

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345237</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/13/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>BARBOUR COURT NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>515 BARBOUR ROAD</b> <b>SMITHFIELD, NC 27577</b>		
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F 323 SS=J	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and staff and family interviews, the facility failed to implement measures for one of two sampled residents (Resident #2), to prevent recurrence of physically aggressive behavior by a resident (Resident #2), toward another resident (Resident #1) in the locked Alzheimer ' s unit.</p> <p>Immediate Jeopardy began on 3/4/2015 at 8:00 PM, when Resident #2 grabbed both of Resident #1 ' s wrists and began to shake her. The facility failed to have interventions in place to prevent Resident #2 from this physical aggression. The Immediate Jeopardy was identified to the administrator on 3/13/2015 at 11:25 AM. Immediate Jeopardy was removed on 3/13/2015 at 5:35 PM when the facility implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems are in place that are effective.</p> <p>The findings included:</p>	F 323	<p>Barbour Court Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.</p> <p>Barbour Court Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Barbour Court Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.</p> <p>F323 <input type="checkbox"/> 483.25(h) FREE OF ACCIDENTS</p>	3/27/15	

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

TITLE

(X6) DATE

Electronically Signed

03/27/2015

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 323	<p>Continued From page 1</p> <p>Resident #1 was admitted on 9/14/2012 with diagnoses of Alzheimer ' s disease, dementia without behaviors and anxiety.</p> <p>The annual Minimum Data Set (MDS) dated 8/7/2014 noted Resident #1 to be severely impaired for cognition and needed limited assistance for all Activities of Daily Living (ADLs) with the physical assistance of one person. The Care Area Assessment (CAA) indicated that Resident #1 had behavioral symptoms, and this area went to care plan.</p> <p>The care plan dated 2/15/2015 noted a focus of ineffectual coping during physical aggression related to cognitive impairment of Resident #1. The goal was to ensure safety for the resident and staff. Interventions included monitoring the resident closely, psychiatric consult, medication or treatment as prescribed by physician, document behaviors per facility protocol.</p> <p>Resident #2 was admitted 1/31/2015 with diagnosis of dementia without behavioral disturbance.</p> <p>A review of the clinical record progress note on 2/8/2015 at 9:15 PM revealed that Resident #2 was found in Resident #1 ' s room standing in front of her, holding her wrists with Resident #1 pinned up against the sink. Both were yelling at the other. Both residents were assessed for injuries with none noted. A review of a written statement dated 2/8/15, by Nurse #2 indicated the physician was contacted to send Resident #2 to the hospital ED.</p> <p>A review of the hospital Emergency Department</p>	F 323	<p>HAZARDS/SUPERVISION/DEVICES</p> <p>Corrective action for Residents Affected</p> <p>On 3/4/15, at approximately 8:07 pm, C.N.A and Hall Nurse witnessed Resident #1 and Resident #2 in a physical altercation. The C.N.A and Hall Nurse immediately separated Resident #1 and Resident #2. On 3/4/15, the Hall Nurse assessed Resident #1 for any injuries with no negative findings. On 3/4/15, the MD and RP of Resident #1 and Resident #2 were notified by Hall Nurse regarding the resident to resident altercation. Resident #1 was re assessed by the hall nurse for injuries on 3/5/15 with a bruise observed to her lower arm. The MD and RP was notified of resident #1 of the bruise on 3/5/15.</p> <p>On 3/5/15, Resident #2 was seen by the MD for behaviors. On 3/10/15 resident # 2 was placed on 24 hour 1:1 monitoring at 5 pm and has continued on 1:1 supervision on 3/11 and presently remains on 24 hours 1:1 supervision. Resident #2 will remain on 1:1 supervision until he is discharged, experiences a decline in functioning or no longer would meet the criteria to be placed on a designated Alzheimer's unit. On 3/12/15 the RN Administrator completed a drug regimen review with the MD via telephone with no medication changes identified. On 3/13/15 the consultant pharmacist completed the drug regimen review with no recommendation for medication changes. The MDS Nurse reviewed and updated resident #2's care plan on 3/11/15.</p>		

