STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 03/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation was conducted from 03/09/17 through 03/11/17. Immediate Jeopardy was identified at: CFR 483.25 at tag F323 at a scope and severity (J) CFR 483.75 at tag F490 at a scope and severity (J) Immediate Jeopardy began on 03/06/17 and was removed on 03/11/17. An extended survey was conducted.	F 000		
F 224 SS=D	483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and (b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced	F 224		4/4/17

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

Electronically Signed | 04/02/2017

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F 224	Continued From page 1 by: Based on observation, staff, and resident interviews and record review, the facility failed to attend to the needs of one of three residents reviewed (Resident #2) when the Resident was left on the bedpan. Findings included: Resident #2 was admitted 10/10/2014 with diagnoses of bowel obstruction, morbid obesity, anxiety and chronic pain. The annual Minimum Data Set (MDS), dated 10/13/2016 noted Resident #2 to be cognitively intact and had adequate vision with glasses and needed extensive assistance for all Activities of Daily Living with the physical assistance of one to two persons. Resident #2 was independent for eating, after having the tray set up. The Care Area Assessment (CAA) focused on the area of ADL care and this area was care planned. The care plan dated 1/10/2017 noted Resident #2 required assistance with ADLs related to decreased mobility, and had a goal of Resident #2's needs would be met and the highest ability in self-function would be maintained. Interventions included: Participation in daily care as able. Mechanical lift for transfers. Provide assistance as required for completion of ADL tasks. On 3/9/2017 at 12 noon, Resident #2 was observed in bed, was wearing glasses and aclock was noted to be in the room, visible to her. Resident #2 stated she had to have help to do all of her care. Resident #2 stated on 3/7/2017 she turned on the call light at 9:30 AM and told the Nursing Assistant (NA #6) who was assigned to her that she needed to get on the bedpan, and	F 224	Brian Center Health and Rehabilitation/Salisbury acknowledges receipt of the Statement of Deficiencies and purpose of this Plan of Correction to the extent that the summary of findings is factually correct in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as written allegation of compliance. Preparation and submission of this Plan of Correction is in response to the CMS 2567 from the survey conducted on March 9-11, 2017. Brian Center Health and Rehabilitation/Salisbury's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Furthermore, the Brian Center Health and Rehabilitation/Salisbury reserves the right to refute any deficiency on the Statement of Deficiencies through Informal Dispute Resolution, formal appeal and/or other administrative or legal procedures. F224 Corrective action accomplished for those residents found to have been affected by the deficient practice: ADL care was provided for Resident #2 by NA #5 and nurse. Clean linen and water was provided by NA #5 and nurse to properly clean resident #2 and get her up.	

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F 224	Continued From page 2 NA #6 could set up her water, soap, towels and washcloths for her bath. Resident #2 indicated she would often complete as much of her bath as possible and the NA would finish washing her and get her up. Resident #2 stated at 10:45 AM she finished and was uncomfortable having been on the bedpan for so long. Resident #2 noted no one answered her call light and she continued to wait, then called the receptionist at the front desk and told her she needed help. Meanwhile, she tried to remove the bedpan and spilled it on the bed and on herself. Resident #2 stated she began to call out for help, and called the front desk again and the receptionist came to the hall and told NA #6 that Resident #2 needed help. Resident #2 stated she waited 30 more minutes and when help came it was not NA #6, but several other NAs and nurses who cleaned her up. Resident #2 said "I was so upset and my voice was hoarse from calling for help and NA #6 never even said anything to me." On 3/10/2017 at 11:00 AM, in a telephone interview, NA #6 stated that she put Resident #2 on the bedpan at 9:30 AM and set up her bath. NA #6 indicated when she was going to go into Resident #2's room, another resident fell, and the staff had to "huddle"(meet to plan help for the fallen resident), had to find a mechanical lift and had to find a battery that was charged for the lift, to get the fallen resident up. NA #6 stated she then started to go in to help Resident #2, when another resident fell and staff had to get him up. NA #6 indicated that a lot was going on at that time. NA #6 indicated by the time she got through helping with the other residents, someone else had taken care of Resident #2. In an interview on 3/10/2017 at 1:50 PM, NA #5	F 224	Corrective action accomplished for those residents having the potential to be affected by the deficient practice: Staff were educated by ADON or designee about abuse and neglect and expectations is such behavior is observed on 3/16/17. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: Weekly audits will be conducted for four weeks, and randomly thereafter, by DON or designee, from a random sampling of residents to ensure proper ADL care is being provided. If any adverse outcomes are identified via the weekly audit, immediate action will be taken, to include reporting incident via 24 hour report. Monitoring Process: The results of the weekly audits will be reviewed in Quality Assurance and Performance Improvement Committee monthly, with QAPI committee responsible for on-going compliance.	

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F 224	Continued From page 3	F 224		

stated she was with another NA and a nurse when they went in to Resident #2's room to assist her. NA #5 noted the nurse stayed in the room and she and the other NA got the things together, linen and clean water and cleaned Resident #2 up. NA #5 stated Resident #2 was very upset and crying. NA #5 indicated NA #6 did not tell anyone else to help Resident #2, and NA #6 went to lunch without asking any other NA to take care of Resident #2.

On 3/10/2017 at 2:00 PM, in an interview, Certified Medication Aide (CMA) #2 stated she walked into Resident #2's room, the call light was on and Resident #2 was crying and the bed was a mess with the cold bath water at the bedside and dirty bedpan spilled in the bed. CMA #2 got the unit manager to come in, and CMA #2 and NA #5 cleaned up Resident #2. CMA #2 stated Resident #2 was very upset.

In an interview on 3/10/2017 at 3:00 PM, Nurse #5 stated she went into Resident #2's room and found her upset and in a mess in her bed and assessed that she was not hurt, and CMA #2 and NA #5 cleaned Resident #2 up and changed the bed. Nurse #5 stated this happened about 11:30 AM. Nurse #5 noted she told the Administrator that afternoon.

On 3/10/2017 at 3:30 PM, in an interview, the Administrator stated he found out about NA #6 leaving Resident #2 for a long period of time on 3/8/2017, and he filed a 24 hour report and would file a 5 day report and would substantiate neglect for Resident #2. The Administrator noted he would have gotten a statement and terminated NA #6, but NA #6 called out from work that day.

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F 241	Continued From page 4	F 241		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review, the facility failed to attend to the needs of one of three residents reviewed for dignity (Resident #2), when the resident was left on the bedpan for two hours and resulted in the resident being embarrassed and upset. Findings included: Resident #2 was admitted 10/10/2014 with diagnoses of bowel obstruction, morbid obesity, anxiety and chronic pain. The annual Minimum Data Set (MDS), dated 10/13/2016 noted Resident #2 to be cognitively intact and needed extensive assistance for all Activities of Daily Living with the physical assistance of one to two persons. The Care Area Assessment (CAA) focused on the area of ADL care and this area was care planned. The care plan dated 1/10/2017 noted Resident #2 required assistance with ADLs related to decreased mobility, and had a goal of Resident #2's needs would be met and the highest ability in self-function would be maintained. Interventions included: Participation in daily care as able. Mechanical lift for transfers. Provide assistance	F 241	F 241 Corrective action accomplished for those residents found to have been affected by the deficient practice: ADL care was provide for Resident #2 by NA #5 and nurse. Clean linen and water was provided by NA #5 and nurse to properly clean Resident #2 and get her up. Corrective action accomplished for those residents having the potential to be affected by the deficient practice: Staff were educated by ADON or designee regarding providing care with dignity on 3/29/17. Measures put in place or systemic changes made to ensure that the deficient practice will not occur: Weekly audits will be conducted for four weeks, and randomly thereafter, by Department Heads and Managers on Duty for dignity concerns. If any adverse	4/4/17

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F 241	Continued From page 5 as required for completion of ADL tasks. On 3/9/2017 at 12 noon, Resident #2 was observed in bed wearing eyeglasses and a clock was noted in the room. Resident #2 stated she had to have help to do all of her care. Resident #2 stated on 3/7/2017 she turned on the call light at 9:30 AM and told the Nursing Assistant (NA #6) who was assigned to her that she needed to get on the bedpan, and NA #6 could set up her water, soap, towels and washcloths for her bath. Resident #2 indicated she would often complete as much of her bath as possible and the NA would finish washing her and get her up. Resident #2 stated at 10:45 AM she finished and was uncomfortable having been on the bedpan for so long. Resident #2 noted no one answered her call light and she continued to wait, then called the receptionist at the front desk and told her she needed help. Meanwhile, she tried to remove the bedpan and spilled it on the bed and on herself. Resident #2 stated she began to call out for help, and called the front desk again and the receptionist came to the hall and told NA #6 that Resident #2 needed help. Resident #2 stated she waited 30 more minutes and when help came it was not NA #6, but several other NAs and nurses who cleaned her up. Resident #2 indicated this was before lunch trays arrived. Resident #2 said "I was so upset and my voice was hoarse from calling for help and NA #6 never even said anything to me." On 3/10/2017 at 11:00 AM, in a telephone interview, NA #6 stated that she put Resident #2 on the bedpan and set up her bath at around 9:30 AM. NA #6 indicated when she was going to go into Resident #2's room, another resident fell, and the staff had to "huddle"(meet to plan help for the	F 241	outcomes are identified via the weekly audit, immediate action will be taken, to include reporting incident via 24 hour report. Monitoring Process: The results of the weekly audits will be reviewed in Quality Assurance and Performance Improvement Committee monthly, with QAPI committee responsible for on-going compliance.	

