STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115521	A. Building B. Wing	05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A.G. Rhodes Home, Inc - Cobb	900 Wylie Road Marietta, GA 30067

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44243 Based on record review, interviews, review of facility video footage, and policy review, it was determined the facility failed to protect one of four residents (R) R#23 from sexual abuse. Observation of facility video footage revealed on 1/1/22, R#270 (a cognitively intact resident) stood in front of R#23 for approximately 11 minutes while R#23, who was severely cognitively impaired, was seated in a chair. Observation of the video revealed during the approximate 11 minutes, R#270 touched/rubbed R#23's breast area on four separate occasions. On two of the four occasions, R#270 touched/rubbed R23's breasts while R#270 was standing in front of the resident with his/her genitals exposed. R#270 was also observed touching/rubbing his/her genitals in front of R#23. In addition, the facility failed to protect one of four residents, R#58, from potential sexual abuse. According to the facility, on 1/2/22, staff witnessed R#270 with his genitals exposed on/beside R#58's bed. This had the potential to cause psychocial harm to R#23 and R#58. Findings include: Review of the facility policy titled, Abuse Prohibition Policy and Procedures, revised 1/3/22, revealed the facility is committed to actively preserving each elder's right to be free from abuse or mistreatment of any kind. Sexual abuse was defined as Sexual abuse is non-consensual sexual contact of any type with an elder as defined at 42 CFR 483.5. Generally, sexual contact is nonconsensual if the elder either appears to want the contact to occur but lacks the cognitive ability to consent; or does not want the contact to occur. Sexual abuse includes but is not [sic] limited to: a. Unwanted intimate touching of any kind especially of breasts or perineal area. According to the policy, the facility would investigate each elder-to-elder altercation as a potential situation of abuse. The policy further revealed, In the event of confirmed elder to elder abuse of any kind [the facility] shall provide each elder with a physical assessment, provide care planning interventions to address the elder's distressed behaviors, evaluate the effectiveness of the interventions, and provide immediate interventions to assure the safety of elders. According to the policy, If there is an elder-to-elder altercation, the staff will: (i) complete a thorough assessment of each elder in order to identify situations or factors that may have triggered the behavior and (ii) implement measures to protect the victimized elder from any further incidence of abuse. Based on the results of the assessment, interventions strategies will be developed on the care plan or behavior management plan to prevent reoccurrence, including monitoring for factors that trigger abusive behaviors from the aggressor. The care plan, including interventions, will be evaluated on a regular basis and updated and revised as necessary. According to the policy, For any alleged violation of sexual abuse, staff must: a. Immediately implement safeguards to prevent further potential abuse to protect the alleged victim(s). (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of R#270's Admission Record revealed the facility admitted the resident with diagnoses which included encephalopathy, Parkinson's disease, major depressive disorder, and post-traumatic stress disorder. A review of R#270's admission Minimum Data Set (MDS), dated [DATE], revealed the resident was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. The resident required extensive assistance with bed mobility, transfers, walking, locomotion on and off the unit, and dressing. The MDS indicated he had no physical, verbal, or other behavioral symptoms directed and/or or not directed toward others, including abusing others sexually, public sexual acts, and disrobing in public. The MDS revealed he utilized a wheelchair for mobility. Review of Progress Notes, dated 1/5/22 at 9:05 a.m. revealed the facility discharged R#270. On discharge, the resident was independent with bed mobility, dressing, toileting, personal hygiene, and with a walker. Review of a facility investigation revealed on 1/6/22, R#265 reported R#270 came into her room and touched her inappropriately. She stated the incident occurred on 1/2/22 and 1/3/22 when R#270 rubbed his/her genitals on her buttocks. The facility interviewed another resident, R#71, who stated she had observed a resident enter R#265's room and alerted a staff member. The interview coincided with camera footage which revealed on the afternoon of 1/2/22, R#270 entered the room of R#265. R#71 beckoned Certified Nursing Assistant (CNA) CCC, who proceeded into R#265's room. According to the investigation, CNA CCC asked R#265 if she had been touched and the resident said, No I am fine. The facility notified the police of R#265's allegation. According to the facility's investigation, dated 1/13/22, the facility unsubstantiated that R#270 abused R#265, stating R#265 could not discern whether the she was dreaming, sleeping/awake during the alleged incident. The facility concluded R#265's probable history of prior sexual abuse and negative urine test for an infection, compounds speculation of [R#265's] behaviors suggesting Parkinson's related. Further review of the facility's investigation revealed on 1/2/22, prior to R#265 making the allegation on 1/6/22, the facility had implemented interventions to safeguard the safety/wellbeing of others initiated-ie [id est; that is]; 30 minute visual checks prompted [for R#270] and [R#270] was moved to another room/hallway on 1/2/22. A review of R#270's care plan and Progress Notes revealed no documented evidence the facility implemented an intervention for 30-minute visual checks for the safety/wellbeing of others. An interview with Police Detective WWW on 5/16/22 at 11:43 a.m. revealed he went to the facility to investigate R#265's alleged sexual abuse. Although Police Detective WWW advised the surveyor that he was unable to understand her narrative of the alleged abuse, the police had reviewed facility video footage from the time R#270 was admitted to the facility until the resident was discharged . Per Police Detective WWW, the video footage revealed an instance when R#270 exposed himself and fondled R#23's breast. Police Detective WWW revealed that although not caught on camera, the facility reported that staff, CNA SSS, had observed R#270 exposing himself to R#58 in the room R#58 shared with R#265. He stated that the investigation was still open, and he was not allowed to share anything further. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a facility Addendum to Incident Report, dated 1/26/22, revealed the facility reviewed video footage going back from 1/5/22, the day R#270 was discharged . The addendum revealed while the facility was aware R#270 had gone into the room shared by R#265 and R#58, video footage revealed R#270 exposed himself to R#23 while the resident sat in a chair and touched R#23 around the breast area. The facility addendum revealed R#270 came back a few minutes later and sat in a chair while R#23 stood in front of R#270. R#270 proceeded to put his/her hand under R#23's gown. 1. A review of R#23's Admission Record revealed the resident had diagnoses that included Alzheimer's disease, unspecified dementia with behavioral disturbance, age-related nuclear cataract, cognitive communication deficit, and major depressive disorder. A review of R#23's quarterly Minimum Data Set (MDS), dated [DATE], revealed the resident was severely cognitively impaired, with a Brief Interview for Mental Status (BIMS) score of three. The resident required extensive staff assistance with all activities of daily living. A review of facility video footage dated 1/1/22 at 7:06 p.m. revealed a 12 minute, 38 second video of a facility hallway where R#23 was sitting in a chair. R#270 entered the hallway at the 53 (0:53) second mark of the video and walked toward R#23 utilizing a walker. As R#270 walked toward the resident, R#270 looked in every door. The video revealed at one minute and 25 (1:25) seconds, R#270 stopped in front of R#23 and although there is no audio, the residents appear to be conversing. R#270 rubbed R#23's right shoulder area, looked down the hallway, and touched the resident's left breast area. At one minute, 57 seconds (1:57), he looked down the hallway and took R#23's left hand toward his genital area. R#270 stepped closer to R#23 and his genital area and R#23's hand were no longer visible on the video. R#270 then rubbed R#23's breast area with his left hand. He stepped back and walked away but after looking into a nearby room, the resident turned around and went back to R#23. Review of the video revealed R#270 was facing the camera and his back was toward the hallway. R#270 turned to look down the hallway, then rubbed his own genital area. After the third time rubbing his genital area, he placed his hand on R#23's forehead, looked down the hallway and rubbed his genital area again for approximately 22 seconds until a staff member entered the hallway. The staff member was observed with bags in her hand. She carried the bags to the end of the hallway, then turned around and entered a room off the hallway. While watching for the staff member, still standing in front of R#23, R#270 rubbed his own genital area twice. At the eight minute and 15 second mark (8:15) of the video, the staff member left the hallway. R#270 pulled down his pants and exposed his genitals at the eight minute, 29 second mark (8:29) of the video. He stood in front of R#23 with his genitals exposed for approximately one minute and 34 seconds. During the approximate 1.5 minutes, R#270 attempted to take R#23's hand on one occasion, touched/rubbed his own genital area twice and touched/rubbed R#23's breast area twice while his genitals were exposed. After pulling up his pants, R#270 continued to stand beside R#23 and appeared to be conversing with her. Further review of the video revealed while talking, R#270 touched his own genital area and rubbed R#23's left shoulder area on two occasions. At the 12 minute, 5 second mark (12:05) of the video, he turned and walked away from R#23, who was still seated in a chair, and walked into another room. An interview with the Administrator on 5/18/22 at 10:12 a.m. revealed after R#265's allegation, the facility reviewed closed-circuit television (CCTV) archived video footage and found that on 1/1/22 at approximately 7:00 p.m. through 7:20 p.m., R#270 was seen on the video touching R#23's breast and exposing his own genitals to her. The Administrator stated the incident was added as an addendum to the investigative report filed with the state department for R#265's allegation of sexual abuse. