STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425398	A. BUILDING _____ B. WING _____	08/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKDALE ANDERSON	311 SIMPSON RD ANDERSON, SC 29621

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** - Minimal harm or potential for 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** Based on interview, record review, review of facility documents, and review of facility policy, the facility failed to assure that one (Resident #4) of three sampled residents was free from abuse. Resident #4 was the victim of resident-to-resident abuse, after which a small abrasion on the temple was noted. Findings include: Review of Resident #4's Nursing Progress Note dated 05/17/20 at 1:58 PM revealed that At approximately 7 AM, resident's roommate (Resident #6) threw plastic vase with water in it. When the Certified Nursing Assistant (CNA) responded to the call light, Resident #4 stated, That crazy (gender) threw water at me. The Nursing Progress Note continued, At approximately 1215 roommate (room number deleted) threw a cup of water at resident and a skin abrasion was noted to the right temporal area. Staff provided first aid to Resident #4 and removed the roommate, Resident #6, from the room. The physician was notified and, per the Nursing Progress Note, gave a new order to start neurochecks on resident and continue skin care to right temporal area of head daily. Review of an Initial 2/24 Hour Report form dated 05/18/20 revealed that the facility reported the incidents of 05/17/20 as Alleged abuse with Resident #6 named as the Alleged Perpetrator. The form noted that Resident #6's actions resulted in (Resident #4) receiving a scrape/abrasion to head on R (right) temple region. Review of a Five-Day Follow Up Report dated 05/22/20, Summary Report of Facility Investigation documented that that Resident #6 displayed physically aggressive behaviors toward former roommate (name) on the morning of 05/17/20, resulting in resident (name(receiving small abrasion to her head from objects thrown at her by former roommate. Review of this form revealed that it did not indicate that there had been two separate incidents (07:00 AM and 12:15 PM). The Immediate Corrective Action/assessment following Reportable Incident portion of the form noted that Resident #6 was unable to verbalize reasoning of his/her actions and was currently being treated for [REDACTED]. Review of Resident #4's Admission Record revealed that the resident's [DIAGNOSES REDACTED]. Per the resident's most current Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/26/20, the resident had a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment, and displayed no behaviors. Three attempts to interview the resident were conducted during the survey; however, the resident, who was in isolation due to COVID-19 status, was asleep during each attempt. Review of Resident #6's Admission Record revealed that the resident's [DIAGNOSES REDACTED]. Per the resident's most recent MDS, with an ARD of 06/06/20, the resident had a BIMS score of 12, indicating moderate cognitive impairment and displayed verbal behaviors during the assessment period. An interview with Resident #6 on 08/13/20 at 9:20 AM revealed the resident was not oriented to time but remembered the incident with Resident #4. Resident #6 stated, We didn't get along very well. (Resident #4) was loud and would talk down to me. One day (Resident #4) was getting louder and louder, talking down to me. I had a little plastic vase with a flower and water in it to make it look real. I threw it at (Resident #4). Resident #6 stated that he/she did not hurt or bruise Resident #4, but did make the resident mad, wet, and made Resident #4 be quiet. It worked. Interview with the Director of Clinical Services (DCS) on 08/12/20 at 2:45 PM revealed that Resident #4 and Resident #6 were roommates who have a love-hate relationship. The DCS stated that the resident got along pretty well, although they would fuss with each other. The DNS stated that the investigation found that Resident #6 threw the plastic vase at Resident #4 because Resident #4 would not wake up at Resident #6's request. The DCS stated that Resident #4 was found to have a small abrasion on the temple; however, it looked like a scratch and the DCS was not sure that the abrasion was from being hit by the vase. Interview with CNA #3 on 08/13/20 at 7:03 AM revealed that he/she was aware of an incident between the two residents on 05/17/20. CNA #3 stated he/she thought it was lunch time and they were fussing back and forth. CNA #3 stated the belief that it was just frustration from having to stay in the room all the time. CNA #3 stated that, I did not see it happen, but the vase was on