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F 241	Continued From page 6	F 241		

fallen resident), had to find a mechanical lift and had to find a battery that was charged for the lift, to get the fallen resident up. NA #6 stated she then started to go in to help Resident #2, when another resident fell and staff had to get him up. NA #6 indicated that a lot was going on at that time. NA #6 indicated by the time she got through helping with the other residents, someone else had taken care of Resident #2.

In an interview on 3/10/2017 at 1:50 PM, NA #5 stated she was with another NA and a nurse when they went in to Resident #2's room to assist her. NA #5 noted the nurse stayed in the room and she and the other NA got the things together, linen and clean water and cleaned Resident #2 up. NA #5 stated Resident #2 was very upset and crying. NA #5 indicated NA #6 did not tell anyone else to help Resident #2, and NA #6 went to lunch without asking any other NA to take care of Resident #2.

On 3/10/2017 at 2:00 PM, in an interview, Certified Medication Aide (CMA) #2 stated she walked into Resident #2's room, the call light was on and Resident #2 was crying and the bed was a mess with the cold bath water at the bedside and dirty bedpan spilled in the bed. CMA #2 got the unit manager to come in, and CMA #2 and NA #5 cleaned up Resident #2. CMA #2 stated Resident #2 was very upset.

In an interview on 3/10/2017 at 3:00 PM, Nurse #5 stated she went into Resident #2's room and found her upset and in a mess in her bed and assessed that she was not hurt, and CMA #2 and NA #5 cleaned Resident #2 up and changed the bed. Nurse #5 stated this happened about 11:30 AM. Nurse #5 noted she told the Administrator

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F 241	Continued From page 7 that afternoon. On 3/9/2017 at 2:30 PM, in an interview, the Administrator stated he had filed a 24 hour report with the state in regard to an issue of neglect for Resident #2 by NA #6. The Administrator indicated he interviewed the nurse and NAs on the hall and found NA #6 had gone to lunch and not told anyone Resident #2 needed assistance. The Administrator indicated he would substantiate neglect occurred and NA #6 would be terminated.	F 241		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services,	F 309		4/4/17

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F 309	Continued From page 8 consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident, staff and physician interviews and record review the facility failed to provide nasal spray to 1 of 1 resident with sinusitis. (Resident #4). Findings included: Resident #4 was admitted 12/23/14 with diagnoses that included diabetes, hypertension and sinusitis. A quarterly Minimum Data Set (MDS) dated 12/24/2016, indicated Resident # 4 had no long term or short term memory impairment and required moderate to extensive assistance with his Activities of Daily Living. A review of Resident #4's current physician's orders revealed there was no order for nasal spray. A review of Resident #4's Medication Administration Records (MARs) revealed nasal spray was discontinued in 06/2016. A review of the medical consults indicated Resident #4 had been seen by an Ear, Nose, and	F 309	F309 Corrective action to be accomplished for those residents found to have been affected by the deficient practice: Resident #4 received first dose of saline nasal spray on 3/10/17 after order was clarified and continues to receive medication per order. Corrective action accomplished for those residents having the potential to be affected by the deficient practice: An audit was completed by Assistant Director of Nursing and Unit Managers on 3/15/17 on all residents to ensure all consultations had been properly addressed for the last 30 days. Measures put in place or systemic changes made to ensure that the deficient practice will not occur: All report of consultations will be logged on the follow up consultation notification	

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F 309	Continued From page 9 Throat (ENT) specialist on 02/15/2017. The consult sheet documented a diagnosis of chronic sinusitis. There was a recommendation to continue nasal saline. An interview on 03/09/2017 at 05:09 PM with Certified Medical Assistant (CMA) #2 on 03/09/2017 revealed Resident #4 never had nasal spray ordered. An interview on 03/10/2017 at 08:23 AM with Resident #4 revealed he had been seen by an ENT consultants who stated he had sinusitis and had ordered nasal spray and antibiotics to treat the sinusitis. He stated he had brought back a paper from the doctor for the facility. He stated that was a couple weeks ago and he hadn't had any nasal spray yet. He stated he would feel better if he had the nasal spray for his sinuses. An interview on 03/10/2017 at 09:25 AM with the Medical Director (MD) disclosed he was usually notified of a specialist consult if there are new orders. Staff were to call me and verify the orders. He stated "I do not remember a consult recommending a nasal spray that I had not agreed with" for Resident #4. During an interview on 03/10/2017 at 11:49 AM with Nurse # 6 stated there was no order for nasal spray at this time. She did not remember him going out to an ENT appointment. She stated there was a communication sheet that was returned with the resident when they return from an outside doctor's appointment. New orders were picked up from those sheets. An interview on 03/10/2017 at 05:00 PM with the Director of Nursing (DON) indicated that she	F 309	and order sheet after each doctor appointment by the staff nurse. The consultation will then be placed in the physician communication book for review by the attending physician. The new orders will be entered into electronic medical record. Weekly audits will be conducted by the Unit Managers, Assistant Director of Nursing or designee of the residents follow up consultation notification and order tool. Monitoring Process: The results of the weekly audits will be reviewed in Quality Assurance and Performance Improvement Committee monthly, with QAPI committee responsible for on-going compliance.	

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F 309	Continued From page 10 expected staff to review the consult communications forms when a resident returned from an outside appointment and to notify the MD of new orders, send the medication order to the pharmacy as needed and begin the new orders.	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record reviews, The facility failed to provide care for 1 of 10 residents reviewed for activities of daily living assistance (Resident #2), making the resident wait for assistance while on the bedpan. Findings included: A review of the medical record revealed Resident #2 was admitted 10/10/2014 with diagnoses of bowel obstruction, anxiety and chronic pain. The annual Minimum Data Set (MDS), dated 10/13/2016 noted Resident #2 to be cognitively intact and had adequate vision with glasses and needed extensive assistance for all Activities of Daily Living (ADLs) with the physical assistance of one to two persons. The Care Area Assessment (CAA) focused on the area of ADL care, and this area was care planned. The care plan dated 1/10/2017 noted Resident #2 required assistance with ADLs related to decreased mobility and had a goal of Resident	F 312	F312 Corrective action accomplished for those residents found to have been affected by the deficient practice: ADL care was provided for Resident #2 by NA #5 and nurse. Clean linen and water was provided by NA #5 and nurse to properly clean Resident #2 and get her up. Corrective action accomplished for those residents having the potential to be affected by the deficient practice: Staff were educated regarding providing ADL care for all residents as needed by the DON and/or designee on 3/29/17. Measures put in place or systemic changes made to ensure that the deficient practice will not occur:	4/4/17

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F 312	Continued From page 11 #2's needs would be met, and the highest ability in self-function would be maintained. Interventions included: Participation in daily care as able. Mechanical lift for transfers. Provide assistance as required for completion of ADL tasks. On 3/9/2017 at 12 noon, Resident #2 was observed in bed. Resident #2 stated she had to have help to do all of her care. Resident #2 stated on 3/7/2017, she turned on the call light at 9:30 AM and told the Nursing Assistant (NA #6) who was assigned to her she needed to get on the bedpan. Resident #2 indicated she would often complete as much of her bath as possible, and the NA would finish washing her and get her up. Resident #2 stated at 10:45 AM, she was uncomfortable having been on the bedpan for so long. Resident #2 noted no one answered her call light, and she continued to wait then called the receptionist at the front desk, using her cell phone, and told her she needed help. Meanwhile, she tried to remove the bedpan and spilled it on the bed and on herself. Resident #2 stated she began to call out for help and called the front desk again, and the receptionist came to the hall and told NA #6 that Resident #2 needed help. Resident #2 stated she waited 30 more minutes, and when help came, it was not NA #6, but several other NAs and nurses who cleaned her up. On 3/9/2017 at 2:30 PM, in an interview, the Administrator indicated he had gone to the "huddle" (gather with staff to plan how to help when a resident falls) on 3/7/2017 and there was enough staff there to take care of the situation without the help of NA #6. The Administrator stated he had interviewed the nurse and NAs on	F 312	Weekly audits will be conducted for four weeks, and randomly thereafter, by DON or designee, from a random sampling of residents to ensure proper ADL care is being provided. If any adverse outcomes are identified via the weekly audit, immediate action will be taken, to include reporting via 24 hour report. Monitoring Process: The results of the weekly audits will be reviewed in Quality Assurance and Performance Improvement Committee monthly, with QAPI committee responsible for on-going compliance.	