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	2. A review of R#58's Admission Record revealed the resident had diagnoses that included dementia without behavioral disturbance, contractures, cognitive communication deficit, and altered mental status. A review of R#58's quarterly Minimum Data Set (MDS), dated [DATE], revealed the Staff Assessment for Mental Status indicated the resident had severely impaired cognition. The resident was totally dependent on staff for bed mobility, transfer, locomotion, dressing, eating, toilet use, and personal hygiene. A review of facility video footage revealed on 1/2/22 at 12:23 p.m. R#270 went into the room shared by R#265 and R#58. At 12:24 p.m. R#71 turned around to look for R#270 in the room and stayed in the area in the front of the room. At 12:26 p.m. on 1/2/22, CNA SSS went into the room shared by R#265 and R#58. During an interview on 5/18/22 at 10:02 a.m. R#71 did not recall what prompted the resident to notify CNA SSS when R#270 was observed going into the room. The resident did not recall anything about the incident. According to the facility, CNA SSS, was on vacation. The surveyor attempted to contact CNA SSS on 5/19/22 at 10:04 a.m., on 5/19/22 at 10:27 a.m. and on 5/20/22 at 2:22 p.m., without success. During an interview on 5/18/22 at 10:12 a.m., with the Administrator, revealed she was aware that on 1/2/22, R#71 alerted CNA SSS when R#270 went into the room shared by R#265 and R#58. The Administrator stated, quoting CNA SSS's observation that R#270 was observed on the bed space and/or bedside of [R#58] who was [R#265's] roommate with [R#270's] pants down and his [genitals] exposed to [R#58]. She stated she did not deem the incident a reportable incident given that there was no sexual contact of any form observed. However, during a follow-up interview with the Administrator on 5/19/22 at 4:11 p.m., she acknowledged that R#270 exposing himself to R#58 and R#23 fit the nudity language under the regulatory language of F600. She stated she did not see the mere exposure situation perpetrated by R#270 against R#58 as a potential abuse at the time of the incident. She reiterated the facility's action regarding moving R#270 out of the unit to another unit and having staff check the resident every 30-minutes. The Administrator added that R#270 was discharged to another facility. In addition, the Administrator stated that the facility's interdisciplinary team (IDT) met to discuss the situation. Per the Administrator, the families of the victims of the abuse (R#58 and R#23) were notified, and the residents were assessed for any evidence of sexual assault, psychological breakdown, changes in behaviors and no concerns were identified. During an interview on 5/19/22 at approximately 9:55 a.m. with the Social Worker (SW) VVV stated that if a resident was involved in sexual abuse, the facility assessed the resident for signs of trauma. She stated the nursing department spoke to the resident to get an insight of how she felt. SW VVV stated that if the victim was not able to verbalize how they felt due to cognitive impairment, staff went off their non-verbal cues. SW VVV added that staff also observed for changes in behavior, like withdrawal. Per SW VVV, the facility involved the medical director and alerted the family. Social Worker VVV stated the facility conferred as a group to determine whether R#270 abused residents. Social Worker VVV stated the situation with R#270's exposure to R#58 was deemed inappropriate, not unwanted sexual contact. According to SW VVV, exposure to nudity was not traumatizing, so it was not considered an abuse. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/19/22 at 9:30 a.m. with the Director of Nursing (DON) stated when R#270 exposed himself to another resident, it was considered an inappropriate exposure. Per the DON, the facility immediately removed him from the unit, his room was changed, and the resident was later discharged . The DON stated that the IDT team held a meeting, and the residents who were identified as the victims were assessed for any outcome. She stated the facility completed head-to-toe skin assessments for any indication of sexual assault and assessed the residents for any change in mental status that may have resulted from the exposure. She stated that calls were made to the family members of the victims of R#270's inappropriate exposure, notifying them of the incident. The Director of Nursing reiterated that the situation was considered inappropriate behavior. During an interview with the Director of Clinical Services on 5/18/22 at 2:38 p.m., she stated the situation with R#270's interaction with R#58 should have been handled differently. Per the Director of Clinical Services, everyone analyzed situations differently. The Director of Clinical Services stated that if she had handled the investigation, she would have considered it some sort of sexual abuse.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44243 Based on interview, record review, review of facility video footage, and facility policy review, it was determined the facility failed to report an incident of abuse for one of four residents (R) (R#58) reviewed for abuse. Specifically, R#270 exposed his genitals to R#58 on 1/2/22, and the facility failed to report the alleged incident to the Georgia Department of Community Health (DCH). Findings include: A review of the facility's Abuse Policy titled, Abuse Prohibition Policy and Procedures, revised 1/3/2022, revealed 7. Reporting/Response to the Georgia Department of Community Health (DCH), Health Facility Regulation Division (HFRD). B. Upon receiving an allegation of abuse, the Reporting Personnel shall complete and submit a Facility Report to the Georgia Department of Community Health (DCH), Health Facility Regulation Division (HFRD) Long Term Care Section. C. If the event that an allegation of abuse is made, the Reporting Personnel shall submit a completed Facility Report to HFRD immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse or results in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse and does not result in serious bodily injury. A review of the Admission Record revealed the facility admitted R#58 with diagnoses which included unspecified dementia without behavioral disturbance, cognitive communication deficit, and altered mental status, unspecified. The quarterly Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) assessment was not completed with the resident and the resident's cognitive skills for daily decision making were severely impaired. The resident required one-person physical assistance for bed mobility, transfer, locomotion, dressing, toilet use, and personal hygiene. Review of the Admission Record revealed the facility admitted R#270 on 12/15/21. Resident #270's diagnoses included Parkinson's disease, major depressive disorder, and post-traumatic stress disorder. The admission Minimum Data Set (MDS), dated [DATE], revealed the resident was cognitively intact, with a BIMS score of 15 out of 15. The resident required extensive assistance with bed mobility, walking, locomotion, dressing, eating, toilet use, and personal hygiene. The resident required extensive assistance with transfer. An interview with Police Detective WWW on 5/16/22 at 11:43 a.m. revealed he was at the facility to investigate an alleged sexual abuse situation against R#265. Police Detective WWW advised they reviewed the video footage from the time R#270 (the alleged assailant) was admitted at the facility until his discharge from the facility. Police Detective WWW stated although not caught on camera, during the investigation the facility reported a staff member, Certified Nurse Assistant (CNA) SSS observed R#270 expose himself to R#58 in the room she shared with R#265. He stated that the investigation was still open, and he was not allowed to share anything further. (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	On 5/16/22 at approximately 12:11 p.m. the Administrator provided a copy of the facility's investigation dated 1/13/22 with an addendum dated 1/26/22, into the alleged sexual abuse perpetrated by R#270 against R#265. The investigation revealed the facility reviewed video footage from the time frame R#270 was admitted to the facility 12/15/21, until the resident's discharge 1/5/22. The investigation affirmed the narrative of Police Detective WWW as reported above. CNA SSS, who was identified in the facility's investigation as the staff member who observed R#270 expose himself to R#58 in her room, was reported as being on vacation. Surveyor attempted to contact CNA SSS on 5/19/22 at 10:04 a.m., on 5/19/22 at 10:27 a.m., and on 5/20/22 at 2:22 p.m. without success. During an interview on 5/18/22 at 10:12 a.m., the Administrator stated there was one episode when CNA SSS was tipped off by R#71. According to the Administrator, R#71 alerted CNA SSS when R#270 went in the room R#265 shared with R#58 on 1/2/22. The Administrator stated CNA SSS observed R#270 by the bedside of R#58 who was R#265's roommate. CNA SSS observed R#270's pants were down, and his genitals were exposed to R#58. The Administrator acknowledged that the facility did not report CNA SSS's observation of R#270's exposure to R#58 to the State Department of Community Health. She stated she did not deem the incident a reportable incident, given that there was no sexual contact of any form observed to have been perpetrated by R#270 against R#58. The facility provided the surveyor access to the video footage with the timeline which showed the moment R#270 went into the room R#58 shared with R#265. The video showed R#270 went in the room R#265 shared with R#58 on 1/2/22 at 12:23 p.m. At 12:24 p.m., R#71 turned around to look for R#270 in the room and stayed in the area in the front of the room. At 12:26 p.m. the video showed CNA SSS went in the room of resident #58 and #265. During an interview with the Director of Clinical Services on 5/18/22 at 2:38 p.m., she stated that the situation