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F 323	<p>Continued From page 2</p> <p>(ED) records dated 2/8/15, revealed that Resident #2 was pleasantly confused at the ED. The ED patient Summary Report noted the Primary Impression: dementia with aggressive behavior. Under medications listed, it was indicated that Xanax (antianxiety medication) 0.5 milligrams (mg.) was given in the ED. Also listed was a prescription for Xanax 0.5mg 1 by mouth at bedtime for 30 days.</p> <p>A review of the Resident Concern Review dated 2/9/2015 revealed that 1) Resident #2 was sent to the local hospital ED on 2/8/2015 per doctor order. 2) In-service was started on 2/9/2015 on how to monitor residents with dementia and Alzheimer ' s. 3) Social Worker spoke with Resident #2 ' s responsible party (RP) to schedule a care plan meeting.</p> <p>The progress note on 2/9/2015 at 12:08 PM noted that Resident #1 had purple bruises on lower arms, wrists and hands.</p> <p>The care plan dated 2/10/2015 noted a focus of problematic manner in which Resident #2 acts characterized by ineffective coping, physical aggression or combativeness related to: anger, loss of control, unfamiliar environment. The goal was that safety would be ensured for the residents and staff. Interventions included: Medication as prescribed by physician, Monitor and document behavior per facility protocol.</p> <p>The admission MDS dated 2/13/2015 noted Resident #2 to be severely impaired for cognition and needed only supervision for walking and eating but needed extensive assistance for</p>	F 323	<p>Corrective action for Residents Potentially Affected</p> <p>On 3/10/15 a 100% head to toe assessment was completed by the MDS nurse, Assistant Director (ADON) of Nursing, Staff facilitator, treatment nurse, and Quality Improvement (QI) nurse on all residents in the locked dementia unit to include resident #1 and #2 to check for any signs and symptoms of injury or suspected signs of resident abuse. An incident report was completed, MD and RP notified, and an investigation was initiated by the QI Nurse for any injuries observed during the audit on 3/10/15 and completed on 03/25/15. There were six residents observed with bruise like areas during this audit that needed completion of an incident report which was completed on 3/10/15 with appropriate follow up with MD and RP notification by the ADON, MDS Nurse, Staff Facilitator Treatment Nurse, and QI Nurse. On 3/13/15 the head to toe skin assessment was expanded and was completed by ADON, MDS Nurse, Staff Facilitator Treatment Nurse, and QI Nurse to the remaining residents in the facility for any signs and symptoms of injury or suspected signs of resident abuse. An incident report was completed, MD and RP notified, and an investigation initiated by the QI Nurse for any injuries observed during the audit by 3/13/15.</p> <p>On 3/10/15, 100% review of all resident progress notes to include resident #1 and resident #2 from 3/4/15-3/10/15 was completed by the RN-Corporate Nurse to</p>		