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F 312	Continued From page 12 the hall and found NA #6 had gone to lunch and not told anyone Resident #2 needed assistance. The Administrator stated his expectation was the staff would make sure their assignments were covered before they took breaks. On 3/10/2017 at 10:30 AM, in a telephone interview, Nursing Assistant (NA) #6 stated she had put Resident #2 on the bedpan and set her up for a bath about 9:30 AM on 3/7/2017. NA #6 stated she was going to go into Resident #2's room when another resident fell, and NA #6 had to "huddle" (gather with staff to plan how to help the fallen resident), find a mechanical lift for the fallen resident, then find a charged battery for the lift. NA #6 stated when she was finished with that, another resident fell, and she helped with that resident. NA #6 stated "there was a lot going on at that time." In an interview on 3/10/2017 at 1:50 PM, NA #5 stated she went into the room with the nurse and CMA #2 to help Resident #2. NA #5 indicated she was not assigned to Resident #2, NA #6 was, but NA #6 had gone to lunch without telling anyone that resident #2 needed help. NA #5 stated she and CMA #2 went in and cleaned up resident #2, got her up and changed the bed. On 3/10/2017 at 2:00 PM, in an interview, Certified Medication Assistant (CMA) #2 stated she saw the light on for Resident #2 and went into her room and found Resident #2 was in the bed and the bedpan was spilled, and Resident #2 was upset and crying. CMA #2 stated she got the unit manager to come in and assess Resident #2, and she and NA #5 cleaned her up.	F 312		
F 323	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT	F 323		4/4/17

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F 323 SS=J	Continued From page 13 HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to supervise one of one sampled residents with known sexually inappropriate behaviors to prevent sexual abuse between this resident (Resident #8) and a cognitively impaired resident (Resident #1) and failed to implement effective interventions to prevent further inappropriate sexual behaviors for one of one sampled residents with known sexually inappropriate behaviors (Resident # 8).	F 323	F323 Corrective action accomplished for those residents found to have been affected by the deficient practice: Resident #1 was sent to the hospital for evaluation and then returned to the facility with no new orders. MD and family were notified on 3/6/17. Resident #1 care plan	

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F 323	Continued From page 14 Immediate jeopardy began on 3/6/17 when Resident # 8 was found by staff in a sexual altercation with Resident # 1 and was removed on 3/11/17 at 1:50 PM when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level of D (not actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure all staff members were in-serviced on monitoring residents for inappropriate behaviors, taking immediate action to protect resident's from sexual behaviors, and assessing newly admitted residents for socially inappropriate behaviors. Findings included: Resident # 8 was admitted to the facility from a hospital on 3/3/17. The resident's admission diagnoses included schizophrenia, dementia, and substance abuse. Resident #8 resided on the facility's Behavioral Health unit on the 300 hallway. Review of Resident #8's referral paperwork dated 2/28/17 which was provided to the facility by the transferring hospital prior to the resident's admission to the facility revealed nursing progress notes and a psychiatric consult. A progress note dated 2/19/17 indicated that Resident # 8 had some altered mental status. A psychiatric consult dated 2/21/17 revealed that Resident # 8 had a medical history significant for dementia, psychosis, substance abuse disorder and schizophrenia. The consult noted concerns regarding Resident # 8's ability to care for himself and the potential risk of harm to himself and others. The consult indicated that Resident # 8's	F 323	was updated based upon psychosocial well-being related to sexual encounter on 3/6/17. She was seen by psych services on 3/7/17. Resident #8 was discharged from facility on 3/6/17. Corrective action accomplished for those residents having the potential to be affected by the deficient practice: The DON/ADON/MDS Nurse and Unit Managers audited all behaviors of current residents for sexual inappropriateness to ensure interventions are in place at this time on 3/10/17. As a result of the behavior audit, two residents were identified as having inappropriate verbal sexual behaviors. Plan of care updated as indicated. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: Following the review of the behavior audit, the Administrator, Director of Nursing, or designee ensured interventions were care planned and appropriate notification and follow up actions were taken to prevent sexually inappropriate behaviors. Completed on 3/10/17. Education included, in the event of behaviors, staff are to put residents on 1:1, notify authorities, and notify Administrator. This education completed by DON, ADON and Administrator. The DON, ADON, Unit Managers and Dept.	

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F 323	Continued From page 15 current/on-going psychiatric symptoms included dementia. The consult indicated that Resident # 8's insight and judgment were limited. The consult recommended one to one observation for elopement risk/cognitive deficits, social work services, and psychiatric services as needed. Resident # 8 was involuntarily discharged from the facility on 3/6/17 to the local hospital, therefore a comprehensive admission Minimum Data Set assessment was not completed and a comprehensive care plan had not been developed. An admission note written by Nurse # 3 on 3/3/17 at 3:25 PM indicated Resident # 8 arrived to the facility with a driver. The medication technician answered the door and Resident # 8 entered unit. The driver handed the medication technician Resident # 8's paperwork. The medication technician asked if the driver would like to see a nurse. The driver replied, no, my responsibility was to just get him here. The Physician's Assistant verified the resident's medications. Resident # 8 was oriented to his room, the bathroom and call bell. Resident # 8 verbalized his understanding. An interview conducted with the Admissions Director on 3/9/17 at 5:05 PM indicated that the initial referral she received for Resident # 8 indicated he had altered mental status, was forgetful and needed long-term care placement. The referral paperwork indicated he was homeless and had been on one on one observation because of elopement risk at the hospital. The Admissions Director indicated she had written that Resident # 8 was at zero risk of harm to self or others on the top page of the	F 323	Heads re-educated staff to observe residents for signs of inappropriate behavior and appropriate interventions for management, to include reporting these observations to the DON, ADON, Unit Manager and/or Administrator immediately. Licensed staff were educated on 3/10/17. Nurses will assess new admissions for behaviors(including socially inappropriate behaviors) and document in the medical record. This documentation will be completed on the skilled nursing assessment. Nurse consultant provided education to Administrator, DON, ADON and Unit Managers regarding follow up to behaviors/adverse events, to include instructing staff to place residents on 1:1 as needed, notify authorities as needed, and send out of facility as situation warrants to protect other residents. This education completed on 3/11/17. Monitoring Process: The Quality Assurance and Performance Improvement Committee met on 3/101/17 to review this action plan. DON, ADON, or designee will monitor behavior documentation routinely to ensure appropriate follow up and actions/interventions taken. Results of this monitoring to be reviewed in Quality Assurance and Performance Improvement Committee monthly, with	

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F 323	Continued From page 16 referral sheet. The Admissions Director indicated she did not know Resident # 8 was a sex offender and that information had not been included with his referral paperwork. The Admissions Director indicated she did not receive notice from the transferring hospital to let the facility know when Resident # 8 would arrive. The Admissions Director indicated that Resident # 8 arrived to the facility unexpectedly on 3/3/17 and she was not sure who had admitted him or what was done with his admission packet. The Admissions Director indicated after the incident on 3/6/17 she contacted the social worker at the transferring hospital to enquire as to why the facility was not made aware of Resident # 8's sex offender status. The Admissions Director indicated she was told that Resident # 8 had not had any behaviors at the hospital with any female staff members. Review of Resident # 8's progress notes since his admission to the facility on 3/3/17 revealed the following notes which identified inappropriate behaviors: A behavior note was written on 3/4/17 at 2:45 pm by Nurse # 2 as a late entry for the 3 PM - 11 PM shift on 3/3/17. The note indicated Resident # 8 was found in the hallway fondling a female residents breasts. Both residents were immediately separated. At 7:15 PM, Resident # 8 brought a female resident into an empty room. Nursing assistants intervened and the residents were separated. At 7:25 PM, Resident # 8 brought a different female resident into an empty room. The female resident was heard to yell, "NO!" Again, the residents were separated and Resident # 8 was taken to his room. Calls were placed to the Medical Director, Administrator, and	F 323	QAPI committee responsible for on-going compliance.	