the floor and the wet linens told the story. Per CNA #3, Resident #4 had a little mark on (his/her) face but the CNA was not sure if it was from the vase or something else. CNA #3 stated that at that point, Resident #6 was moved to another room, and had no problems since. Interview with Licensed Practical Nurse (LPN) #2 on 08/13/20 at 10:18 AM revealed that the 07:00 AM incident between Resident #6 and Resident #4 occurred at shift change. LPN #2 stated he/she had just arrived when Resident #6 threw a plastic vase at Resident #4, trying to wake the resident up. LPN #2 stated Resident #4 had no injuries at that point. LPN #2 stated, I thought about separating the residents and taking Resident #6 to another room; but it was shift change and a lot was going on. LPN #2 stated that later that day, a second incident occurred between the two residents. Resident #6 threw the water pitcher and got (Resident #4) all wet. She got a little scratch, not bruised or bleeding. LPN #2 stated that no one saw the incident - staff saw the aftermath and at that point, staff moved Resident #6 to another room. Further interview with LPN #2 revealed that he/she received a write up because I didn't separate them the very first time. LPN #2 stated, I should have separated them when the 7:00 AM incident happened, continuing that, It could have prevented the second incident. Review of the facility policy titled, Abuse, Neglect, & Exploitation Policy, last revised 10/18, revealed: . A. The resident has the right to be free from abuse, neglect, mistreatment, misappropriation of resident property and exploitation . E. Protection: 1. Upon learning of alleged abuse, neglect, mistreatment of [REDACTED].
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** Based on interview, record review, review of facility documents, and review of facility policy, the facility failed to assure that all alleged violations of abuse were reported to the State Survey Agency (SSA - responsible for certification activities) within two hours. The facility failed to report timely for two of three sampled abuse investigations, which included an allegation of sexual abuse of Resident #6 and an allegation of resident-to-resident abuse of Resident #4. Findings include: Review of the facility's investigations from 01/01/20 - 08/12/20 revealed that there had been three allegations/incidents which had been reported to the SSA as either suspected abuse or an injury of unknown origin. 1. Review of an Initial 2/24 Hour Report, dated 05/18/20, revealed that the facility made a report of Alleged Abuse to the SSA, with the type of alleged abuse being described as physical. Review of this document revealed that Resident #6 was named as the Alleged Perpetrator. The form noted that Resident #6's actions resulted in (Resident #4) receiving a scrape/abrasion to head on R (right) temple region. Review of this form revealed that the Date/Time of Reportable Incident was listed as 05/17/20 at approximately 7:00 AM. Further review of the 05/18/20 Initial 2/24 Hour Report form revealed that there were two Report Type blocks listed - one for 2 hr (hour) initial and one for 24 hour initial. The 24 hour initial block was checked on this form. Review of the fax cover sheet revealed that the Initial 2/24 Hour Report form was not sent to the SSA until 11:12 AM on 05/18/20, approximately 28 hours after the incident listed on the form occurred. Interview on

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

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

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) 08/13/20 at 10:52 AM with the Director of Clinical Services (DCS) revealed he/she served as the Abuse Coordinator and was the staff primarily responsible for submitting allegations of abuse to the SSA. The DCS stated that the staff working during first shift on 05/17/20, a weekend, did not report suspected abuse at the time this incident occurred. The DCS stated that a second resident-to-resident incident occurred on 05/17/20, in which Resident #6 threw a cup of water at Resident #4 at approximately 12:15. Per the DCS, it was at this time that the abrasion on Resident #4's temple was noted. The DCS stated that staff failed to notify the Assistant Director of Clinical Services (ADCS) until the end of their shift, between 2:00-3:00 PM. The DCS was then informed by the ADCS, and the DCS added, I have 24 hours from when I'm made aware of the incident to report it to the SSA. Further interview with the DCS revealed that a report must be made to the police and SSA in two hours if a crime was alleged; however, this resident-to-resident allegation, didn't qualify as a crime. During this interview, the DCS showed a cheat sheet which had been tweaked