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F 323	<p>Continued From page 3</p> <p>transfers, personal hygiene, using the toilet and bathing with the physical assistance of one person. The CAA indicated areas of cognitive loss/dementia and behavioral symptoms which were care planned. The CAA described behaviors of refusing care, holding a resident against their will, attempting to hit staff and cussing and threatening staff.</p> <p>A review of the clinical record revealed in the nurse notes that on 3/4/2015 at approximately 8:00 PM, Resident #2 walked to the sofa where Resident #1 was sitting and grabbed both of her arms and began shaking her.</p> <p>A review of incident reports dated 3/4/2015, for both Resident #1 and Resident #2 revealed that neither of the residents were taken to the hospital, no injuries were observed and the physician and Responsible Parties (RP) were notified. Both incident reports stated that Resident #2 grabbed Resident #1 by the arms and began shaking her.</p> <p>On 3/10/2015 a review of Resident #2 's care plan revealed that an intervention of 1:1 had been added at 5:00 PM, to continue indefinitely for the resident.</p> <p>On 3/10/2015 at 2:30 PM, in an interview, Nursing Assistant #1 stated that on 3/4/2015 she was in a room with a resident and heard noise. NA #1 stated that when she got to the residents, Nurse #1 and NA #2 had the residents separated. NA #1 stated that the following day the NAs watched the residents because of what had happened, but there was not a meeting or a discussion of what should be done to protect Resident #1 from Resident #2. NA #1 stated 1:1 supervision was</p>	F 323	<p>ensure that all documentation of resident to resident altercations have been documented appropriate, interventions implemented and MD/RP notified. No negative findings were found during this audit. On 3/11/15, all resident behavior records to include resident #1 and #2 were reviewed to assure these records were not related to resident to resident altercations by the RN Corporate Consultant. No areas of concern were identified during this audit.</p> <p>On 3/10/15, the RN-corporate nurse consultant completed a review of all resident to resident altercations from 3/4/15 -3/10/15 to ensure appropriate interventions were provided related to all identified altercations to include resident #1 and #2. There were no other resident to resident altercations identified during the audit.</p> <p>The RN Nurse Consultant, ADON, Treatment Nurse, Staff Facilitator, MDS Nurse, Nursing Supervisor and QI nurse initiated on 3/13/15 a 100% resident to resident altercation questionnaire with all staff to include license nurses, CNAs, dietary staff, therapy staff, housekeeping staff, maintenance staff, activities, payroll, bookkeeping receptionist and social workers staff on resident to resident altercation. All staff that has not been questioned will not be allowed to work until the questionnaire is completed. Staff answering any question inappropriately was re-educated upon identification by the RN Nurse Consultant, ADON, Treatment Nurse, Staff Facilitator, MDS Nurse, Nursing Supervisor and QI nurse.</p>		

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F 323	<p>Continued From page 4 not implemented at this time for Resident #2.</p> <p>On 3/10/2015 at 2:50 PM, in an interview, Nurse #1 indicated that she was at a resident 's door giving medications on 3/4/2015 when she turned around and observed Resident #2 walking toward the back of the common room. The nurse stated that she tried to walk between Resident #2 and Resident #1, but Resident #2 got past her and went straight to Resident #1 and grabbed her by the arms and then by the leg. Nurse #1 indicated that she and NA #2 got them separated, and Resident #2 was taken to a chair and, he sat down. Nurse #1 stated she assessed Resident #1 and found no obvious injury. Nurse #1 stated that she called the supervisor and informed her of what happened. Nurse #1 indicated that the supervisor came to the unit and suggested that Resident #2 be medicated and calls be made to family and the physician. Nurse #1 stated she filled out incident reports. Nurse #1 stated she worked the following day, and staff did not implement any new interventions to protect Resident #1 from Resident #2. Nurse #1 specified that 1:1 was not implemented at this time for Resident #2.</p> <p>On 3/10/15 at 3:02 PM, in an interview, NA #2 stated that she was in the large common room with all of the residents on 3/4/2015, when Resident #2 grabbed Resident #1. NA #2 indicated that she and Nurse #1 and NA #1 got Resident #2 to let go of Resident #1 and Resident #2 was taken to the other end of the room, and he continued to be agitated. NA #2 stated Resident #1 was taken to her room and assessed by Nurse #1, and the supervisor came to the unit. NA #2 stated that the NAs talked among themselves about watching Residents #1 and #2</p>	F 323	<p><b>Systemic Changes</b></p> <p>On 3/10/15 an in-service was initiated for all staff that have worked to include license nurses, including Nurse #1, CNAs to include NA #1 and NA #2, dietary staff, therapy staff, housekeeping staff, maintenance staff, activities, payroll, bookkeeping receptionist and social workers on the resident-to-resident abuse policy by the staff facilitator. This in-service included that Residents have the right to be free from verbal or physical abuse or other mistreatment by other residents. Incidents of aggressive, sexual, or abusive behavior by one resident toward another resident must be reported immediately to the supervisor and the resident protected from harm. The supervisor and/or employee must report the inappropriate behavior to the Administrator and/or DON. Any employee who fails to immediately report suspected abuse or inappropriate behavior by one resident to another resident will face disciplinary action up to and including termination of employment. For all staff who have not worked, a certified letter, return receipt requested was sent on 03/27/15.</p> <p>On 3/11/15 an in-service was initiated and completed on 3/11/15 with the DON, Administrator, ADON, treatment nurse, staff facilitator, MDS nurses, Nursing Supervisor, QI nurse, and second shift LPN by the RN-Corporate nurse consultant regarding those residents that exhibit combative behaviors and are a danger to other residents need to be</p>		