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Director of Nursing (DON). The Medical Director called back and the situation was explained to him. A new order was given, and at 8 PM Resident # 8 was sent out to the Emergency Room (ER). The Administrator called back and the situation was explained to him.

A nursing note made on 3/4/17 at 1:34 AM indicated that Resident # 8 returned from the hospital with no new orders. No signs or symptoms of distress were noted.

A behavior note made on 3/4/17 at 5:55 AM indicated Resident #8 was walking around and opening other resident's doors. Resident # 8 was redirected by staff. Resident # 8 asked staff how old they were and told them "I like pretty girls." Resident was redirected back to his room.

A nursing note written by Nurse # 4 on 3/4/17 at 11:16 AM indicated that Resident #8 required redirection after attempting to lead a female residents into his room.

A behavior note written by Nurse # 4 on 3/4/17 at 7:13 PM indicated that Resident #8 was observed trying to make a female resident kiss him in the hallway. Resident # 8 had the back of the female residents head and pulled her face toward him. A nurse intervened and Resident # 8 stated he did not know it was wrong to try and be friendly. Nurse # 4 indicated Resident # 8 was educated on acceptable behaviors. The nurse indicated Resident # 8 was able to verbalize his understanding and was able to repeat what behaviors were against the rules.

A nursing note written on 3/5/17 at 4:06 AM indicated that Resident #8 had been to the

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nurse's station multiple times during the night. Resident # 8 touched a NA inappropriately on the breast and was advised that behavior was not acceptable. Resident # 8 was monitored closely by staff and advised that he could either sit in dayroom or lie down in his bed. Resident # 8 looked in each room as he walked by them. Resident # 8 was advised that inappropriate behavior were not acceptable. Staff continued to monitor Resident # 8.

A nursing note written by Nurse # 4 on 3/5/17 at 12:09 PM indicated that Resident #8 attempted to get female residents to go into his room to watch TV with him. Resident # 8 also wandered into female residents' rooms. Resident # 8 was redirected numerous times. The female residents were removed from his room and returned to day room.

A nursing note written by Nurse # 4 on 3/5/17 at 8:50 PM indicated Resident #8 continued to require redirection regarding keeping his hands to himself. Resident # 8 was able to repeat regulations regarding other resident. The note indicated that Resident # 8 stated he was just being friendly.

A nursing note written on 3/6/17 at 2:47 AM indicated that Resident #8 was out of bed wandering on the halls, looking in rooms and making attempts to enter other resident's rooms. Staff continually redirected Resident # 8 and reminded him not to enter other resident's rooms. Resident # 8 was noted with increased agitation and anxiety at 1:00 am and 1 milligram (mg) of Ativan (antianxiety medication) was given as needed. Resident # 8 was encouraged to go back to bed. Resident # 8 got out of bed and was

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seen ambulating on the hall when he was observed urinating on the floor in the hallway. Resident was taken back to his room and encouraged to go back to bed. Staff continued to monitor Resident # 8.

A general note written by speech therapy on 3/6/17 at 9:00 AM indicated Resident # 8 exhibited sexual behaviors towards staff and was inappropriate for treatment services at that time.

A behavior note written by Nurse # 1 on 3/6/17 at 11:32 indicated that Resident #8 was pacing the hall and making sexual advances towards female residents and staff. Resident # 8 asked the nurse to help him find his room so they could go in the room together. Resident # 8 was verbally redirected and educated that his comments were inappropriate. Resident # 8 appeared to disregard the nurse and continued having inappropriate behaviors. The Medical Director was notified of Resident # 8's behaviors. The Psychiatry Nurse Practitioner (NP) was also notified of Resident # 8's behaviors and recommended that Resident # 8 be closely monitored. The Psychiatry NP indicated that she would be at the facility to evaluate Resident # 8 on 3/6/17. Resident # 8 was noted to be in his room lying in bed with his eyes closed. Staff continued to monitor Resident # 8.

A nursing note written on 3/6/17 at 1:35 pm indicated that Resident # 1's RP was notified of the event and she was being sent to the hospital for evaluation.

A summary note written by Nurse # 1 on 3/6/17 at 2:02 PM indicated that Resident # 8 was involved in a sexual encounter (with Resident #1). The

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Police were notified. The Medical Director and Resident #8's responsible party were notified of the encounter.

A nursing note written by Nurse # 1 on 3/6/17 at 2:12 PM clarified that Resident # 8 was placed immediately on one to one observation with staff.

A discharge note written by Nurse # 2 on 3/6/17 at 4:00 PM indicated Resident # 8 was escorted out of facility in handcuffs by police. A call was placed to the ER and Resident # 8's paperwork was faxed to the ER.

Resident # 1 was admitted to the facility on 12/29/15 with diagnoses including Alzheimer's disease, dementia, hypertension, diabetes, and persistent mood disorder. Review of an annual Minimum Data Set (MDS) assessment dated 1/5/17 indicated that Resident # 1 had severe cognitive impairment. The assessment also indicated Resident # 1 had no behaviors and did not reject care.

Review of a hospital discharge summary dated 3/6/17 revealed Resident # 1 was very alert but extremely demented and unable to follow commands or answer questions appropriately. Resident # 1 had no obvious injuries. Resident # 1 was being seen in the emergency room because staff at the nursing facility witnessed another demented resident (Resident #8) putting his penis in Resident # 1's mouth. Resident # 1 was fine the entire visit in the emergency room according to the discharge summary. The police department confirmed a report was filed by the nursing facility.

Review of a nursing note dated 3/6/17 at 5:20 PM

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revealed that Resident # 1 returned to the facility from the emergency room. Resident # 1 was in no acute distress. The responsible party was informed that Resident # 1 was back at the facility. Resident # 1 had no signs or symptoms of mental anguish or trauma at that time.

Review of a written statement made by Nurse # 1 dated 3/6/17 at 12:20 pm revealed she walked into room 312 and found resident # 8 shoving his private parts into a female residents mouth (resident # 1). Nurse #1 immediately told him to stop and attempted to separate him from her. Resident # 8 refused to stop and continued act. Nurse # 1 immediately stepped between them and removed the female resident (resident # 1) from the room and placed her one to one with staff. Nurse # 1 stayed with resident # 8 until staff arrived. Resident # 8 was placed one to one with staff as well.

An interview with the Administrator on 3/9/17 at 10:00 AM revealed that he was currently in the process of completing the 5 day report for the incident involving Resident # 1 and Resident # 8. The Administrator revealed that Resident # 8 was admitted to the facility on 3/3/17. The Administrator indicated there were some concerns about Resident # 8 touching other residents on the evening of 3/3/17. The Administrator indicated that Resident # 8 was sent out to the hospital for a psychiatric evaluation on 3/3/17. He further indicated the hospital returned Resident # 8 to the facility with no psychiatric concerns found. The Administrator revealed that on 3/6/17 a nurse walked into a room and discovered that Resident # 8 had his pants down and his penis was in Resident # 1's mouth. The Administrator indicated the nurse

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separated the residents. The police were then called and Resident # 1 was sent out for evaluation and her RP was notified. The Administrator indicated a police officer came to the facility and contacted the medical center police where Resident # 8 had been transferred from. The Administrator indicated the medical center police were familiar with Resident # 8 and at this point in time the Administrator learned that Resident # 8 was a registered sex offender. The Administrator indicated that the police officer contacted his sergeant and the district attorney's office at this time. The Administrator indicated that once the police officer notified him that Resident # 8 would not be arrested the Administrator went to the magistrate's office and filed involuntary commitment paperwork to have the police remove him from the facility. The Administrator indicated that the police removed Resident # 8 from the facility on 3/6/17. The Administrator indicated that the facility was not informed by the transferring hospital that Resident # 8 was a registered sex offender. The Administrator indicated if the facility had known that Resident # 8 was a registered sex offender the facility would not have accepted him.