over the years and which he/she used as the basis for determining reporting timeframes. The DCS stated that he/she had provided this document to both the Executive Director (ED) and ADCS, as they served as backups for reporting. Review of this document, titled, Timeframes for Reporting (updated 7.18.19), revealed that it included information which was not based on current regulations. The document showed that for Certification (the SSA) abuse was to be reported Immediately (in accordance with Omnibus Adult Protection Act), but not to exceed 24 hours after discovery of the incident. The document also indicated Abuse - Note: no requirement to report resident-to-resident abuse. Further interview with the DCS on 08/13/20 at 10:52 AM revealed he/she was unaware of the 11/28/17 change in the federal regulation regarding time frames for reporting suspected abuse. The DCS repeated his/her belief that there was 24 hours to report suspected abuse, and stated he/she was unaware, until shown the federal regulation, that all allegations involving abuse must be reported to the SSA immediately, but not later than two hours after the allegation is made. 2. Review of a Nursing Progress Note dated 01/20/20 at 4:21 PM revealed that Resident #6 made allegation of sexual abuse at approximately 1:30 pm to a CNA (Certified Nursing Assistant) while toileting.' Per this note, Resident #6 complained of constipation while toileting stating that that the sexual assault has resulted in (resident) becoming constipated. States that people are raping (resident) because they want to acquire (resident) immunity to HIV/AIDS. Upon multiple interviews, resident is unable to provide details as to when/where this assault occurred. New orders were obtained to send the resident to the hospital for an evaluation/assessment related to the allegation of sexual abuse and to request the emergency department to perform a psychiatric consult if possible. Review of the investigation file revealed no evidence of an Initial 2/24 Hour Report form. However, the file did contain an Accident/Incident Reporting Form Bureau of Health Facilities Licensing form which documented that Resident #6 verbalized allegation of sexual assault on 01/20/20. Review of facility emails revealed that the report was received by the SSA on 01/20/20 at 6:24 PM, approximately five hours after the resident made the allegation of sexual abuse. A Five-Day Report provided to the SSA on 01/27/20 found that, after an investigation by the facility, which included police response and a thorough external exam in the hospital which found no evidence suggestive of any recent sexual abuse, the allegation was unsubstantiated. Interview on 08/13/20 at 10:52 AM with the DCS confirmed that the allegation of sexual abuse was also not reported within two hours of the allegation being made known. The DCS said that the delay was for the same reason as in Example #1, stating the belief that he/she thought there was 24 hours to report allegations of abuse. Interview with the ED on 08/13/20 at 1:27 PM revealed that he/she served as a back-up reporter for the Abuse Coordinator position if the DCS was not available. The ED stated that, prior to surveyor intervention, his/her understanding was that the facility had two hours to report if there was serious bodily injury from any source that was willfully inflicted, and otherwise, 24 hours to report any allegation of abuse or neglect. The ED stated that he/she had not realized that the regulation called for two-hour reporting for all abuse allegations and thought the two-hour time frame was only required if the allegation was serious. Review of the facility policy titled, Abuse, Neglect, & Exploitation Policy, last revised 10/18, revealed: G. External Reporting: 1. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property shall be reported: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. c. Such alleged violations shall be reported to: The State Survey Agency.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observation, interview, and review of facility documents, the facility failed to maintain an infection control program in which all visitors were screened for possible signs of COVID-19, such as temperature, potential signs/symptoms, and risk factors including exposure and travel, prior to entry to the facility. Two employees failed to gather all required information for COVID-19 screening prior to allowing visitor access to the nursing facility. Findings include: 1. a. Observation on 08/12/20 at 8:35 AM revealed that to enter the campus where the nursing facility was entered, all cars were required to stop at a sentry point. As the surveyor came to a stop, Screener #1 came out of the guard booth carrying a