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F 323	<p>Continued From page 5</p> <p>more closely because of what happened. NA #2 stated there was no meeting about anything they should do to protect Resident #1 from Resident #2.</p> <p>On 3/11/2015 at 10:30 AM, in an interview, NA #2 stated that Resident #1 and Resident #2 are not around each other. NA #2 stated when the incident happened on 3/4/2015, Resident #1 was very upset and asked why Resident #2 did that to her, then she asked to go to bed. NA #2 stated the next day Resident #1 was fine and did not act scared at all and does not act scared now.</p> <p>On 3/11/2015 at 3:45 PM, in an interview, the Director of Nursing (DON) stated she got a call from a nurse on 3/4/2015 saying Resident #2 had grabbed Resident #1. Nurse #1 assessed Resident #1 and could not find any injury. The DON indicated she told Nurse #1 to give Resident #2 the intramuscular (IM) antianxiety medication. The DON stated the incident was spoken of in the daily staff meeting on 3/5/2015 and also spoken of in the clinical meeting after staff meeting, but nothing was decided in regard to actions to be taken to protect Resident #1 from Resident #2. As far as other measures that would be put into place at that time to protect other residents, the DON stated that there was a meeting with Resident #2 's family on 3/11/15 at 10:38 AM, to talk about all of the things we could do to calm him down when he became agitated. The DON noted that there was an order from the physician to medicate Resident #2 with the IM antianxiety medication. The DON stated the facility does not have a policy to monitor residents in the locked unit, but the facility does orient staff to deal with behaviors when they are hired. The DON confirmed that no interventions were</p>	F 323	<p>closely monitored i.e. 1:1 to ensure other incidents do not occur. This in-service was expanded by the RN Nurse Consultant on 3/12/15 and completed on 03/23/15 to all licensed nurses to include Nurse #1 regarding placing residents on 1:1 supervision, sending the resident to the ER and notifying the Administrator and DON immediately notified of all resident to resident altercations including after hours and weekends. For all staff who have not worked, a certified letter, return receipt requested was sent on 03/27/15.</p> <p>An in-service was initiated on 3/10/15 by the Director of Nursing to all Licensed Nurses to include Nurse #1 and Certified Nursing Assistants, to include NA#1 and NA#2. This in-service included how imperative it is to monitor residents with Dementia and Alzheimer's very closely. If you are working in the SPARKS unit, you should be making rounds and checking on the residents frequently if they are not visible in the common areas then you need to seek them out and assure their safety. It only takes a moment for someone to fall or become engaged in an undesirable activity related to these declines in cognition. The in-service was amended on 3/13/15 and completed on 03/23/15 on how to identify a resident that is becoming agitated or beginning to exhibit signs and symptoms of agitation and what appropriate interventions would be to decrease the resident's agitation to include, redirection, snacks, family interaction, reminiscing and music. If the resident's behavior is unable to be redirected the nurse must be notified. The</p>		