An interview with Nursing Assistant (NA) # 2 on 3/9/17 at 3:35 PM revealed that she worked on the 300 hall on 3/4/17 and 3/5/17 on 2nd shift. NA # 2 indicated that she had to check on Resident # 8 often because he would follow women up and down the hall, would rub their shoulders and asked them did they want to come with him. NA # 2 indicated that staff would remove the women residents away from Resident # 8. NA # 2 indicated that Resident # 8 was not on one to one and she was told if she did not see Resident # 8 within a five minute period she

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should check on him.

An interview with Nurse # 1 on 3/9/17 at 4:28 PM revealed that she worked on the 300 hall on 3/6/17 on 1st shift. Nurse # 1 indicated that she had been monitoring resident # 8 throughout the shift because she had noticed him wandering. Nurse # 1 indicated she stepped off the unit for about 10 minutes. When she returned to the unit she did not see Resident # 8 so she went to his room and found the door closed. Nurse # 1 indicated she knocked on the door and entered the room. Resident # 1 was sitting on the bed facing the doorway and Resident # 8 was standing facing her with his penis in her mouth. Nurse # 1 indicated that Resident # 8 was shoving his penis into Resident # 1's mouth. Nurse # 1 indicated she asked Resident # 8 to stop and he did not stop or respond. Resident # 1 did not say anything. Nurse # 1 indicated that Resident # 1 had a blank face with no emotion. She indicated that Resident # 1 was not fighting Resident # 8 off and was not trying to get away, she was just sitting there. Nurse # 1 indicated that she immediately separated the residents. She indicated Resident # 1 took her hand and she took her out of the room to a NA. Nurse # 1 indicated she radioed for additional help and remained with Resident # 8 until additional male staff could stay with him one on one to ensure nothing else happened. Nurse # 1 indicated that staff called 911 and that Resident # 1 was sent out to the hospital. Nurse # 1 indicated that she had seen both residents right before she left the unit and had only been off the unit for about 10 minutes. Nurse # 1 indicated that Resident # 1 had been walking in the hallway and Resident # 8 was in his room lying in bed. Nurse # 1 indicated she was not aware of any interventions that were

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in place for Resident # 8's behaviors. Nurse # 1 indicated she heard that he had wandering behaviors but not anything sexual related. Nurse # 1 indicated that she had noticed that Resident # 8 had increased wandering behaviors the day of the incident and had tried to keep a close eye on him for that reason.

An interview conducted with Nurse # 2 on 3/9/17 at 5:43 PM revealed that she had been working on the 300 hall the evening of 3/3/17. Nurse # 2 revealed that around 5:00 PM on 3/3/17 she saw Resident # 8 with a red envelope. Nurse # 2 recalled asking Resident # 8 to see the red folder and opened it to find information regarding him being a registered sex offender. Nurse # 2 indicated that she was "floored and really angry." She indicated that staff watched Resident # 8 to make sure nothing happened. Nurse # 2 indicated that she put the red folder containing the sex offender paperwork in Resident # 8's chart so other staff would know. Nurse # 2 indicated that later on, she observed Resident # 8 was seen trying to bring a female resident into a room. She recalled thinking to herself that something had to be done. Nurse # 2 indicated that she called the Physician to ask what could be done and the Physician said to send Resident # 8 out to the hospital. Nurse # 2 indicated she called the Administrator and Director of Nursing (DON) and told them that Resident # 8 needed to go out of the facility. Nurse # 2 indicated that she thought she made it clear to the Administrator that Resident # 8 was a convicted sex offender. Nurse # 2 was not certain if the folder containing the sex offender paperwork went with Resident # 8 to the hospital. Nurse # 2 indicated that she called the Administrator and asked did he want Resident # 8 to come back to the facility from the

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hospital and was told yes. Nurse # 2 indicated that she was shocked and could not believe that the facility accepted Resident # 8 back from the hospital. A second interview with Nurse # 2 conducted on 3/10/17 at 12:18 PM revealed that she thought she had told the Administrator about Resident # 8's sex offender status on Friday, 3/3/17, when she called him but indicated "to be completely honest, I would not swear to it." Nurse # 2 indicated it was a busy night and she did not know. Nurse # 2 indicated she was told by the Physician to send Resident # 8 out to the ER for altered mental status so she did. Nurse # 2 indicated she did not tell EMS about the inappropriate behaviors but she thought she had told the ER nurse, but could not be certain.
An interview with Nurse # 3 on 3/9/17 at 5:55 PM revealed that on 3/3/17 Nurse # 2 indicated to her that Resident # 8 had a red folder on his person and that she had some trouble getting Resident # 8 to give her the folder. Nurse # 3 indicated that she and Nurse # 2 opened the red folder around 4:30-5 PM on 3/3/17 and discovered it contained information regarding registering as a sex offender. Nurse # 3 indicated around the same time Resident # 8 started to have some behavior issues of touching people. Nurse # 3 indicated that she did not see Resident # 8 touch anyone. Nurse # 3 indicated she was there when Nurse # 2 called the Administrator, DON, and MD. She indicated that Nurse # 2 left a message for the Administrator and the DON to return her call. Nurse # 3 heard the conversation with the MD in which Nurse # 2 indicated that Resident # 8 had tried to fondle some of the women and pull some women in a room. The MD indicated to send Resident # 8 out to the hospital for evaluation. Nurse # 3 indicated that Resident # 8 was sent out via ambulance to the hospital.

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An interview conducted with the Physician on 3/9/17 at 6:25 PM revealed that on 3/3/17 Resident # 8 was being inappropriate. The Physician indicated that Resident # 8 was on the facility's behavioral health unit which also had dementia residents. The Physician indicated that sexual inappropriateness is not unusual with behavior disturbances. The Physician indicated that Resident # 8's behaviors were more than unusual and "it didn't feel safe" so he was sent out to the hospital. The Physician did not recall the nurse who telephoned him about Resident # 8 telling him that he was a registered sex offender but was not sure. The Physician indicated he thought the first time he became aware of Resident # 8's sex offender status was on Monday, 3/6/17, after the incident. The Physician indicated that when a resident returned from the hospital with no new orders he was not made aware so he was not aware Resident # 8 returned to the facility. The Physician indicated that he did not see Resident # 8 because he was not in the facility over the weekend (3/4/17 or 3/5/17).

On 3/9/17 at 8:30 PM, in a telephone interview, Nurse # 4 stated when she came to work on Saturday, March 4, 2017 at 6 AM, she received report from the nurse leaving the overnight shift. The night nurse stated that Resident # 8 arrived on Friday and went out and the Administrator let him come back. Nurse # 4 stated she kept a close eye on the resident who did try to get other residents to come to his room, but she would quickly re-direct him and so he stayed in the day room. Nurse # 4 stated at one point he held hands with a female resident and Nurse # 4 told him he could not do that, and the resident asked why not. Nurse # 4 stated she told him that

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touching was not okay. Nurse # 4 indicated the resident followed the medication cart and talked to her for quite a while about his past history. Nurse # 4 noted Sunday was the same, Resident # 8 was kept in the day room or walked around with the nurse who was giving medications.

An interview with the Administrator on 3/10/17 at 10:30 AM indicated that the Administrator did not recall being told that Resident # 8 was a sex offender when Nurse # 2 called him on 3/3/17. The Administrator indicated he was told that Resident # 8 had some inappropriate behaviors but was not aware he was a sex offender until Monday, 3/6/17. The Administrator indicated if he had known Resident # 8 was a sex offender he would have gotten him out of the building on Friday, 3/3/17. The Administrator indicated that nothing was said to him on Friday, 3/3/17, to make him think the facility should not take Resident # 8 back after he went to the hospital. The Administrator indicated that the resident had been cleared by psychiatric services at the hospital prior to his admission and did not see psychiatric services when the facility sent him out to the ER.

An interview conducted with NA # 1 on 3/10/17 at 11:35 AM indicated that she was working on the 300 hall on the morning of 3/6/17. NA # 1 indicated that she saw Resident # 8 right after lunch (approximately 12 PM) as well walking in the hallway. She indicated that Resident # 8 asked her how old she was and told staff he had gotten out of prison for rape. NA # 1 indicated Resident # 8 was "touchy" with staff members.