with R#270's interaction with R#58 should have been handled differently. Per the Director of Clinical Services, everyone analyzed situations differently. The Director of Clinical Services stated that if she had handled the investigation, she would have considered it some sort of sexual abuse and reported it to the State Department of Community Health. During an interview with the Director of Nursing (DON) on 5/19/22 at 9:30 a.m., she stated when R#270 exposed himself to another resident, it was considered an inappropriate exposure. Per the DON, the facility immediately removed him from the unit. She stated his room was changed, and the resident was ultimately discharged . The DON reiterated that the situation was considered inappropriate behavior and was not necessarily a reportable incident. (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/19/22 at approximately 9:55 a.m., Social Worker VVV stated that if a resident was involved in sexual abuse, the facility assessed the resident for signs of trauma. She stated the nursing department spoke to the resident to get an insight of how the resident felt. Social Worker VVV stated that if the victim was not able to verbalize how they felt, staff went off their non-verbal cues. Social Worker VVV added that staff observed the victim for changes in behavior, like withdrawal. Per Social Worker VVV, the facility involved the medical director and alerted the family. Social Worker VVV stated the facility conferred as a group to determine if the situation was abuse or not. Social Worker VVV stated the situation with R#270's exposure to R#58 was deemed inappropriate, not unwanted sexual contact. She stated exposure was not traumatizing so it was not considered an abuse, hence not considered a reportable incident. She stated that it would have been considered a reportable incident if R#58 had been inappropriately touched, molested, and/or raped. She stated that there were no noted changes in the residents' behavior. During a follow-up interview with the Administrator on 5/19/22 at 4:11 p.m., she acknowledged that the exposure from R#270 to R#58 fit the nudity language under the regulatory language of F600. The Administrator stated she did not see the mere exposure situation perpetrated by #270 to R#58 as a potential abuse at the time of the incident.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45555 Based on record review and staff interviews, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the diagnosis of multiple sclerosis for one resident (R) R#20 of 56 residents whose MDS was reviewed. Specifically, the facility failed to ensure R#20 used a splint or brace before indicating the resident utilized one on the MDS. Findings include: Review of the clinical record revealed R#20 was admitted to the facility on [DATE] with a diagnosis of multiple sclerosis. The resident's most recent quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) was coded as 15, which indicates no cognitive impairment. Section G revealed resident required extensive assistance with bed mobility, dressing, toilet use and personal hygiene, total dependence with transfers and bathing. Section 0 revealed resident received at least 15 minutes of splint or brace assistance through a restorative nursing program for two out of seven days during the assessment period. Interview on 5/19/22 at 12:55 p.m. with R#20 stated she did not use splints or braces and had never had them and did not require them. Review of R#20's Care Plan revealed no evidence or documentation of the resident receiving splint or brace assistance. Review of R#20's May 2022 Physician's Orders revealed the resident had no orders for the use of splints or braces. A review of the task list for R#20 indicated the resident was to have splint/brace application on day and evening shift. A review of the task titled Splint/Brace application from 4/23/22 through 5/21/22, revealed documentation of the number of minutes spent providing splint or brace assistance. According to this report R#20 received assistance 15 to 30 minutes a day on 23 of the 29 days. Interview on 5/19/22 at 12:59 p.m. with Certified Nurse Assistant (CNA) EEE, stated R#20 did not wear splints or braces. Interview on 5/19/22 at 1:00 p.m. with CNA RR, stated R#20 had a splint but the resident did not wear it and she had not been putting it on the resident. She stated she always documented that she did not put the splint on R#20 because she had not seen it and the resident stated she did not have one. After reviewing the task documentation, CNA RR confirmed that she had in fact documented application of a splint or brace for at least 15 minutes on several occasions over the last 29 days and stated she must have documented by mistake. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/22/22 at 3:09 p.m. with CNA BBB, stated R#20 did not have a brace. She stated she only knew of one resident on the hall with a splint or brace and it was not R#20. CNA BBB stated she must have documented the brace application by mistake. Interview on 5/22/22 at 3:16 p.m. with CNA CCC, stated she followed the task list in the computer to know what care to provide for each resident. She stated R#20 did not have a brace and must have documented it by mistake because she had never seen a splint in the resident's room. Interview on 5/22/22 at 3:20 p.m. with Licensed Practical Nurse (LPN) QQ, stated if a resident had a splint or brace that needed to be applied, it would be on the task list for the CNAs to do. LPN QQ stated R#20 did not wear a brace and was unsure why it was on the task list or how it got there. Interview on 5/23/22 at 2:27 p.m. with the MDS Coordinator, Registered Nurse (RN) DDD, stated when she was completing the MDS, she reviewed the documentation and talked with the staff about what they were documenting. During further interview, she stated she did a physical assessment to verify what the CNA's and nurses were documenting. MDS Coordinator DDD stated she did not recall R#20 ever having a splint and did not realize it was coded on the MDS. She stated she thought it triggered on the MDS because the CNAs were charting it on the task list. She stated the task lists were manually put in by the Director of Nursing (DON) or other nursing supervisor. Interview on 5/25/22 at 10:05 a.m. with the DON, stated R#20 never had splints and was unsure how it ended up on the task list. The DON stated she thought the task list was generated from the MDS and care plan. The DON further stated she was unsure why the staff were documenting the splint. She stated the staff should be documenting correctly and letting her know if any changes need to be made. Interview on 5/25/22 at 10:20 a.m. with the Administrator, stated the task list was updated with the MDS and the staff should not be documenting something they were not doing. Follow-up interview on 5/25/22 at 11:37 a.m. with the DON, stated the Director of Clinical Services (DCS) had spoken with one of the therapists and confirmed that R#20 did not have the use of splints mentioned in the therapy notes or recommendations.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45555 Based on observations, record review, interviews, and policy review, the facility failed to ensure care and services were provided in accordance with physician orders for one resident (R) (R#321) of one sampled resident reviewed for treatment of swelling and thrombosis (blood clot) to the legs. Specifically, the facility failed to ensure staff applied compression stockings (TED hose) and elevate the lower extremities to reduce swelling. Findings include: Review of the undated policy titled, Policy for Edema/TED Hose, revealed edema (swelling) is a result of excess fluids collecting in the tissues, often caused by an underlying disease process that interfered with circulation (decreased blood perfusion) to the legs and feet. Edema is treated by medications or nonpharmacological approaches, such as elevation of extremities, TED (thromboembolic disease) hose, etc. [et cetera]. TED hose (or anti-embolic stockings) exert pressure on the veins to promote venous blood return to the heart. Procedure 1. The patient with edema should be encouraged/assisted to elevate affected extremities with edema on a routine basis throughout the day. The physician may also place orders for specific times of extremity(s) elevation to decrease edema. 2. The use of TED hose requires a physician order. 3. TED hose usage requires a licensed nurse to determine the correct size, length, and a physician order for when to remove them and for how long. A review of the clinical record for R#321 revealed resident was admitted to the facility on [DATE] with diagnoses of but not limited to diabetes, obesity, aftercare following joint replacement surgery, osteoarthritis right knee, hypertension (HTN), obstructive sleep apnea (OSA), and chronic embolism and thrombosis of deep veins of lower extremity. The resident's most recent Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) was coded as 15, which indicated no cognitive impairment. Section G revealed resident required extensive assistance of one to two people for activities of daily living (ADLs), including dressing. The resident did not exhibit any rejection of care. Review of the May 2022 Physician Orders revealed an order dated 4/25/22 for R#321's heels to be elevated while in bed for skin management. Further review revealed an order dated 5/12/22 for TED hose to both lower extremities. There was no frequency or duration specified. Review of the May 2022 Medication Administration Record (MAR) revealed an order dated 5/12/22 for TED hose scheduled at 7:00 a.m. and 7:00 p.m. Nurses' initials were documented to indicate this was completed daily 5/13/22 through 5/19/22. Further review of the MAR revealed the order for elevation of the heels while in bed was entered as an as-needed (PRN) order, and there were no nurses' initials documented to indicate this was done during the month of May 2022. Review of a MD (Medical Doctor) Note, dated 5/10/22 at 11:03 a.m. indicated R#321 had a total knee replacement on 4/25/22 and a hospitalization on [DATE] for a small non-occlusive deep vein thrombosis (blood clot) of the right distal femoral/proximal popliteal vein (vein that carries blood from the lower extremity back toward the heart). The note indicated the resident had right lower extremity swelling. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R#321's care plan dated 4/26/22, revealed no reference to TED hose use or the need to elevate the lower extremities due to swelling. Review of Progress Notes, dated from 5/12/22 through 5/20/22, revealed no references to R#321's TED hose use or that the resident refused the TED hose, only that the left leg was elevated on a pillow. Interview on 5/16/22 at 3:53 p.m. R#321's family member stated the resident was supposed to be wearing TED hose and keeping his feet elevated, but the facility was not assisting the resident to do this. Observation at this time revealed R#321 sitting in his room, in a wheelchair that had foot pedals that could be elevated; however, the resident's feet were resting on the floor. The resident did not have TED hose on at this time. Observation on 5/17/22 at 3:06 p.m. of R#321 revealed the resident sitting up in the wheelchair in his room reading. The resident was wearing shorts and did not have TED hose on, and his legs were not elevated Interview on 5/17/22 at 3:14 p.m. with R#321 stated he had not seen any TED hose and that the staff had not put any type of compression stockings on him. Observation on 5/18/22 at 10:06 a.m. of R#321 revealed the resident was sitting up in the wheelchair in the resident's room. The foot pedals on the wheelchair were down, and the resident's feet were on the floor. The resident was wearing non-slip socks and was not wearing TED hose. Observation on 5/19/22 at 11:06 a.m. of R#321 revealed the resident sitting in the wheelchair in his room doing a crossword puzzle. The foot pedals were not on the wheelchair, and the resident's feet were on the floor. The resident was not wearing TED hose. The resident had slight swelling visible to the right knee. Observation on 5/20/22 at 11:46 a.m. of R#321 revealed the resident sitting in the wheelchair in his room. The foot pedals were not on the wheelchair, and the resident's feet were on the floor. The resident was not wearing TED hose. Observation of R#321 on 5/21/22 at 11:01 a.m. revealed the resident sitting up in the wheelchair in his room. The resident's call light was on, and the resident stated he wanted to get in bed to put his feet up but needed assistance. The foot pedals were not on the wheelchair. R#321 was wearing non-slip socks but was not wearing TED hose. There was no TED hose seen in the room or the bathroom. Interview on 5/21/22 at 11:14 a.m., with Certified Nurse Assistant (CNA) KKK, stated if a resident had TED hose, it would be on the task list for the CNA to do. She stated TED hose usually are put on at 6:00 a.m. and came off at 6:00 p.m. She stated R#321 did not wear TED hose. Review of the task list in R#321's electronic medical record revealed no instructions for the nurses or CNAs to apply TED hose or elevate the resident's legs/feet. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/21/22 at 11:26 a.m. with Licensed Practical Nurse (LPN) AAA, stated R#321 did wear TED hose but the night shift usually put them on before she arrived for her shift. She stated she had not had a chance to make sure the TED hose was on that day but then stated the resident did not want the TED hose on that morning, just wanted to elevate his feet. Upon entering R#321's room, LPN AAA stated the TED hose were usually kept on the shelf or the back of the wheelchair but was unable to find them. LPN AAA stated the TED hose had possibly been sent to laundry or the resident's family member may have taken them home. After reviewing R#321's MAR, which was initialed by LPN AAA to indicate the TED hose were on, she stated she must have documented by mistake. Review of the May 2022 MAR revealed the TED hose had been initialed as being applied at 7:00 a.m. on 5/21/22; however, after the above interview with LPN AAA, the documentation was changed, with a progress note that indicated the TED hose were not on and the bilateral lower extremities were elevated. Observation on 5/22/22 at 1:40 p.m. of R#321 revealed the resident had TED hose on both legs. The resident stated he did not know where they came from or why they were on. Interview on 5/25/22 at 10:05 a.m. with the Director of Nursing (DON) stated interventions that could be used to decrease edema in a resident's legs included elevating them while sitting, putting them on pillows, medications such as diuretics as prescribed, and the use of compression stockings as prescribed. The DON stated it was both the nurse and CNA's responsibility to ensure the TED hose were put on. She stated it should be on the task list for the CNA and then the nurse should follow up. She stated if the resident refused, the nurse should document it. The DON stated R#321 had orders for TED hose and should be wearing them. The DON stated if the resident was refusing or saying he did not want to wear the TED hose, the family and physician should be notified, and it should be documented. She stated the use of TED hose should be on the care plan, and the MDS nurse should document if the resident refused. She stated she was unsure why the staff were documenting they were doing something if they weren't. She stated the staff should be documenting correctly and letting her know if changes needed to be made. Interview on 5/25/22 at 10:20 a.m. with the Administrator stated the staff should be following physician orders and should not be documenting something they were not doing.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33516 Based on observations, record review, interviews, and policy review, the facility failed to ensure fall prevention interventions were added to the care plan and consistently implemented for one resident (R) (R#95) of three residents reviewed for accidents/hazards. Findings include: Review of the facility policy titled Fall Prevention Policy and Procedure dated 4/1/21, revealed the policy is 1. The facility will identify each resident who is at risk for falls and will plan care and implement interventions to assist in fall prevention. The facility will attempt to prevent falls by providing an environment that is free from potential hazards. 2. Nursing will complete the fall risk assessment. 3. A resident's fall prevention program will be implemented that educates staff in creative, functional strategies while recognizing residents and their need to maintain the highest practical level of function. Procedure: 1. Nursing assesses all residents for fall risk through the fall risk assessment upon admission, quarterly, and with a significant change. 2. Upon determination that the resident is at risk, individual interventions will be implemented. 3. If a fall occurs, the IDT [Interdisciplinary Team] will assess for injury from the fall, start neuro [neurological] checks every shift x [times] 72 hours, if appropriate investigate the reason and determines [sic] the intervention to prevent future falls. Review of the clinical record for R#95 revealed resident was admitted to the facility on [DATE] with diagnoses of but not limited to cerebral atherosclerosis, diabetes, osteoporosis, anxiety, hypertension (HTN), hypothyroidism, and depression. The resident's admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) was coded as three, which indicated severe cognitive impairment. Section G revealed resident requires extensive assistance with bed mobility, transfers, locomotion on and off the unit, and toilet use. The resident was not steady when moving from a seated to standing position, moving on and off the toilet, and during surface-to-surface transfers. The resident utilized a wheelchair for mobility. Section J revealed the resident had not experienced falls since admission but did experience a fall in the last two to six months prior to admission. Section V revealed resident at risk for falls. Review of the Order Summary Report revealed a verbal order dated 4/14/22 for fall risk interventions, to include keeping R#95's room free of clutter, placing the call light, and frequently used personal belongings within reach, placing the bed in a low position, assessing for pain, and assisting with transfers as needed every shift. Review of the care plan dated 4/15/22, revealed the resident was at risk for falls and injury related to adjusting to placement in a new environment. Interventions included keeping the bed in a low position, keeping the call light within reach, and having therapy to evaluate and treat as needed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/17/22 at 9:12 a.m., with family member of R#95, revealed the resident fell two to three weeks ago. Family member stated R#95 was kept at the nurses' station while awake because the resident tried to get up independently. Interview on 5/21/22 at 11:27 a.m., with Licensed Practical Nurse (LPN) AAAA stated after reviewing the medical record for R#95, revealed the resident had a fall on 4/23/22 at 10:00 p.m. She stated the resident was in bed and slipped out of the bed and onto the floor because she wanted to go somewhere. During continued interview, she stated the resident did not hit her head, and the bed was in the low position and the security light was on in the room. The interventions after the fall were to offer a snack and fluids, assist the resident to the bathroom, keep the bed in a low position, and keep the resident up in a chair in a common area for more efficient monitoring. Review of the care plan revealed the interventions to offer a snack and fluids, assist to the bathroom, and keep the resident up in a chair in a common area for more efficient monitoring were not updated after the fall on 4/23/22. Interview on 5/21/22 at 11:27 a.m. with LPN AAAA stated the resident had another fall on 4/29/2022 at 7:45 PM. The resident sat on the floor in the resident's room while in the wheelchair. The interventions were a low bed and having snacks, water, and the call light at the bedside. LPN AAAA stated the resident reported she got up and sat on the floor. LPN AAAA said the resident was confused and was sitting on the floor, relaxed, with her arms crossed. Review of the care plan revealed the intervention section was updated on 4/29/22 to include that the resident was found seated on her buttocks on the floor, with arms crossed on her chest, facing the door with the wheelchair right behind the resident. The care plan indicated the resident was in the wheelchair prior to being noted on the floor and that the resident stated she got down and just sat on the floor. No apparent injuries were noted, and the resident was able to move bilateral extremities. The resident denied falling or hitting her head. There is no evidence that new fall prevention interventions were added to the care plan after the 4/29/22 fall. Interview on 5/21/22 at 11:27 a.m. with LPN AAAA stated R#95 had a third fall on 5/18/22 at 9:00 p.m. The interventions were one-on-one (1:1) supervision, someone to be with the resident at all times until stabilized or sleeping, and to provide snacks. The LPN stated the resident did not have a sitter, so the staff put the resident at the nurses' station or in the TV room and just watched her. LPN AAAA further stated technically, the resident did have 1:1 supervision and, We can see her from the nurses' station. Observation on 5/17/22 at 2:34 p.m., R#95 was observed sitting up in bed watching television. Observation revealed the bed was not in the low position. Observation on 5/17/22 at 2:47 p.m. a visitor was observed in R#95 room for a visit. The resident was observed sitting in bed, and the bed was not in the low position. Observation on 5/19/22 at 3:15 p.m., R#95 was observed sitting in bed watching television. The bed was in the low position, but there was no evidence of staff members in the room to provide 1:1 supervision. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 5/21/22 at 10:53 a.m. the resident was observed sitting in a wheelchair near the nurses' station. There was no evidence of staff members providing 1:1 supervision of the resident. Interview on 5/21/22 at 10:56 a.m. with Certified Nursing Assistant (CNA) ZZZ, stated interventions for residents who were at risk for falls were to place fall mats down, provide a low bed, take the resident to an area where people can see them during the day if there was no sitter, offer help if the resident had to go to the bathroom, and offer snacks. CNA ZZZ stated she worked with R#95 and had taken the resident to sit at the nurses' station to be watched after the resident was showered that morning. She stated sometimes the resident watched television in the day room. The CNA indicated she was not working when R#95 fell , but she was aware the resident was a fall risk. She stated she thought the resident fell while trying to get up from bed. Interview on 5/21/22 at 11:27 a.m. with LPN AAAA, stated when a resident had a fall, the nurse would ask the resident what happened and look for any broken bones or head injuries. The LPN said interventions were placed immediately, based on what the resident was trying to do at the time of the fall. LPN AAAA stated the Director of Nursing (DON) would investigate the root cause of residents' falls and would talk to staff and discuss interventions for the resident, and then the interventions were then documented on the incident reports. Observation on 5/22/22 at 1:29 p.m. R#95 was observed sitting up in bed watching football. There was no evidence of staff members in the room to provide 1:1 supervision. Observation on 5/23/22 at 11:13 a.m. the resident was self-propelling in the wheelchair on the hall opposite where her room was located. There was no evidence of staff members with the resident to provide 1:1 supervision, and the resident was away from the nurses' station and day room. Interview on 5/23/22 at 2:27 p.m. with the MDS Coordinator, Registered Nurse (RN) DDD, stated she and the DON reviewed the incidents daily. She stated new interventions were supposed to be implemented when the incident report was completed. RN DDD said if she did not see interventions in the incident report, she returned the paper copy to the DON and followed up with an email to the DON. RN DDD confirmed R#95's care plan was not updated with interventions for the fall on 4/23/22. She stated the team knew what worked and what did not work and would implement a different intervention when needed. During a follow-up interview on 5/23/22 at 3:40 p.m. with RN DDD, stated she did not decide what interventions were put in place, the DON indicated the interventions on the incident reports and then she added them to the care plan. RN DDD stated it was not okay to use the same intervention for each fall. She stated she missed the fall on 4/29/22, but the interventions would have been the same because they were not changed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/23/22 at 4:30 p.m. with DON BB, revealed she reviewed the incident reports daily, talked to the nurses, and reviewed the interventions. She stated resident falls and interventions are discussed during the morning meetings with the interdisciplinary team (IDT) and the at-risk meetings to determine what happened and the cause of the fall. She stated she communicated the interventions put in place by putting them on the communication board. She stated the nurses gave report to the CNA about interventions that were in place after each fall. DON BB stated the fall on 4/23/22, the resident was verbalizing she wanted something to eat. The immediate interventions put in place were to offer snacks and then toileted the resident. She stated she gave a copy of the incident report and the interventions to the MDS Coordinator to update the care plan. The DON confirmed the care plan was not updated with interventions after the fall. The DON stated an assessment of the environment was done after the fall on 4/29/22 because R#95 was confused but could tell staff if she was hungry or trying to go somewhere. The DON confirmed the care plan did not include interventions that were put in place after the 4/29/22 fall. The unwitnessed fall on 5/18/22 was because R#95 tried to do things independently. The DON stated the interventions were to monitor the resident's behaviors and was supposed to have close monitoring for behaviors and to redirect. The DON indicated R#95 did not have a one-to-one staff assigned but that the resident was monitored at the nurses' station. She said the interventions should have been close monitoring instead of 1:1. The DON indicated it was important for the care plan to be updated for continuity of care. She said the staff should review the care plan every time they went to do care for the resident, every shift they work, to see if there were any changes.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45555 Based on observations, record review, interviews, document review, and policy review, the facility failed to have an effective infection control program to prevent the spread of COVID-19. The facility failed to implement measures to prevent the potential spread of COVID-19 throughout the facility. As of 5/18/22, the facility had four residents (R) (R#63, R#83, R#109, and R#322) and three staff members (staff EE, XXX and YYY) who tested positive for COVID-19. On 5/20/2022, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility's Administrator, Chief Executive Officer (CEO), and Director of Clinical Services (DCS) were informed of the Immediate Jeopardy (IJ) on 5/20/2022 at 5:33 p.m. The noncompliance related to the immediate jeopardy was identified to have existed on 5/11/2022. The IJ is outlined as follows: The IJ began on 5/11/2022 when the facility became aware that resident (R) (R#83) had been exposed to COVID-19 on 5/9/2022. The resident became symptomatic and subsequently tested positive, but the facility failed to implement outbreak testing and/or contract tracing for residents and staff until 5/13/2022. As of 5/18/22, there were a total of four residents and three staff members to test positive for COVID-19. R#29 was symptomatic and tested positive on 5/13/22 and was transferred to the hospital and returned to facility on 5/16/22; R#63 was symptomatic and tested positive on 5/13/22 and remained in the facility; R#109 was symptomatic and transferred to hospital and tested positive at the hospital and remained in the hospital. In addition, the facility failed to inform the residents and their families of the confirmed COVID-19 infections in the facility. During the survey beginning on 5/16/2022, staff members were observed entering the facility without completing COVID-19 screening and without donning face masks. Further observations on 5/18/2022 revealed residents in common areas of the facility without social distancing and staff not wearing appropriate personal protective equipment (PPE). The facility failed to follow the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid (CMS) guidance for screening, prevention, and reporting of COVID-19. The IJ was related to the facility's noncompliance with the program requirements, as follows: F880: 483.80(a)(1)(2)(4)(e)(f)-Infection Prevention and Control (Scope/Severity[S/S]: J.) F885: 483.80(g)(3)-Reporting-Residents, Representatives, and family (Scope/Severity[S/S]: J.) F886: 483.80(h)(1)-(6)-COVID-19 Testing-Residents & Staff (Scope/Severity[S/S]: J.) The IJ situation was ongoing at the time of exit on 5/25/2022. Findings include: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled [Facility initials] Employee Policy-Coronavirus, updated 1/3/22, indicated all employees entering the building must complete screening process. 1. Employee must complete a screening questionnaire at the kiosk every time they enter the community. Review of the facility's policy titled [Facility initials] COVID-19 Clinical Protocol, updated 6/1/21, indicated if all participants are fully vaccinated, they may choose to have close contact and to NOT wear source control during activity. If any unvaccinated participants are present, all participants should wear source control and unvaccinated residents/elders should physically distance . During periods of high to moderate transmission and during a facility outbreak, staff should wear eye protection (face shield or goggles). Review of the Centers for Disease Control and Prevention (CDC) COVID-19 Tracker, the facility, located in Cobb County, was in high community transmission level as of 5/9/22. Review of the daily county COVID-19 status report revealed the county the facility resided in had rates above 10.3% since 5/9/22. Review of the facility's COVID-19-line listing, as of 5/18/22, the facility had four residents and three staff members who tested positive for COVID-19. The facility was currently in outbreak status. 