thermometer. Screener #1 asked the surveyor their name, who they represented, and their telephone number. The screener then provided directions to an Administration building and recommendations on where to park, prior to returning to the guard booth. At no time did Screener #1 raise the thermometer to the surveyor's forehead and take their temperature. Screener #1 did not ask any screening questions about possible symptoms of COVID-19 including a fever within the past 14 days, chills, cough, shortness of breath, difficulty breathing/wheezing, sore throat, fatigue/lethargy/malaise, red eyes, headaches, gastrointestinal symptoms, loss of smell and/or taste, muscle pain, aches, or sneezing/runny nose. In addition, Screener #1 failed to ask any questions about exposure risk, including known exposure to anyone under investigation or with a confirmed case of COVID-19 in the previous 14 days, work at other facilities in the previous 14 days, travel, and/or direct contact with anyone with someone who had taken a COVID-19 test but did not yet have results. Screener #1 failed to provide any documentation to indicate that screening had been completed and that the surveyor was clear to enter the nursing facility. Upon entry to the facility at 8:41 AM, there was no evidence of a screening process. The surveyor was permitted entrance to the facility and shown to an office, where an entrance conference was held with the Executive Director (ED) and Assistant Director of Clinical Service, who also served as the facility's Infection Preventionist (IP). Interview with the IP at 9:18 AM revealed that the facility's process for COVID-19 screening was that everyone, including both staff and visitors, are screened at the sentry point, prior to being allowed access to the campus, and there was no separate screening prior to entry to the nursing facility. The IP stated that the screeners were agency staff, who received training from both the agency and the nursing facility, and whose duties included taking everyone's temperature. When informed that the screener failed to take the surveyor's temperature, the IP showed a copy of the facility's screening form and asked if the screener had asked each of the questions listed on the form. When informed that Screener #1 failed to ask any of the questions listed on the form, the IP stated, Everyone is supposed to be done if they drive in. At that point, the IP took the surveyor's temperature, which measured 97.7 degrees Fahrenheit and asked screening questions. Interview with the Director of Clinical Service (DCS) on 08/12/20 at 10:50 revealed that the ED had spoken with Screener #1, who claimed that he/she took the surveyor's temperature upon entrance to the campus. However, when Screener #1 provided the form on which screening information was to be recorded, the temperature section for the surveyor was blank. The DCS stated that the IP had then added the surveyor's temperature to the record, initialing it to show that he/she had added it. An interview was conducted with Screener #1 by telephone on 08/12/20 at 11:05 AM. During this phone call, the DCS was also present. Screener #1 stated his/her responsibilities included taking temperatures and asking screening questions before giving everyone who was allowed entry a sticker to show they had been cleared for admission into the campus. Screener #1 stated that he/she had taken the surveyor's temperature. When told that the screener had not lifted the hand with the thermometer to the surveyor's forehead, Screener #1 replied that he/she took the surveyor's temperature from the side and it was 98.6. Screener #1 had no response as to why the temperature section of the form was blank when it was provided to the ED. Screener #1 also claimed that he/she had asked screening questions, including whether the surveyor had been to the facility before, to which the surveyor responded, Yes. When told that this question was not asked, and informed that the surveyor had never been to this facility before, Screener #1 had no response except to repeat that he/she had asked all questions. Screener #1 then claimed to have given the surveyor a piece of paper with a yellow sticker on it. Interview with the DCS on 08/12/20 at 11:15 AM revealed that the thermometer the facility used was a temporal scanner, which had to be held to the forehead to provide an accurate temperature. The DCS stated that he/she had previously spoken to Screener #1 about taking temperatures from the side, and that Screener #1 needed reeducation. During this interview, the DCS also confirmed that the surveyor did not have a yellow sticker such as all the staff in the unit, including the DCS, were wearing. b. Observation upon entry to the