On 3/10/17 at 2:12 PM an interview was conducted with the Police Officer (PO) who came

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to the facility on 3/6/17 following the incident. The PO indicated he was dispatched to the facility for a sexual assault case that had already occurred. He indicated that an employee caught a male patient putting his penis into a female resident's mouth. The PO spoke with the Administrator when he arrived. The PO spoke with Nurse # 1 and she told him that she had been watching resident # 8 due to his erratic behavior that morning and making inappropriate comments to the nurses. She had been keeping an eye on him to make sure he was being watched. She left resident # 8 in his room, room 312. She said she was gone for 10 minutes. When Nurse # 1 returned to his room she saw Resident # 1 sitting on Resident # 8's bed. Nurse # 1 said he (Resident # 8) was standing over Resident # 1 with his penis in her mouth. Nurse # 1 said she told him to stop and he did not stop. Nurse # 1 said that Resident # 1 looked distressed. After he did not stop she physically separated both parties. The residents were kept separated with one to one staff, then the police were called. The nurse indicated to the officer that resident # 8 was doing it for sexual gratification and that he knew what was going on. The officer learned from staff that Resident # 1 cannot give consent. The PO indicated he asked to speak with Resident # 1 and it was like speaking with a child. The PO indicated that Resident # 1 was smiling and seemed happy to see a new face. She did not seem upset or distressed when he saw her. The PO indicated he spoke with Resident # 8 and he seemed fine. He was alert and conscious. The PO indicated he confronted Resident # 8 about the allegations. He indicated Resident # 8 would go off on a tangent about wanting to go to another facility and that he was a Veteran. The PO indicated he asked Resident # 8 if he knew why

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the PO was here. The PO indicated to Resident # 8 that he wanted Resident # 8 to tell him what happened. The PO indicated Resident # 8 looked confused and deflected him. The PO indicated he thought Resident # 8 knew what was going on. The PO indicated he clarified for Resident # 8 what he was talking about, and asked what happened between Resident # 8 and the female who was in here earlier. The PO indicated Resident # 8 said Resident # 1 came into his room and hugged him. The PO indicated that Resident # 8 again went off on multiple tangents and had to be reminded to tell the PO what happened with the girl. The PO indicated he was very blunt and asked Resident # 8 what he did to the girl. The PO indicated that Resident # 8 said Resident # 1 came into his room, gave him a hug, sat on his bed and then Resident # 8 went on another tangent. The PO asked Resident # 8 did he have his penis in her mouth. The PO indicated Resident # 8 said yeah, I did. The PO indicated that Resident # 8 finally admitted that he did have his penis in her mouth and said we are both adults. The PO indicated that he explained that what happened was not OK because Resident # 1 cannot consent. The PO indicated that Resident # 8 again said they were both adults and indicated that he "didn't finish." The PO indicated that Resident # 8's facial expressions seemed to imply that he knew he was in trouble and he asked the PO was he going to get a warrant to arrest him. The PO told him no, not at this time. The PO indicated he spoke with his Sargent and relayed the events. The PO indicated he was seeking guidance because he had never been in this situation before. The PO indicated his Sargent directed him to call District Attorney's (DA) office to see what they advised. The DA's office was informed of the situation and

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indicated due to Resident # 8's advanced age and prior offender status the case should be forwarded to the criminal investigations division. The PO indicated that the case was still open and on-going. The PO called Adult Protective Services (APS) and filed a report over the phone. The PO indicated that it was his opinion that Resident # 8 knew what he did was wrong based on their conversations.

An interview conducted with Certified Medication Aide (CMA) # 1 on 3/10/17 at 3:37 PM revealed that she worked with Resident # 8 on Sunday, 3/5/17. CMA # 1 indicated Resident # 8 was alert and oriented. CMA # 1 indicated he was very sexual in the things he said. She indicated that Resident # 8 told staff about some of the things for which he had been in prison. She also indicated that Resident # 8 was not confused and seemed to understand what he was saying to staff when he was being inappropriate.

An interview conducted with the Director of Nursing (DON) on 3/10/17 at 4:02 PM revealed that the Administrator called her on 3/3/17 about Resident # 8 touching Resident # 1's breast. The DON revealed that the Physician decided to send Resident # 8 out to the hospital. The DON indicated that she and the Administrator were in agreement with sending the resident out to the hospital. The DON indicated that she thought Resident # 8 might have some altered mental status and that was pretty much it. The DON indicated that she did not speak with Nurse # 2 that night. The DON further revealed that she did not speak to anyone else the rest of the weekend regarding Resident # 8 and was not aware the behaviors had continued throughout the weekend. The DON indicated that Resident # 8

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returned to the facility early Saturday morning (3/4/17) with no new orders. The DON indicated she did not know he was back in the facility until Monday morning (3/6/17) when she returned to work. The DON indicated that after the incident she asked Resident # 8 what was going on and he said nothing. The DON indicated she asked Resident # 8 if he exposed himself and he said no. The DON indicated that she asked Resident # 8 if he was aware what he did was inappropriate. The DON indicated Resident # 8 replied with "something along the lines of his zipper was down and he was having problems with his zipper." At this point the DON indicated male staff were with Resident # 8 so she went to check on Resident # 1. The DON indicated Resident # 1 acted as her normal self. The DON indicated that Resident # 1 did not have any injuries to her face or mouth. The DON indicated that she called the Physician, obtained orders and Resident # 1 was sent to the hospital. The DON indicated that she went to the nursing station to get both charts and at that point discovered the red folder with Resident # 8's sex offender paperwork inside. She indicated that she called the Administrator over to let him know at that time as well. The DON indicated the police came and interviewed Resident # 8. The police did not remove Resident # 8 from the facility at that time so the facility started the involuntary commitment process to have Resident # 8 removed from the facility. The DON indicated that on Friday, 3/3/17, she thought that Resident # 8 just had dementia, he was in a new environment and getting oriented to the facility. The DON indicated that at that time she thought Resident # 8 might have been disoriented to his surroundings or he was testing the facility's boundaries. The DON indicated she had no idea he was a sex offender. The DON

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indicated that from her interactions with Resident # 8 on Monday morning before the incident took place that she did not think he was alert to the place and situation. The DON indicated that Resident # 8 did not answer her questions totally and she felt that there was some impairment there.

An interview conducted with the Administrator on 3/10/17 at 4:34 PM revealed the Administrator was not notified Resident # 8 returned to the facility after being sent out to the hospital. The Administrator indicated he was asked if it was OK to take Resident # 8 back from the hospital. The Administrator indicated that based on the information presented to him by the nurse he did not see any reason not to take Resident # 8 back. The Administrator indicated this call occurred on 3/3/17 around 10 PM, while the resident was still at the hospital. The Administrator indicated that he would not be notified when a resident returned from the hospital so he would not have been aware that no new treatments or interventions were put into place. The Administrator indicated if there were new orders the MD would have been called. Since there were no new orders there was no reason to call the MD. The Administrator indicated the hospital did not make any changes or interventions. He indicated that he can only recommend the hospital do something but the ER doctor makes the decision to send the resident back to the facility. The Administrator indicated that if the ER doctor clears the resident to return to the facility he is not a physician so he cannot challenge that.

On 3/10/17 at 6:05 PM, the Administrator was informed of the immediate jeopardy. The facility provided a credible allegation of compliance on

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3/11/17 at 12:35 PM. The allegation of compliance indicated:

How corrective action will be accomplished to remove the IJ for each resident that was affected by the IJ situation, (Resident #8 and Resident #1):

Resident #8 was admitted to the facility on 3/03/2017.

Resident #8 displayed inappropriate behavior of touching female resident on Friday 3/03, and was sent out to the hospital for evaluation. The resident returned to the facility with no new orders.

The Resident was observed closely throughout the remainder of weekend, and had frequent redirection by staff members assigned to this unit. The resident displayed inappropriate touching of female residents and staff and attempted to take residents to his room or empty rooms. Also, the resident made inappropriate remarks to staff and female residents.

On Monday 3/6/17, the resident was found in his room by a nurse with his pants down and his penis in Resident #1's mouth. The nurse removed Resident #1 and she stayed with Resident #8 until other staff arrived. Both residents were put on one on one supervision. The police was notified. The Administrator and DON on site were notified of event. Administrator completed involuntary transfer for Resident #8. Resident #8 will not return to facility.

Resident #1 was sent to the hospital for evaluation and then returned to the facility with no

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new orders. MD and family were notified on 3/6/17. Resident #1 care plan was updated based upon psychosocial well-being related to sexual encounter on 3/6/17. She was seen by psych services on 3/7/17.

Admitting Nurse received education and Final Written Warning for failure to report information found in red folder (which revealed information from the hospital that resident was a known sex offender) upon her knowledge of the information, and failure to put immediate interventions in place on 3/4 upon residents return from hospital to prevent future behaviors.