1. Facility failed to ensure employees entering the facility were screened for signs and symptoms of COVID-19 prior to entering the facility and/or providing care to residents. Observation on 5/16/22 at 8:39 a.m. revealed an unidentified staff member entered the building without wearing a mask or undergoing screening. The staff member in question walked into a hallway to the right of the entrance (office hallway) and entered an office to the right. Shortly thereafter, Activity Assistant CC entered the facility without wearing a mask and did not undergo screening before entering an elevator to the upstairs unit. Observation on 5/18/22 at 12:43 p.m. revealed during a communal activity in the library, staff members were wearing N95 masks but no eye protection. Observation on 5/19/22 at 2:45 p.m. revealed the entrance to the facility had two sets of double doors that automatically opened when approached. A kiosk was situated to the left of the entrance, approximately 14.5 feet into the facility lobby. The kiosk facilitated the screening of staff and visitors for COVID-19, including obtaining an individual's temperature and printing out an adhesive badge (also referred to as a sticker) to be applied to the individual's body, indicating that the individual had been screened and approved to enter the facility. A hall to the administrative offices was to the right, where staff testing occurred. Interview on 5/18/22 at 12:03 p.m. with CNA RR, stated the screening process began on the first floor with staff sanitizing their hands, then they logged in and screened themselves using the kiosk. She said everyone had to be screened to come in the facility. Interview on 5/18/22 at 12:16 p.m. with CNA MM, stated he was required to undergo screening prior to working, including having his temperature taken and answering all screening questions. CNA MM stated if his temperature was bad, then he did not clock in and would have to get tested for COVID-19. CNA MM stated all staff had to undergo screening to enter the facility. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A.G. Rhodes Home, Inc - Cobb	900 Wylie Road Marietta, GA 30067

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 5/18/22 at 12:25 p.m. with CNA VV, described the kiosk machine screening process, stating the machine produced a sticker after screening questions were answered, which she noted she was not wearing, but had available in her jacket. Interview on 5/18/22 at 12:28 p.m. with Activity Assistant CC, acknowledged she failed to undergo screening before entering the facility on Monday 5/16/22. Activity Assistant CC stated she knew to self-screen for COVID-19 prior to coming into the facility, but stated she needed to use the bathroom. She acknowledged there was a bathroom downstairs. She acknowledged she was not wearing face protection when she entered the facility on 5/16/22. Interview on 5/18/22 at 12:32 p.m. with RN WW, stated staff were supposed to make sure all visitors had a sticker indicating they had completed a COVID-19 screening. Interview on 5/18/22 at 12:39 p.m. with CNA XX, stated she had to check in at the kiosk and made sure she was wearing an N-95 mask because the facility had three positive residents in the facility. She stated visitors were supposed to undergo screening, but she did not know if everyone was undergoing screening. She stated someone was supposed to be at the front desk to make sure visitors were being screened, but she did not think staff from all shifts were being screened. CNA XX stated she was not wearing the N-95 mask for which she was fit-tested . 2. Ensure proper social distancing during communal activities: Observation on 5/18/22 at 12:43 p.m. revealed 17 residents and five staff gathered in the library for music therapy while sitting 6-12 inches apart and within arm's reach. Interview on 5/18/22 at 12:03 p.m. with CNA RR, stated residents were supposed to be socially distanced, noting some residents went to the dining room and some residents stayed in their rooms to eat. CNA RR stated residents participated in group activities while social distancing. Interview on 5/18/22 at 12:16 p.m. with CNA MM, stated residents in isolation could only have activities in their rooms when in outbreak status, but residents from the third floor could go eat lunch and could go out on activities in the community. Interview on 5/18/22 at 12:25 p.m. with CNA VV stated residents could participate in activities during an outbreak because it was under control. She stated that, as far as she knew during outbreak status, the residents had to eat meals in their rooms but, right now, the facility only had a few cases so the residents could participate in activities and eat in the dining room. 3. Ensure proper use of personal protective equipment (PPE) during an outbreak of COVID-19; Observation on 5/17/22 at 5:19 p.m. on the third-floor blue hall revealed Occupational Therapist (OT) SS spoke with Certified Occupational Therapy Assistant (COTA) TT. OT SS wore a mask positioned under the chin. Observation on 5/18/22 at 12:08 p.m. revealed Certified Nurse Assistant (CNA) NN was wearing her eye protection on the top of her head. CNA NN stated there were no changes to the PPE required to be worn during an outbreak, and stated she always wore an N95 mask, which was fit tested . (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 5/18/22 at 12:14 p.m. revealed CNA YY pushed R#102 down a hallway past a nurses' station. R#102 was not wearing a mask and CNA YY was not wearing eye protection. Observation on 5/18/22 at 12:16 p.m. revealed Housekeeper OO was cleaning room [ROOM NUMBER] without wearing eye protection. Eye protection was observed to be on the housekeeping cart outside the room. At the same time, CNA NN was observed walking into room [ROOM NUMBER] wearing eye protection on top of her head. Observation on 5/18/22 at 12:23 p.m. revealed Registered Nurse (RN) Supervisor PP walked down a hall and into room [ROOM NUMBER] without wearing eye protection. Observation on 5/18/22 at 12:31 p.m. revealed Licensed Practical Nurse (LPN) KK, CNA LL, and CNA MM, served lunch without wearing eye protection. Observation on 5/18/22 at 12:41 p.m. revealed Dietitian JJ and Director of Dining Services II sat while working in the dining room during lunch without wearing eye protection. Observation on 5/18/22 at 12:45 p.m. revealed RN FF, LPN GG, and RN BB, the Director of Nursing (DON), wore no eye protection at the nursing station. Observation on 5/19/22 at 11:28 a.m. revealed an unidentified staff member took a resident off the elevator on the second floor while the staff member wore no eye protection. Another staff member on the elevator going down to the first floor was observed not wearing eye protection. Observations on 5/19/22 at 2:45 p.m. of staff entering the facility for the oncoming shift revealed CNA FFF entered the facility without a mask or eye protection. While answering questions at the kiosk, CNA FFF was told twice by ICP DD to put on a mask, which she ultimately did. A few of the staff entering the facility were only wearing surgical masks. Observation on 5/20/22 at 10:20 a.m. revealed Physical Therapy Assistant (PTA) GGG wore no eye protection and inappropriately wore an N-95 mask with the straps down. Observation on 5/20/22 at 10:22 a.m. of an unidentified therapy staff member assisting a resident at the weights revealed the staff member was not wearing eye protection and did not assist the resident to wear a mask properly. Observation on 5/20/22 at 10:24 a.m. revealed Certified Occupational Therapy Assistant (COTA) HHH wore a mask inappropriately and wore no eye protection. Observation on 5/22/22 at 1:43 p.m. revealed Volunteer D on the second-floor green hall entered rooms to give communion. The volunteer was not wearing eye protection. An unidentified staff member walked down the hallway toward the nurses' station at that time and was wearing eye protection on his/her forehead. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 5/18/22 at 12:03 p.m. with CNA RR stated she is required to wear an N95 mask but had not been fit-tested for the mask she was wearing, noting she had to cut the elastic to make the mask fit better. CNA RR stated while in outbreak status the staff had to sanitize and wash their hands frequently while providing care and wear N-95 masks. CNA RR was not wearing eye protection during the interview. Interview on 5/18/22 at 12:05 p.m. with LPN QQ, stated the facility encouraged the use of head coverings, goggles, gowns, and shoe covers. LPN QQ acknowledged she was not wearing eye protection during the interview. Interview on 5/18/22 at 12:16 p.m. with CNA MM stated that staff wore a gown, gloves, shield and goggles, hairnet, and shoe covers during an outbreak. CNA MM stated staff wore cloth/recycled gowns on the third floor, which were washed. He stated staff had to wear gloves when providing care and wash their hands. He noted he was fit-tested and was wearing the mask for which he was fit-tested . CNA MM was not wearing eye protection during the interview. Interview on 5/18/22 at 12:25 p.m. with CNA VV, stated she was not wearing the mask for which she was fit-tested . CNA VV was not wearing eye protection during the interview. Interview on 5/18/22 at 12:32 p.m. with RN WW, stated staff dedicated to work the COVID hall were required to wear an N-95 mask and goggles. Interview on 5/18/22 at 12:41 p.m. with CNA MM, stated he knew to wear a mask and goggles, but noted goggles were optional in outbreak status. CNA MM acknowledged he was not wearing eye protection during the interview. 4. Ensure visitors were provided visitation instructions/guidance, to include hand sanitizing, mask protocol, and social distancing during outbreak status. Observation on 5/18/22 at 11:58 a.m. revealed two sets of visitors/residents were observed sitting in a gazebo area with tables. The individuals were not adhering to social distancing guidance and, while the visitors wore surgical masks, the residents were not properly wearing their masks. Interview on 5/18/22 at 12:03 p.m. with CNA RR reported that families were allowed to visit and had to wear a regular (surgical) mask. Interview on 5/18/22 at 12:20 p.m. a family member of R#323 stated she was not informed about the positive COVID-19 cases or any outbreaks and was not given any visitor restrictions. The family member stated she was given a booklet for visitors that indicated visitation was allowed between 8:00 a.m. and 6:00 p.m. During an interview on 5/22/22 at 1:46 p.m. with volunteer D stated he saw approximately 10 residents in the facility. Volunteer D stated masks were available when first entering the facility, but he did not see any eye protection or any information about wearing eye protection.

