

A telephone interview, on 6/17/21 at 5:46 PM, with Certified Nursing Assistant (CNA) #4, revealed on the day of the incident, 6/7/21, she was getting vital signs when Registered Nurse (RN) #5 told her to get one of the residents and change him because his family was waiting for him. CNA #4 stated that while she was in the room changing that resident, RN #5 came in the room and told her that Resident #1 was in the hallway naked and was hitting her and said she needed some help. CNA #4 stated that she left the resident and went into the hallway to help. Resident #1 was in his room naked, and RN #5 told her to put the laundry cart in front of his door. CNA #4 stated she put the laundry cart in Resident #1's doorway and was going back to finish the other resident when Resident #1 moved the laundry cart. She stated she put the linen cart back in front of his door and got the lift and put it in front of the linen cart. CNA #4 confirmed she locked the wheels on the linen cart and the lift. She stated that when she came out of the other resident's room the cart and lift had been moved. CNA #4 stated that RN #5 told her that she had already taken care of Resident #1. CNA #4 stated

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

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

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

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

An interview, on 6/18/21 at 10:00 AM, with Employee #2 revealed that she was walking to the therapy department and noticed a laundry cart in front of the door of Resident #1 with a lift wedged under the laundry cart and blocking the doorway of the room. She stated that she went into therapy and reported it to her supervisor, Employee #1. Employee #2 stated that she saw

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the Director of Nurses at the medication cart in the hallway talking to the nurses. Employee #2 stated that she unlocked the cart and the lift and moved them. She stated Resident #1 was sitting close to the laundry cart in his room. He appeared to be in no distress. She stated that she did not remember seeing Resident #1 push on the cart. She stated that she moved the equipment across the hall and thinks that she went back to therapy at that time because other people had come to the room. She remembered seeing the Director of Nursing and she saw CNA #4 come out of another room. She stated that she had had not seen seclusion before.

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

An interview on 6/18/21 at 10:25 AM, with Employee #7 revealed Employee #2 came into therapy room and told them to come look at this. Employee #7 stated she saw a laundry cart against the door and a lift against the laundry cart in front of Resident #1's room. She stated that Resident #1 was sitting calmly behind the cart looking out the door around the side of the cart.

An observation and interview, on 6/18/21 at 11:10 AM, with the Administrator (ADM) confirmed the cart that was placed in front of Resident #1's door was a three (3) compartment cart that held dirty linen in one section, trash in another section and

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dirty briefs in the other section. She confirmed that he could be injured trying to push the cart out of the way and possible danger due to the dirty items in the bins. The cart was approximately two (2) feet wide by five (5) feet long.

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

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

An interview, on 6/18/21 at 4:30 PM, with CNA #3, revealed that she had seen Resident #1 outside the room with a laundry cart halfway

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blocking the door. She said he may have pushed it out of the way to get out of the room. She stated that she had seen this twice. CNA #3 stated she could not remember when she saw it. CNA #3 stated that Resident #1 does have behaviors and he hits at the nurses, but the cart should not have been in the doorway. She stated that she should have moved it.

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

An interview, on 6/18/21 at 11:09 AM, with the Administrator (ADM), revealed that she called in the seclusion incident to the State Agency within two hours. She confirmed that the therapy staff notified her of the incident. She stated that RN #5 should have been making sure all the residents were taken care of and that the staff was doing what they should have been doing. The ADM confirmed that telling the CNA to put the linen cart in front of a Resident's door was not a prudent practice for any nurse. She stated that she should have sent both of them home, but she thought at the time that it was OK for RN #5 to stay and finish her shift because she was in the building until 10:30 or 11:00 PM. She stated that she had staff that could have covered if she had sent RN

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINEYARD COURT NURSING CENTER	2002 5TH STREET NORTH COLUMBUS, MS 39705

(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) COMPLETE DATE
M 500	Continued From page 12	M 500		

#5 home. She stated at the time she did not feel like Resident #1 was in any harm, although, she did agree that the incident should not have happened. The ADM stated that during her interview with RN #5 and CNA #4, they both understood the severity of the situation and RN #5 and CNA #4 knew where they went wrong. No one had reported any other similar incident until this incident on 6/7/21. The Administrator stated, at the time, she felt like she did what she should, but in hindsight she stated she should have sent them both home.

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

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

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

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

Record review of the Face Sheet revealed the facility admitted Resident #1 on 3/6/19. Admitting diagnoses included Conversion disorder with seizures or convulsions, Unspecified Psychosis

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M 500	Continued From page 13	M 500		

not due to a substance or known physiological condition; Epilepsy unspecified, not intractable, without status epilepticus; Cerebral Palsy, Unspecified; Persistent Mood (affective) disorder; Unspecified, Impulse disorder, Unspecified Convulsions; Cognitive communication deficit; Restlessness and agitation.