Address how corrective action will be accomplished for those residents having the potential to be affected by the same IJ:

The DON /ADON/MDS Nurse and Unit Managers audited all behaviors of current residents for sexual inappropriateness to ensure interventions are in place at this time on 3/10/17.

As a result of the behavior audit, two residents were identified as having inappropriate verbal sexual behaviors.
1) One of the resident's care plan was updated on 3/10/17 and followed by psych services.
2) The other resident's care plan was initiated on 3/10/17 and he was referred to psych services.

As a result of the audit, two residents were identified as having inappropriate sexual behaviors. The two residents' care plans were in place and they were followed by psych services.

Following this review of the behavior audit, the

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Administrator, Director of Nursing, or Manager on Duty will ensure interventions are care planned and appropriate notification and follow up actions are taken to prevent sexually inappropriate behaviors. Completed on 3/10/17.

Facility staff will be educated on reviewing and taking immediate action to protect residents from sexual behaviors, and implementing interventions to prevent future behaviors, including notification of Administrator and/or DON/ADON. The education included all staff. The Director of Nursing, ADON, Unit Managers, and Dept. Heads will complete education for their staff. Licensed staff were education on 3/10/17. Any remaining staff that have not received education will be educated prior to returning to duty.

Education included in the event of behaviors staff are to put residents on 1:1, notify authorities, and notify Administration. This education completed by DON, ADON and Administrator.
The Director of Nursing, ADON, Unit Managers, and Dept. Heads will re-educate all staff to observe residents for signs of inappropriate behavior and appropriate interventions for management, to include reporting these observations to the Director of Nursing, Assistant Director of Nursing or Unit Manager and or Administrator immediately. Licensed staffs were education on 3/10/17. Remaining staff will be educated prior to returning to duty. Beginning 3/11/2017 all new hires will receive this education.

Nurses will assess new admissions for behaviors (including socially inappropriate behaviors) and document in the medical record, this documentation will completed on the Skilled Nursing Assessment.

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BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

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F 323	Continued From page 36 Nurse Consultant provided education to Administrator, DON, and ADON, UM regarding follow up to behaviors/adverse events, to include instructing staff to place residents on 1:1 as needed, notify authorities as needed, and send out of facility as situation warrants to protect other residents. This education completed on 3/11/2017. The Quality Assessment and Performance Improvement Committee met on 3/10/2017 to review this action plan. DON, ADON or designee will monitor behavior documentation routinely to ensure appropriate follow up and actions/interventions taken. Results of this monitoring to be followed by Quality Assurance and Performance Improvement Committee. The credible allegation was verified on 3/11/17 at 1:50 PM by interviewing the staff to ensure that they had been educated on reviewing and taking immediate action to protect residents from sexual behaviors, implementing interventions to prevent future behaviors including notifying the Administrator and/or DON, and the assessment of/documentation of newly admitted residents with behaviors. The results of the behavior audit were reviewed and record review was conducted to ensure the care plan was updated for the residents identified as having inappropriate verbal sexual behaviors and inappropriate sexual behaviors.	F 323		
F 353 SS=D	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with	F 353		4/4/17

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F 353	Continued From page 37 the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	F 353		

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F 353	Continued From page 38 (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record reviews, the facility failed to provide sufficient nursing staff to meet the needs for 1 of 11 residents (Residents #2) reviewed for assistance needed for toileting. Findings included: 1. This citation is cross referenced to F312. The facility failed to provide care for 1 of 10 residents reviewed for activities of daily living assistance (Resident #2), making the resident wait for assistance while on the bedpan. 2. This citation is cross referenced to F224. The facility failed to attend to the needs of one of three residents reviewed (Resident #2) when the Resident was left on the bedpan. On 3/9/2017 at 12 noon, in an interview, Resident #2 stated she often had to wait a long time for any assistance, and felt there was not enough staff in the facility. On 3/10/2017 at 11:00 AM, in a telephone interview, NA #6 stated there definitely was not enough staff in the facility. On 3/9/2017 at 4:00 PM, in an interview, Nursing Assistant (NA) #2 stated there was not enough staff for the facility. NA #2 stated it had been bad for a while, but NAs just did the best they could and hope the administration would get some	F 353	F353 Corrective action accomplished for those residents found to have been affected by the deficient practice: Facility is currently staffed sufficiently to provide ADL care as indicated. Corrective action to be accomplished for those residents having the potential to be affected by the deficient practice: Staffing to be monitored by Administrator and DON or designee to ensure adequate staffing in place to meet the needs of the residents. Measure put in place or systemic changes made to ensure that the deficient practice will not occur: Daily staffing meeting to be held with Administrator, DON and Staffing Coordinator to review schedule and staffing needs to ensure adequate staff in place and/or take necessary measures to ensure adequate staffing levels. Manager on Duty to review staffing on weekends and report any concerns to the Administrator and/or DON immediately for resolution.	

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F 353	Continued From page 39 more staff. In an interview on 3/9/2017 at 4:20 PM, Nursing Assistant (NA) #3 stated there was not enough staff in the building which made it hard on the staff that does work. NA #3 indicated the NAs get as much done as they can and help each other if possible but residents do not always get assistance as quickly as they should. On 3/9/2017 at 8:30 PM, in a telephone interview, Nurse #4 stated "We need more staff." Nurse #4 indicated at times there was 1 Nursing Assistant (NA) on the 300 hall, and on the 100 hall there was 1 or 2 for the evening shift (3PM-11PM) for 60, or more, residents. On 3/10/2017 at 10:35 AM, in an interview, the Director of Nursing (DON) stated the facility does need staff, and has placed advertisements locally, offered bonuses, and had job fairs. The DON stated there were several NAs in orientation. The DON ended the interview by saying "we are working on it." In an interview on 3/10/2017 at 11:40 AM, Nursing Assistant (NA) #5 stated there was not enough staff in the facility. NA #5 indicated the NAs work together, but it was difficult to get everything done for the residents.	F 353	Monitoring Process: Administrator and DON or designee to ensure daily staffing levels appropriate to ensure adequate ADL care is provided. These areas will be audited as indicated in plan of correction for F224, F241 and F312. Results of the audits and staffing meetings to be reviewed monthly in QAPI committee meeting with QAPI committee responsible for on-going compliance.	
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425		4/4/17

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F 425	Continued From page 40 (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview and record review, the facility failed to provide a prescribed medication for one of two residents reviewed for medications (Resident #14). Findings included: A review of the medical record revealed Resident # 14 was admitted 3/8/2017 with diagnoses of fractured vertebrae of the back and aftercare from the hospital. A review of the orders for Resident #14 noted an order written on 3/8/2017 at 4:49 PM for Zolpidem (Ambien) 10 mg 1 by mouth (po) every night at bedtime (hs) for insomnia. Nurse #1 had transcribed the order. The care plan review, dated 3/9/2017, noted Resident #14 receives sedative/hypnotic Ambien (medication to induce sleep) 10 milligrams (mg) related to insomnia (inability to sleep). The interventions included: Administer sedative/hypnotic medications as ordered by physician. Observe/document side effects and effectiveness every shift. Observe, document, report when necessary for the following adverse effects of sedative/hypnotic therapy: daytime drowsiness, confusion, loss of appetite in the morning, increased risk of falls and fractures,	F 425	F425 Corrective action accomplished for those residents found to be have been affected by the deficient practice: Resident #1 was given Ambien 10mg on March 11, 2017 per physician order, and continues to receive medication per order. Corrective action accomplished for those residents having the potential to be affected by the deficient practice: Licensed staff were educated by the ADON or designee on process for obtaining medications from back up box or emergency pharmacy when not available, and process for notifying physician if medications are not available. Residents are to receive medications as ordered. If a medication is not available on the medication cart or the back-up supply, the pharmacy must be contacted to find out why the medication did not arrive to the facility and the doctor must be notified for further intervention. Measures put in place or systemic changes made to ensure that the deficient	