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) campus on 08/13/20 at 6:03 AM revealed that Screener #2 was working at the sentry point. Screener #2 took the surveyor's temperature, then asked where the surveyor was going, the purpose of their visit, and their phone number. Screener #2 then provided a yellow sticker and returned to the guard booth without asking any screening questions about symptoms or possible exposure to COVID-19. Screener #2 was then requested to return to the surveyor's car, where he/she was asked about the screening process and if there were any questions which were required to be asked before admission to the campus was allowed. Screener #2 stated there were questions on the forms he/she used to log in all staff and visitors; however, he/she only asked the questions if the person had a temperature, looked really bad, or if they're someone I don't know or haven't seen before. Screener #2 was then asked if they had ever met or seen the surveyor before. Screener #2 confirmed that he/she had never seen the surveyor before, and stated the required questions should have been asked, adding, No, I didn't ask. I'm sorry. Interview with the DCS on 08/13/20 at 6:15 AM confirmed that all questions on the form should be asked of everyone going through the screening process. Further interview with the DCS on 08/13/20 at 8:40 AM revealed that he/she had obtained a copy of that day's COVID-19 Screening Log: Visitor and that although the questions had not been asked, Screener #2 had marked all questions for the surveyor under the Exposure Risk section of the form as No. 2. Policy - Interview with the DCS on 08/12/20 at 12:46 PM revealed that the facility did not have a screening policy. The DCS stated that instead, the job description and responsibilities for the screeners, who were provided through an agency, was covered via email. Review of an email from the DCS, dated 03/11/20, titled COVID staffing need - effective immediately, revealed: . As a result of the continued need to increase preventative actions for COVID-19 cases spreading nationwide, Brookdale Corporation has initiated a no visitor restriction effective immediately and until further notice for our SNF (Skilled Nursing Facility) Unit . his person will be stationed in a seat directly in front of our SNF Ambulance Entrance glass doors and will be responsible for screening ALL persons who enter the SNF unit: Basic Job Expectations: Must maintain a seated or standing position at all times in front of entry doors to ensure all persons entering the building are appropriately screened and complete required documentation. Ensure that no one is overlooked/missed when entering the SNF . Confirm that all persons' entrance to the SNF is permitted/appropriate as detailed in requirements listed above (only staff, paid sitters, approved 3rd parties.) . Assist all persons allowed/appropriate to enter the SNF (INCLUDING all staff entering to work in the SNF) with completing a brief COVID-19 symptoms screening form. Will make sure that the forms are properly filled out including documentation of an oral temperature . Further interview with the DCS on 08/12/20 at 12:46 PM revealed that although the job description had initially called for staff to be at the door to the nursing facility, this had changed, and by 03/25/20, (the date of a second email to the agency) the screeners were moved from the front door of the nursing facility to the sentry point at the entrance of the campus. The DCS stated that although the screener's physical location had been moved, their job description did not change, with the exception that they were now using a temporal, rather than an oral, thermometer to take temperatures. Interview with the ED on 08/13/20 at 8:26 AM confirmed that there was no policy regarding screening other than the instructions on the Screening Log. Review of this form included the following instructions: . Screening Logs are applicable to ALL Brookdale Communities AL, MC, Skilled and/or Independent Living . Review of the COVID-19 Screening Log: Visitor form also revealed the questions that were supposed to be asked prior to entry to the grounds included the following: fever of 99.6 within past 14 days, chills, cough, shortness of breath, difficulty breathing/wheezing, sore throat, fatigue, lethargy, malaise, red eyes, headache, GI (gastrointestinal) symptoms, loss of smell, loss of taste, muscle pain or aches, sneezing, runny nose, known exposure to anyone with confirmed or under investigation COVID-19 in the last 14 days, traveled to known affected area outside of US in the past 14 days, traveled to known high affected area within US in the past 14 days, and traveled by plane or cruise ship within and/or outside US in last 14 days.