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F 0885 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Report COVID19 data to residents and families. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45555 Based on record review and interviews, the facility failed to ensure residents, resident representatives, and/or family members were notified by 5:00 p.m. the following day, of confirmed COVID-19 infections in the facility. On 5/9/22 the facility was notified by the family that resident (R) (R#83) had an exposure to COVID-19, and subsequently R#83 tested positive on 5/11/22; however, the facility did not notify residents, resident representatives, and/or family members of the new positive case until 5/21/22, 10 days after R#83 tested positive. The facility's failure had the potential to affect all residents, residents' representatives, and residents' families of the facility. The facility census was 104. On 5/20/2022, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility's Administrator, Chief Executive Officer (CEO), and Director of Clinical Services (DCS) were informed of the Immediate Jeopardy (IJ) on 5/20/2022 at 5:33 p.m. The noncompliance related to the immediate jeopardy was identified to have existed on 5/11/2022. The IJ is outlined as follows: The IJ began on 5/11/2022 when the facility became aware that resident (R) (R#83) had been exposed to COVID-19 on 5/9/2022. The resident became symptomatic and subsequently tested positive, but the facility failed to implement outbreak testing and/or contract tracing for residents and staff until 5/13/2022. As of 5/18/22, there were a total of four residents and three staff members to test positive for COVID-19. R#29 was symptomatic and tested positive on 5/13/22 and was transferred to the hospital and returned to facility on 5/16/22; R#63 was symptomatic and tested positive on 5/13/22 and remained in the facility; R#109 was symptomatic and transferred to hospital and tested positive at the hospital and remained in the hospital. In addition, the facility failed to inform the residents and their families of the confirmed COVID-19 infections in the facility. During the survey beginning on 5/16/2022, staff members were observed entering the facility without completing COVID-19 screening and without donning face masks. Further observations on 5/18/2022 revealed residents in common areas of the facility without social distancing and staff not wearing appropriate personal protective equipment (PPE). The facility failed to follow the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid (CMS) guidance for screening, prevention, and reporting of COVID-19. The IJ was related to the facility's noncompliance with the program requirements, as follows: F880: 483.80(a)(1)(2)(4)(e)(f)-Infection Prevention and Control (Scope/Severity[S/S]: J.) F885: 483.80(g)(3)-Reporting-Residents, Representatives, and family (Scope/Severity[S/S]: J.) F886: 483.80(h)(1)-(6)-COVID-19 Testing-Residents & Staff (Scope/Severity[S/S]: J.) The IJ situation was ongoing at the time of exit on 5/25/2022. (continued on next page)

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F 0885 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Findings include: Review of the facility's COVID-19-line listing, as of 5/18/22, the facility had four residents and three staff members who tested positive for COVID-19 which included: R#83 was exposed to COVID-19 by a family member on 5/9/22 and tested positive on 5/11/22; R#322 had potential exposure from staff member and was symptomatic on 5/13/22-resident tested negative on 5/13/22 prior to leaving facility but tested positive in the hospital; Dietary Employee EE was symptomatic 5/13/22 (unknown symptom and unknown exposure) and tested positive 5/13/22; R#63 tested positive on 5/13/20 during outbreak testing; R#109: symptomatic on 5/14/22 and tested positive on 5/14/22- transferred to hospital; Employee XXX symptomatic (cough and congestion) and tested positive 5/14/22; Employee YYY symptomatic (cough and congestion) and tested positive on 5/14/22. Interview on 5/18/22 at 12:20 p.m. with R#323's family member, stated he was not informed about positive COVID-19 cases or an outbreak of COVID-19 in the facility or given any information about visitor restrictions. The family member indicated he was given a booklet for visitors that identified visitation was allowed between 8:00 a.m.- 6:00 p.m. The family member stated that if he completed a screening downstairs and has a mask on, nobody bothered him. R#323, with a Brief Interview for Mental Status (BIMS) was coded as 15, which indicated no cognitive impairment, was included in the interview, and stated she was admitted on Friday 5/13/22, and no one said anything to her about COVID-19 positive cases in the facility. On 5/20/22 at 9:41 a.m. a review of the facility's COVID-19 website link, revealed the website had last been updated on 5/17/22 at 10:00 a.m. At the time of the review, the website identified a total of three positive residents and one positive staff member. Review of the COVID-19 line- listing revealed that four residents and three staff members tested positive for COVID-19. Interview at this time with the Administrator, this information was updated by the Corporate Communications Officer. Interview on 5/20/22 at 10:39 a.m. with a family member of R#165, while visiting in the outdoor courtyard, stated they were not aware of COVID-19 positive residents in the building and were also not aware of the facility's associated COVID-19 processes. Interview on 5/20/22 at 11:40 a.m. with the Administrator, indicated the family members were informed of the positive COVID-19 cases on 5/11/22 by sending a mass message to all residents' emergency contacts by phone and email. She stated it was an automated program and was not able to be sent out until 5/13/22 because the system was down. She indicated the message informed families to check the facility's website for updates on the status of COVID-19 in the facility. During further interview, she stated she had not sent out any further messages since 5/13/22. Per the Administrator, the residents had a posting in their room to contact nursing or social services to get updates on COVID-19. She stated information was also posted on television monitors throughout the facility, including resident rooms, to contact nursing or social services for COVID-19 updates. The facility was unable to provide evidence that documented the notification being sent to residents' representatives after the first resident tested positive on 5/11/22. (continued on next page)

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F 0885 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 5/20/22 at 2:40 p.m. with a family member of R#323, indicated the resident was admitted to the facility on [DATE] and they had not been informed of positive COVID-19 cases in the facility. R#323's family member stated she came to the facility on [DATE] and was provided admission pamphlets but was not informed of COVID-19 cases in the facility at that time, either. The family member of R#323 confirmed prior to 5/20/22 at 1:00 p.m., she had not been notified of COVID-19 cases in the facility. Interview on 5/20/22 at 4:54 p.m. with R#102, with a Brief Interview for Mental Status (BIMS) was coded as 12, which indicated mild cognitive impairment, who was able to provide reliable information, stated she overheard staff talking about COVID being in the building, but noted no one had specifically informed her. R#102 stated the message on the television said the same thing all the time and didn't indicate whether there had been any changes regarding COVID-19 in the facility. Interview on 5/22/22 at 12:59 p.m. with R#323, with a BIMS of 15, indicating no cognitive impairment, stated she had not been notified of any of the previous cases of COVID-19 in the facility prior to 5/21/22, when a staff member came to her room and told her that the facility had a new case of COVID as of 5/20/22. The family member of R#323, visiting in the room at the time, stated he did not receive a text notification of COVID-19 in the facility prior to 5/21/22 at 11:29 a.m. Interview on 5/22/22 at 1:25 p.m. with R#76, with a BIMS of 13, indicating no cognitive impairment, indicated a staff person informed her of the COVID-19 positive cases on 5/21/22 around 11:00 a.m., but stated she had not received notification of any earlier cases. Interview on 5/22/22 at 1:33 p.m. with R#315, with a BIMS of 14, indicating no cognitive impairment, indicated he was not informed of COVID-19 positive cases prior to 5/21/22. R#315 indicated he was informed there were five cases but had not received any prior notifications and had not been informed whether the positive cases involved residents or staff members. Interview on 5/22/22 at 1:34 p.m. with R#104, with a BIMS of 15, indicating no cognitive impairment, indicated he was not notified of positive COVID-19 cases in the facility until 5/21/22, at which time he was informed of the five cases. Interview on 5/22/22 at 1:52 p.m. with R#113, with a BIMS of 15, indicating no cognitive impairment, indicated she had not been informed about the positive COVID-19 cases until 5/21/22, when there were five cases. Interview on 5/22/22 at 1:34 p.m. with R#69, with a BIMS of 14, indicated a staff person informed her on 5/21/22 right after lunch of the positive COVID-19 cases, noting she signed a paper regarding receipt of the information. R#69 stated no one had previously notified her of positive COVID-19 cases, prior to 5/21/22.