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

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

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

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

2. Administrator began an investigation on 06/07/2021 at 4:30 pm by reviewing camera footage to see persons involved. Administrator determined Employee # 4 had placed dirty linen cart and Hoyer lift in front of resident # 1 doorway. Administrator called Employee # 4 to Administrator office for statement. Employee #4 stated she was told by Employee #5 to place the

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M 500	Continued From page 14 dirty linen cart in front of the Resident #1's door until she could get to dress him. Employee # 4 was then placed on investigative leave. Employee # 5 was called to Administrator office for statement. Employee # 5 was in-serviced one on one on resident's rights, abuse, neglect, and involuntary seclusion of vulnerable adult by the Administrator and Employee # 5 was allowed to finish her shift until 11:00 PM under the supervision of the Administrator and was told not to return to work until the investigation was finished. Employee # 5 continued to work her scheduled shifts on 6/8/2021, 6/9/2021, 6/10/2021, 6/13/2021, 6/14/2021, and 6/15/2021. 3. Employee # 3 assessed Resident #1 for any physical or mental anguish or potential body injury, and none was noted 06/07/2021 at 4:45PM. 4. Administrator in-serviced all available staff on 3-11 shift on 06/07/2021 beginning at 5:00 pm. Resident # 1 was put on frequent well-being checks by nursing staff each two hours. 5. On 06/07/2021 through 06/10/2021, all staff on each shift were in-serviced on resident's rights, abuse, neglect, and involuntary seclusion of vulnerable adults. 6. CNA # 4 who was involved was put on investigative leave on 06/07/2021 at 5:45 PM and terminated on 06/08/2021 by telephone after investigation was complete. 7. On 06/10/2021, cognitive residents that were cared for by CNA # 4 and RN # 5 were interviewed by Employee # 6 with no adverse outcomes.	M 500		

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M 500	Continued From page 15 8. On 6/11/2021, Psychiatric Nurse Practitioner came to facility to assess Resident # 1 for a routine visit. Psychiatric Nurse Practitioner noted there were no new concerns noted from the recent incident on 06/07/2021. The following steps were taken to remove the immediacy: A. Staffing was immediately reviewed by Administrator and Director of Nursing to ensure adequate staff were in place for the following shifts. There were no adjustments needed to the staff scheduled. B. On 6/18/2021, at 5:45 PM, the Staff Development Coordinator immediately began in-servicing all available staff on resident rights, abuse, neglect, and involuntary seclusion of vulnerable adults, and the reporting of such. C. All staff are to be in-serviced on resident's rights, abuse, neglect, and involuntary seclusion prior to returning to work. No staff will be allowed to return to work until in-service education has been completed. D. Resident #1 was observed during the wellness checks 06/07/2021 through 06/18/2021 for any negative outcomes, mental anguish, or changing behaviors and none were noted. E. RN Employee # 5 was terminated on 6/18/2021 at 7:12 PM and was reported to the Board of Nursing on 6/18/2021 at 9:13 PM by the Director of Nursing. F. On 6/18/2021 at 6:00 pm the Quality Assurance Meeting was conducted with the Medical Director via phone, Human Resource	M 500		

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M 500	Continued From page 16 Director, Maintenance Supervisor, Wound Care Registered Nurse (RN), Staff Development Coordinator/Infection Control Nurse, Dietary Manager, Business Office Manager, Social Service Director, Housekeeping Supervisor, RN MDS Coordinator, Medical Records Licensed Practical Nurse (LPN), Activities Director, Director of Nursing, and the Nursing Home Administrator. The Quality Assurance Committee discussed increasing Resident # 1's daily activities, purchasing a cd player/radio for entertainment, reaching out to specialty services to get ideas to assist with resident behaviors, increase staff if behaviors are noted, in-service staff on how to react to resident behavior(s), and view camera more frequently. The policy on Abuse Prohibition was reviewed during the Quality Assurance Meeting and there were no changes needed. Corrective actions to remove the Immediate Jeopardy was completed on 6/18/21. The facility alleges the IJ was removed on 6/19/21. On 6/21/21, the State Agency (SA) validated the facility's Removal Plan through observation, staff interviews, review of in-service sign in sheets and record reviews of documents across all disciplines. The SA verified the facility had implemented the following measures to remove the IJ: The State Agency validated that Resident #1 was free from involuntary seclusion that occurred on 6/7/21 when RN #5 instructed CNA #4 to put a laundry cart in front of Resident #1's doorway to prevent him from leaving his room and CNA #4 also putting a body lift in front of the laundry cart to prevent the resident from leaving his room. The Administrator knew of the incident on 6/7/21	M 500		

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M 500	Continued From page 17 and failed to protect the resident by not suspending RN #5. A. The SA validated through interview and record review that adequate staffing was in place. B. The SA validated through staff interviews and record review that in-service education had been initiated on 6/18/21 concerning resident rights, abuse, neglect, involuntary seclusion of vulnerable adults, and the reporting of such. C. The SA validated through record review and staff interviews that no staff would be allowed to return to work until in service education had been completed. D. The SA validated by observation, staff interview, and record review that Resident #1 had been observed during the Wellness checks for any negative outcomes. None were noted. E. The SA validated through interview and record review that RN Employee #5 was terminated on 6/18/21 at 7:12 PM and was reported to the Board of Nursing on 6/18/21 at 9:13 PM by the Director of Nursing. F. The SA validated through record review and interviews the Quality Assurance Performance Improvement (QAPI) meeting was held on 6/18/21. The SA validated that all corrective actions were completed as of 6/18/21 and the IJ was removed on 6/19/21.	M 500		