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F 323	<p>Continued From page 6</p> <p>implemented by staff to protect Resident #1 from Resident #2 until 3/10/15 when 1:1 supervision was implemented for Resident #2.</p> <p>The Administrator was interviewed on 3/11/2015 at 4:00 PM and stated she did not recall when she learned of the incident that occurred on 3/4/2015 between Residents #1 and #2. The Administrator also stated staff was supposed to notify her immediately for any occurrence of abuse. The Administrator stated her expectation was staff should contact her immediately when abuse occurs. The Administrator stated that no interventions were implemented by staff to protect Resident #1 from Resident #2 from 3/4/15 until 3/10/15 when 1:1 supervision was implemented.</p> <p>On 3/12/2015 at 9:10 AM, in an interview, the Administrator stated all residents on the locked Alzheimer ' s unit were on every 15 minute checks all day, every day.</p> <p>The family member (RP) of Resident #2 was interviewed on 3/12/2015 at 9:22 AM and stated the facility offered psychiatric services for the resident after the first incident on 2/8/2015, and she refused. As far as the incident on 3/4/2015, the family member stated Resident #2 was sitting at a table, got up and grabbed another resident ' s arms, and the staff got him away and called and told the family member that Resident #2 would be medicated with the IM antianxiety medication. The family member stated that she came to a meeting with the facility and it was decided that for the future, if Resident #2 cannot be calmed, then the resident will be sent to the hospital. The family member stated the facility offered psychiatric services and she refused. The family member stated if the facility called her, then she</p>	F 323	<p>nurse will notify the MD and RP and send to the ER per MD order. For all staff who have not worked, a certified letter, return receipt requested was sent on 03/27/15. Once an employee has identified a resident to resident altercation the following will be completed:</p> <ol style="list-style-type: none"> <li>1. Employee witnesses the altercation and intervenes to protect the resident from harm. Then notifies the supervisor.</li> <li>2. The nurse will assess resident(s) involved in the altercations for any signs or symptoms of injury and notify the MD and RP.</li> <li>3. An immediate plan to protect the resident and others will be identified and implemented by the licensed nurse; to include 1:1 supervision and or sending the resident to the Emergency Room for evaluation of aggressive behavior.</li> <li>4. The supervisor will notify the Administrator and Director of Nursing for further recommendations and interventions as indicated.</li> <li>5. The resident's behavior and interventions will be documented in the medical record by the licensed nurse.</li> </ol> <p>Quality Assurance</p> <p>The ADON, treatment nurse, staff facilitator, MDS nurses, Nursing Supervisor, and or QI nurse, will review progress notes, incident reports, and behavior sheets for all residents to include resident #1 and resident #2, 5x per week x 4 week, 3 x per week x 4 weeks and then weekly x 4 weeks to ensure that all documented behaviors to include,</p>		

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F 323	<p>Continued From page 7 could get Resident #2 to calm down.</p> <p>An interview was conducted with a family member of Resident #1 on 3/12/2015 at 11:35 AM, who stated they received a call from Nurse #1 saying there had been an altercation on the Alzheimer ' s unit, and the family member stated they would come in the next day. The family member indicated they came in on 3/5/2015 and saw Resident #1 had bruises on both her wrists. The family member stated to Nurse #2 she was upset, and then she asked one of the NAs to look in the direction of the person who had been involved with Resident #1, and the NA looked at Resident #2. The family member stated when they came to the facility on 3/6/2015, and the Administrator was not there, and the receptionist took them to the Resident Liaison ' s office who wrote out a Resident Concern Form and told the family member that the form would go to the Administrator, and a plan would be formulated. The family member stated she told the Liaison that she was afraid Resident #2 was going to hurt Resident #1. The family member stated when she came to the facility on 3/8/2015 around 3:00 PM, Resident #1 was sitting on the love seat in the large common room and right beside resident #1, at about arm ' s length in a wingback chair was Resident #2. The family member indicated she took Resident #1 home with her for the afternoon, because she was afraid of what might happen. The family member further stated there was a staff person behind the desk and there were NAs in the room.</p> <p>An attempt was made by phone to reach the resident ' s private physician on 3/12/2015 at 12:34 PM and the physician could not be reached. A second attempt was made to reach</p>	F 323	<p>resident to resident altercations were appropriately addressed with interventions to decrease identified behaviors, interventions to protect residents from harm to include 1:1 or sending to the ER, residents were assessed, MD/RP notification, and DON/Administrator notification utilizing an Behavior Monitoring QI Audit Tool). The ADON, treatment nurse, staff facilitator, MDS nurses, Nursing Supervisor, and or QI nurse will immediately address any identified areas of concern by ensuring interventions are initiated for the residents displaying the behavior and retraining with the license nurses and CNAs. The DON or Administrator will review the Behavior Monitoring QI Tool 3x per week x 4 weeks and weekly x 8 weeks for completion and to ensure all identified areas of concern were addressed.</p> <p>The QI committee members consist of the QI nurse, DON, ADON, MDS Coordinator, MDS Nurse 1, MDS Nurse 2, Staff Facilitator, Therapy Manager, Treatment Nurse and Administrator. The Quality Assurance committee will review the results of the Behavior Monitoring QI Audit Tool at the monthly QI meeting for three months for the need to continue monitoring and the frequency of monitoring.</p> <p>Attending physicians of each resident who was found to have received substandard quality of care:</p> <p>Resident #1</p>		