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Perform COVID19 testing on residents and staff. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45555 Based on record review, interviews, and policy review, the facility failed to conduct routine and outbreak testing for COVID-19 for all staff and residents in accordance with the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid Services (CMS) requirements, which potentially caused delays in identifying, treating, and isolating COVID-19 positive residents and staff to prevent them from infecting other residents and staff. This failure resulted in four residents, (R) (R#29, R#63, R#83, and R#109) and three staff (staff EE, XXX, and YYY) who tested positive for COVID-19. On 5/20/2022, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility's Administrator, Chief Executive Officer (CEO), and Director of Clinical Services (DCS) were informed of the Immediate Jeopardy (IJ) on 5/20/2022 at 5:33 p.m. The noncompliance related to the immediate jeopardy was identified to have existed on 5/11/2022. The IJ is outlined as follows: The IJ began on 5/11/2022 when the facility became aware that resident (R) (R#83) had been exposed to COVID-19 on 5/9/2022. The resident became symptomatic and subsequently tested positive, but the facility failed to implement outbreak testing and/or contract tracing for residents and staff until 5/13/2022. As of 5/18/22, there were a total of four residents and three staff members to test positive for COVID-19. R#29 was symptomatic and tested positive on 5/13/22 and was transferred to the hospital and returned to facility on 5/16/22; R#63 was symptomatic and tested positive on 5/13/22 and remained in the facility; R#109 was symptomatic and transferred to hospital and tested positive at the hospital and remained in the hospital. In addition, the facility failed to inform the residents and their families of the confirmed COVID-19 infections in the facility. During the survey beginning on 5/16/2022, staff members were observed entering the facility without completing COVID-19 screening and without donning face masks. Further observations on 5/18/2022 revealed residents in common areas of the facility without social distancing and staff not wearing appropriate personal protective equipment (PPE). The facility failed to follow the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid (CMS) guidance for screening, prevention, and reporting of COVID-19. The IJ was related to the facility's noncompliance with the program requirements, as follows: F880: 483.80(a)(1)(2)(4)(e)(f)-Infection Prevention and Control (Scope/Severity[S/S]: J.) F885: 483.80(g)(3)-Reporting-Residents, Representatives, and family (Scope/Severity[S/S]: J.) F886: 483.80(h)(1)-(6)-COVID-19 Testing-Residents & Staff (Scope/Severity[S/S]: J.) The IJ situation was ongoing at the time of exit on 5/25/2022. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Findings include: Review of a CMS Quality/Survey and (&) Oversight (QSO) Group memorandum, Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements, QSO-20-38-NH, revised 3/10/22, indicated, Routine Testing of Staff, Routine testing of staff, who are not up-to-date, should be based on the extent of the virus in the community. Staff, who are up-to date, do not have to be routinely tested . Facilities should use their community transmission level as the trigger for staff testing frequency. Table 2: Routine Testing Intervals by County COVID-19 Level of Community Transmission Level of COVID-19 Community Transmission/Minimum Testing Frequency of Staff who are not up to date+ Low (blue) = Not recommended Moderate (yellow) = Once a week Substantial (orange) = Twice a week High (red) = Twice a week + Staff who are up to date do not need to be routinely tested . Review of the Georgia Department of Public Health, COVID-19 Daily Status Report, for Cobb County, revealed the community transmission rate had been high (red) since 5/9/22. Review of the facility's policy titled, COVID-19 Testing Protocol, updated 3/25/22, indicated, Routine testing of staff, who are not up-to-date, should be based on the extent of the virus in the community. Facilities should use their community transmission level as the trigger for staff testing frequency. 1.) The facility failed to perform routine COVID-19 testing twice weekly on staff who were not current with all recommended COVID-19 vaccinations, when the community transmission rate was high. Review of the COVID-19 line listing dated 5/12/22 through 5/16/22, revealed four residents (R) (R#29, R#63, R#83, and R#109) and three staff (staff EE, XXX, and YYY) had tested positive for COVID-19 as of 5/18/22. The first COVID-19 positive resident in the facility was identified on 5/11/22. The first COVID-19 positive staff member was identified on 5/13/22. Review of the staffing schedules for 5/16/22 compared with the staff who had been tested since the county's transmission level became high on 5/9/22 revealed that 32 out of 47 nursing staff scheduled to work on Monday 5/16/22, had not been tested since the outbreak began on 5/11/22. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115521	A. Building B. Wing	05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A.G. Rhodes Home, Inc - Cobb	900 Wylie Road Marietta, GA 30067

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 5/18/22 at 9:09 am. with the Infection Control Preventionist (ICP) DD, stated all residents and staff were tested on [DATE]. She stated the receptionist did have some test kits at the front for the staff to test themselves, if she was unable to do the testing herself, but stated she was now doing all the testing herself. She revealed the forms she used for tracking the testing were not up to date, because her assistant was on vacation, and she was having to do everything herself. Interview on 5/18/22 at 10:31 a.m., ICP DD stated she usually kept a running log of staff testing and she had fallen behind and was just jotting the staff names on a roster. ICP DD stated she pulled up the staffing sheets for 5/16/22 and compared it with the list of staff who had been tested to ensure that anyone working that day had been tested . A review of the of staffing sheets and testing records revealed that 32 out of 47 nursing staff scheduled to work on Monday 5/16/22, had not been tested , prior to working their shift. Interview on 5/18/22 at 10:58 a.m. with the Director of Clinical Services (DCS) stated she knew the staff were being tested but was unsure of how often the staff and residents should be tested based on the county transmission level. During further interview, she stated the facility had tested all residents and staff on 5/13/22 and they were to test again today (5/18/22). She stated there was confusion about the testing and she had to ask for guidance. Interview on 5/18/22 at 12:03 p.m. with Certified Nurse Assistant (CNA) RR stated she had only been tested on e time, the previous week, because she had cared for a resident who had tested positive. A review of the testing sheets provided by the ICP revealed CNA RR had been tested on [DATE]. There was no documentation CNA RR was tested the previous week. Interview on 5/18/22 at 12:18 p.m., Housekeeper OO stated he was only tested on ce per week and was tested on [DATE]. Interview on 5/18/22 at 12:25 p.m. with CNA VV, stated she could be tested everyday if she wanted to but stated she thought they were only required to be tested on ce a week. A review of the staffing sheets revealed CNA VV had worked on 5/16/22, 5/17/22 and 5/18/22, but according to the testing sheets, CNA VV was not tested until 5/18/22. 2.) The facility failed to identify an outbreak of COVID-19 in the facility after a resident tested positive and ensure broad-based outbreak testing and/or contact tracing was immediately conducted for residents and staff. Review of the CMS Quality/Survey and (&) Oversight (QSO) Group memorandum QSO-20-38-NH, revised 3/10/22, indicated, Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements. When prioritizing individuals to be tested , facilities should prioritize individuals with signs and symptoms of COVID-19 first, then perform testing triggered by an outbreak investigation (as specified below). (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Testing Trigger: Newly identified COVID-19 positive staff or resident in a facility that is unable to identify close contacts. Test all staff, regardless of vaccination status, facility-wide or at a group level if staff are assigned to a specific location where the new case occurred. Test all residents, regardless of vaccination status, facility-wide or at a group level. The memorandum also indicated, A new COVID-19 infection in any staff or any nursing home-onset COVID-19 infection in a resident triggers an outbreak investigation. In an outbreak investigation, rapid identification and isolation of new cases is critical in stopping further viral transmission. Upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately. Facilities have the option to perform outbreak testing through two approaches, contact tracing or broad-based (e.g. [for example] facility-wide) testing. Review of the CDC guidance titled, Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 [severe acute respiratory syndrome coronavirus 2] Spread in Nursing Homes, located online at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, revealed, Asymptomatic residents with close contact with someone with SARS-CoV-2 infection, regardless of vaccination status, should have a series of two viral tests for SARS-CoV-2 infection. The CDC guidance also indicated, Respond to a newly identified SARS-CoV-2 infected HCP or resident: Because of the risk of unrecognized infection among residents, a single new case of SARS-CoV-2 infection in any HCP or a nursing home-onset SARS-CoV-2 infection in a resident should be evaluated as a potential outbreak. If a facility does not have the expertise, resources, or ability to identify all close contacts, they should instead investigate the outbreak at a facility-level or group-level. Perform testing for all residents and HCP on the affected unit(s), regardless of vaccination status, immediately and, if negative, again 5-7 days later. Review of the facility's COVID-19-line listing, as of 5/18/22, the facility had four residents and three staff members who tested positive for COVID-19 which included: R#83 was exposed to COVID-19 by a family member on 5/9/22 and tested positive on 5/11/22; R#322 had potential exposure from staff member and was symptomatic (cough and sore throat) on 5/13/22-resident tested negative on 5/13/22 prior to leaving facility but tested positive in the hospital; Dietary Employee EE was symptomatic on 5/13/22 (unknown symptom and unknown exposure) and tested positive 5/13/22; R#63 tested positive on 5/13/20 during outbreak testing; R#109: symptomatic (unknown symptom) on 5/14/22 and tested positive on 5/14/22- transferred to hospital; Employee XXX symptomatic (cough and congestion) and tested positive 5/14/22; Employee YYY symptomatic (cough and congestion) and tested positive on 5/14/22. Interview on 5/18/22 at 9:09 a.m. with ICP DD, stated the facility had three residents who tested positive, and she had just found out that a fourth resident that was currently in the hospital had tested positive. She stated the facility had two COVID-19 positive staff members who had tested positive and that a third staff member tested positive that morning (5/18/2022). She stated the positive staff members included a night supervisor, a therapist, and a kitchen employee. Interview on 5/18/22 at 10:08 a.m. with ICP DD, stated she had misread the email she got from the local health department and did not realize the facility was in outbreak status, which required everyone to be tested right away. She stated this was why the residents and staff were not tested until 5/13/22. Interview on 5/18/22 at 10:10 a.m., the Administrator stated there had been some confusion about what outbreak status was and confirmed outbreak testing did not start until 5/13/22, after the facility received an email clarification. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 5/18/22 at 12:08 p.m. with CNA NN stated the staff were tested whenever they wanted to be tested . She stated there were no changes during an outbreak. A review of the staffing sheets revealed CNA NN had worked on 5/16/22 and 5/17/22. According to the testing sheets provided by the ICP, CNA NN was not tested on [DATE] through 5/17/22. The CNA was only tested on [DATE].