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345237</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/13/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>BARBOUR COURT NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>515 BARBOUR ROAD SMITHFIELD, NC 27577</b>		
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F 323	Continued From page 8 the physician on 3/12/2015 at 1:30 PM without success.  A second interview was conducted with NA #2 on 3/12/2015 at 3:00 PM. The NA stated she was on the locked unit on 3/4/2015 when the incident occurred between Resident #1 and Resident #2. When asked to describe the incident in detail, NA #2 stated she was in the large common room and Resident #1 was quietly sitting on a sofa and not interacting with anyone. NA #2 stated Resident #2 was standing beside the television. NA #2 indicated she turned to help another resident to the bathroom when she heard Resident #1 yell " Get away from me. " NA #2 stated when she turned around, she saw Resident #2 approach Resident #1 and grab both of her wrists. NA #2 indicated she, Nurse #1 and NA #1 went immediately to the two residents, and it took all three of them to pry Resident #2 ' s hand off of Resident #1 ' s left wrist. NA #2 stated while the staff were trying to get Resident #2 to let go, Resident #1 held both of her legs straight out in an attempt to push him away, and Resident #2 then grabbed Resident #1 ' s leg and was holding Resident #1 by the right leg and right wrist. NA #2 stated it took all three staff members to get Resident #2 to let go, as he was a very strong man. NA #2 indicated she noticed Resident #1 was red on both of her lower arms afterward. NA #2 stated Nurse #1 assessed Resident #1 right away, and Nurse #1 then gave Resident #2 an injection. NA #2 said " It took a long time for him to calm down. " NA #2 stated she worked with both Resident #1 and Resident #2 every day, and she had never seen Resident #1 interact with Resident #2 at all and she further stated she had never seen Resident #1 provoke Resident #2 in any way. NA #2 stated when she came to work	F 323	Smithfield Family Practice Dr. Raghu Katura 1551 Booker Dairy Rd Smithfield, NC 27577 919-934-8977  Resident #2 Dr. John Yocono C/O Barbour Court Nursing & Rehabilitation Center 515 Barbour Rd Smithfield, NC 27577 919-934-6017		

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F 323	<p>Continued From page 9</p> <p>the following day, the arms of Resident #1 were starting to show bruising.</p> <p>On 3/13/2015 at 4:53 PM, in an interview, the ED coordinator stated that the hospital can do psychiatric evaluations 24 hours a day, 7 days per week. The ED coordinator stated that a psychiatric evaluation was not done on Resident #2 when he came to the ED on 2/8/2015, because the resident was having no behaviors that would trigger for a psychiatric evaluation, and that the decision is up to the ED physician.</p> <p>On 3/13 /15 at 11:25 AM the Administrator was notified of immediate jeopardy for failing to put measures in place to keep Resident #1 safe from Resident #2 after Resident #2 physically grabbed Resident #1 on 3/4/2015. The facility provided and acceptable credible allegation of compliance on 3/13/2015 at 4:50 PM. The following measures were put into place to remove the immediate jeopardy.</p> <p>Allegation of compliance: On 3/4/2015, at approximately 8:07 PM, CNA and Hall Nurse witnessed Resident #1 and Resident #2 in a physical altercation. The CNA and Hall Nurse immediately separated Resident #1 and Resident #2. On 3/4/15, the Hall Nurse assessed Resident #1 for any injuries with no negative findings. On 3/4/15, the MD and RP of Resident #1 and Resident #2 were notified by Hall Nurse regarding the resident to resident altercation. Resident #1 was reassessed by the hall nurse for injuries on 3/5/15 with a bruise observed to her lower arm. The MD and RP was notified of resident #1 of the bruise on 3/5/15. On 3/5/15, Resident #2 was seen by the MD for</p>	F 323			

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F 323	Continued From page 10 behaviors. On 3/10/15 resident # 2 was placed on 24 hour 1:1 monitoring at 5 pm and has continued on 1:1 supervision on 3/11, 12, 13/2015 and presently remains on 24 hours 1:1 supervision. Resident #2 will remain on 1:1 supervision until he is discharged, experiences a decline in functioning or no longer would meet the criteria to be placed on a designated Alzheimer ' s unit. On 3/12/15 the RN Administrator completed a drug regimen review with the MD via telephone with no medication changes identified. On 3/13/15 the consultant pharmacist completed the drug regimen review with no recommendation for medication changes. The MDS Nurse reviewed and updated resident #2 ' s care plan on 3/11/15. On 3/10/15 a 100% head to toe assessment was completed by the MDS nurse, Assistant Director (ADON) of Nursing, Staff facilitator, treatment nurse, and Quality Improvement (QI) nurse on all residents in the locked dementia unit to include resident #1 and #2 to check for any signs and symptoms of injury or suspected signs of resident abuse. An incident report was completed, MD and RP notified, and an investigation was initiated by the QI Nurse for any injuries observed during the audit on 3/10/15. There were six residents observed with bruise like areas during this audit that needed completion of an incident report which was completed on 3/10/15 with appropriate follow up with MD and RP notification by the ADON, MDS Nurse, Staff Facilitator Treatment Nurse, and QI Nurse. On 3/13/15 the head to toe skin assessment was expanded and will be completed by ADON, MDS Nurse, Staff Facilitator Treatment Nurse, and QI Nurse to the remaining residents in the facility for any signs and symptoms of injury or suspected signs of resident abuse. An incident report will be completed, MD and RP notified, and an investigation initiated by	F 323			

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F 323	Continued From page 11 the QI Nurse for any injuries observed during the audit by 3/13/15. On 3/10/15, 100% review of all resident ' s progress notes to include resident #1 and resident #2 from 3/4/15-3/10/15 was completed by the RN-Corporate Nurse to ensure that all documentation of resident to resident altercations have been documented appropriate, interventions implemented and MD/RP notified. No negative findings were found during this audit. On 3/11/15, all resident behavior records to include resident #1 and #2 were reviewed to assure these records were not related to resident to resident altercations by the RN Corporate Consultant. No areas of concern were identified during this audit. On 3/10/15, the RN-corporate nurse consultant completed a review of all resident to resident altercations from 3/4/15 -3/10/15 to ensure appropriate interventions were provided related to all identified altercations to include resident #1 and #2. There were no other resident to resident altercations identified during the audit. The RN Nurse Consultant, ADON, Treatment Nurse, Staff Facilitator, MDS Nurse, Nursing Supervisor and QI nurse initiated on 3/13/15 a 100% resident to resident altercation questionnaire with all staff to include license nurses, CNAs, dietary staff, therapy staff, housekeeping staff, maintenance staff, activities, payroll, bookkeeping receptionist and social workers staff on resident to resident altercation. Staff answering any question inappropriately will be re-educated upon identification by the RN Nurse Consultant, ADON, Treatment Nurse, Staff Facilitator, MDS Nurse, Nursing Supervisor and QI nurse. No staff will be allowed to work until the questionnaire has been completed. On 3/10/15 an in-service was initiated for all staff that have worked and will be completed by	F 323			

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F 323	Continued From page 12 3/13/15 with all staff to include license nurses, CNAs, dietary staff, therapy staff, housekeeping staff, maintenance staff, activities, payroll, bookkeeping receptionist and social workers on the resident-to-resident abuse policy by the staff facilitator. This in-service included that Residents have the right to be free from verbal or physical abuse or other mistreatment by other residents. Incidents of aggressive, sexual, or abusive behavior by one resident toward another resident must be reported immediately to the supervisor and the resident protected from harm. The supervisor and/or employee must report the inappropriate behavior to the Administrator and/or DON. Any employee who fails to immediately report suspected abuse or inappropriate behavior by one resident to another resident will face disciplinary action up to and including termination of employment. As of 3/13/15, 6 staff have not received the in-service. They will not be allowed to work until the in-service has been completed. On 3/11/15 an in-service was initiated and completed on 3/11/15 with the DON, Administrator, ADON, treatment nurse, staff facilitator, MDS nurses, Nursing Supervisor, QI nurse, and second shift LPN by the RN-Corporate nurse consultant regarding those residents that exhibit combative behaviors and are a danger to other residents need to be closely monitored i.e. 1:1 to ensure other incidents do not occur. This in-service was expanded by the RN Nurse Consultant on 3/12/15 to all licensed nurses to include placing residents on 1:1 supervision, sending the resident to the ER and notifying the Administrator and DON immediately notified of all resident to resident altercations including after hours and weekends. As of 3/13/15, 3 licensed nurses have not received the in-service. They will not be allowed to work until the in-service has	F 323			

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F 323	Continued From page 13 been completed. An in-service was initiated on 3/10/15 by the Director of Nursing to the Licensed Nurses and Certified Nursing Assistants. This in-service included how imperative it is to monitor residents with Dementia and Alzheimer ' s very closely. If you are working in the SPARKS unit, you should be making rounds and checking on the residents frequently if they are not visible in the common areas then you need to seek them out and assure their safety. It only takes a " moment " for someone to fall or become engaged in an undesirable activity related to these declines in cognition. The in-service was amended on 3/13/15 on how to identify a resident that is becoming agitated or beginning to exhibit signs and symptoms of agitation and what appropriate interventions would be to decrease the resident ' s agitation to include, redirection, snacks, family interaction, reminiscing and music. If the resident ' s behavior is unable to be redirected the nurse must be notified. The nurse will notify the MD and RP and send to the ER per MD order. Once an employee has identified a resident to resident altercation the following will be completed: 1. Employee witnesses the altercation and intervenes to protect the resident from harm. Then notifies the supervisor. 2. The nurse will assess resident(s) involved in the altercations for any signs or symptoms of injury and notify the MD and RP. 3. An immediate plan to protect the resident and others will be identified and implemented by the licensed nurse; to include 1:1 supervision and or sending the resident to the Emergency Room for evaluation of aggressive behavior. 4. The supervisor will notify the Administrator and Director of Nursing for further	F 323			

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F 323	Continued From page 14 recommendations and interventions as indicated. The resident ' s behavior and interventions will be documented in the medical record by the licensed nurse.  Immediate jeopardy was removed on 3/13/2015 at 5:35 PM when verification of the credible allegation of compliance was evidenced by record review and interview. Surveyors confirmed the facility put into place continuing 1:1 supervision for Resident #2, an updated care plan for Resident #2. In-service for resident to resident altercation and steps to interventions. Interviews revealed licensed nurses throughout the facility were thoroughly knowledgeable in regard to resident to resident altercation.	F 323		