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F 425	Continued From page 41 dizziness. On 3/10/2017 at 9:30 AM, in an interview, Resident #14 stated she had only been in the facility for two days, but wondered why she had not gotten her Ambien medication for sleep. Resident #14 indicated she always took that medication at home. In an interview on 3/10/2017 at 2:30 PM the Corporate Pharmacist stated the orders should be verified by the physician and then faxed to the pharmacy and delivered to the facility. On 3/10/2017 at 4:30 PM, the CMA for the hall was asked if there was an order in the Medication Administration Record (MAR) for the Ambien for Resident #14. The CMA then found the medication listed on the MAR as a scheduled medication for 8 PM. The CMA opened the narcotic box on the medication cart and could not find Ambien in the box. The CMA took out the log book for the narcotic box and looked through the sheets for the Ambien. There was no sheet located for the Ambien. In an interview, on 3/10/2017 at 4:45 PM Nurse #1 stated she did not know why Resident #14 was not receiving her Ambien for sleep. Nurse #1 indicated when a resident comes from the hospital, the orders are checked and verified with the doctor and then faxed to the pharmacy and delivered with the evening delivery of medications. Nurse #1 stated she had verified the orders and sent the orders to the pharmacy. On 3/10/2017 at 5:15 PM, in an interview Nurse #1 stated the pharmacy did not state why they did not get the order for the Ambien, and Nurse #1	F 425	practice will not occur: All new and readmission resident medications will be reconciled with the medication record within 24 hours of admission or readmission to ensure availability of medication by ADON and Unit Managers. The medication administration record will be printed and checked off with medications received from pharmacy on all new and readmissions within 24 hours during reconciliation. This will be conducted by the Unit Managers, ADON or designee. Monitoring Process: Results of the reconciliation review to be reviewed in Quality Assurance and Performance Improvement Committee monthly, with QAPI committee responsible for on-going compliance.	

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F 425	Continued From page 42 acknowledged Resident #14 had not gotten the medication for the previous two evenings. Nurse #1 indicated the Medical Director was in the facility and wrote a prescription for the Ambien, which was faxed to the pharmacy and would be delivered that evening in time for Resident #14 to take at bedtime.	F 425		
F 490 SS=J	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility's administration failed to provide effective leadership to protect one of three sampled residents (Resident # 1) from sexual abuse by a resident (Resident # 8) with known sexually inappropriate behaviors. Immediate jeopardy began on 3/6/17 when Resident # 8 was found by staff in a sexual altercation with Resident # 1 and was removed on 3/11/17 at 1:50 PM when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level of D (not actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure all staff members were in-serviced on monitoring residents for inappropriate behaviors, taking immediate action to protect resident's from sexual behaviors, and assessing newly admitted	F 490	F490 Corrective action accomplished for those residents found to have been affected by the deficient practice: Physician and RP for Resident #1 were notified of event, resident was sent to the hospital for evaluation, daughter declined a rape kit or evaluation at the hospital. Resident was returned with no new orders. Resident #1 was seen by psych services on 3/7/17 to ensure well-being. Care plan updated accordingly. Corrective action accomplished for those residents having the potential to be affected by the deficient practice: An audit of all other residents for sexual	4/4/17

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F 490	Continued From page 43 residents for socially inappropriate behaviors. Findings Included: Cross refer to F 323: Based on record review and staff interviews the facility failed to supervise one of one sampled residents with known sexually inappropriate behaviors to prevent sexual abuse between this resident (Resident #8) and a cognitively impaired resident (Resident #1) and failed to implement effective interventions to prevent further inappropriate sexual behaviors for one of one sampled residents with known sexually inappropriate behaviors (Resident # 8). On 3/10/17 at 6:05 PM, the Administrator was informed of the immediate jeopardy. The facility provided a credible allegation of compliance on 3/11/17 at 12:35 PM. The allegation of compliance indicated: How corrective action will be accomplished to remove the IJ for each resident that was affected by the IJ situation, (Resident #8 and Resident #1): Resident #8 was admitted to the facility on 3/03/2017. Resident #8 displayed inappropriate behavior of touching female resident on Friday 3/03, and was sent out to the hospital for evaluation. The resident returned to the facility with no new orders. The Resident was observed closely throughout the remainder of weekend, and had frequent redirection by staff members assigned to this unit. The resident displayed inappropriate touching of	F 490	behaviors was completed and care plans were reviewed to ensure they addressed behaviors. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: On 3/11/17, the District Director of Clinical Services re-educated the Administrator, DON, ADON, and Unit Managers. The education included ensuring prompt response to resident's behaviors, to include place on 15 minute checks/1:1 observations as indicated. Notification of event to authorities and to the Administrator, DON and/or ADON immediately. On 3/10/17 facility licensed staff were re-educated by the DON, ADON and Unit Managers on recognizing behaviors and providing immediate action/interventions and notification to authorities and facility leadership. The facility will respond appropriately to all future behaviors and ensure safety of residents. All new employees will be educated on behavior monitoring and interventions. On 3/11/17 the Administrator and DON implemented a new system to monitor the management of behaviors by reviewing all events with the District Director of Clinical Services daily to ensure appropriate interventions are in place to address behaviors, and conduct a weekly behavior meeting to further review events occurring	

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F 490	Continued From page 44 female residents and staff and attempted to take residents to his room or empty rooms. Also, the resident made inappropriate remarks to staff and female residents. On Monday 3/6/17, the resident was found in his room by a nurse with his pants down and his penis in Resident #1's mouth. The nurse removed Resident #1 and she stayed with Resident #8 until other staff arrived. Both residents were put on one on one supervision. The police was notified. The Administrator and DON on site were notified of event. Administrator completed involuntary transfer for Resident #8. Resident #8 will not return to facility. Resident #1 was sent to the hospital for evaluation and then returned to the facility with no new orders. MD and family were notified on 3/6/17. Resident #1 care plan was updated based upon psychosocial well-being related to sexual encounter on 3/6/17. She was seen by psych services on 3/7/17. Admitting Nurse received education and Final Written Warning for failure to report information found in red folder (which revealed information from the hospital that resident was a known sex offender) upon her knowledge of the information, and failure to put immediate interventions in place on 3/4 upon residents return from hospital to prevent future behaviors. Address how corrective action will be accomplished for those residents having the potential to be affected by the same IJ: The DON /ADON/MDS Nurse and Unit Managers audited all behaviors of current residents for	F 490	throughout the week to ensure completion of investigations and reporting as required. Licensed nurses and CNAs were re-educated by the DON, ADON and Unit Managers beginning on 3/10/17 and ending on 3/11/17 regarding a change in resident condition/behaviors and when an incident or accident occurs and how to respond and who to notify. Monitoring Process: Results of this monitoring to be reviewed in Quality Assurance and Performance Improvement Committee monthly, with QAPI committee responsible for on-going compliance.	

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sexual inappropriateness to ensure interventions are in place at this time on 3/10/17.
As a result of the behavior audit, two residents were identified as having inappropriate verbal sexual behaviors.

1) One of the resident's care plan was updated on 3/10/17 and followed by psych services.
2) The other resident's care plan was initiated on 3/10/17 and he was referred to psych services.

As a result of the audit, two residents were identified as having inappropriate sexual behaviors. The two residents' care plans were in place and they were followed by psych services.

Following this review of the behavior audit, the Administrator, Director of Nursing, or Manager on Duty will ensure interventions are care planned and appropriate notification and follow up actions are taken to prevent sexually inappropriate behaviors. Completed on 3/10/17.

Facility staff will be educated on reviewing and taking immediate action to protect residents from sexual behaviors, and implementing interventions to prevent future behaviors, including notification of Administrator and/or DON/ADON. The education included all staff. The Director of Nursing, ADON, Unit Managers, and Dept. Heads will complete education for their staff. Licensed staff were education on 3/10/17. Any remaining staff that have not received education will be educated prior to returning to duty.

Education included in the event of behaviors staff are to put residents on 1:1, notify authorities, and notify Administration. This education completed

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by DON, ADON and Administrator.
The Director of Nursing, ADON, Unit Managers, and Dept. Heads will re-educate all staff to observe residents for signs of inappropriate behavior and appropriate interventions for management, to include reporting these observations to the Director of Nursing, Assistant Director of Nursing or Unit Manager and or Administrator immediately. Licensed staffs were education on 3/10/17. Remaining staff will be educated prior to returning to duty. Beginning 3/11/2017 all new hires will receive this education.

Nurses will assess new admissions for behaviors (including socially inappropriate behaviors) and document in the medical record, this documentation will completed on the Skilled Nursing Assessment.

Nurse Consultant provided education to Administrator, DON, and ADON, UM regarding follow up to behaviors/adverse events, to include instructing staff to place residents on 1:1 as needed, notify authorities as needed, and send out of facility as situation warrants to protect other residents. This education completed on 3/11/2017.

To address F490, the District Director of Clinical Services will provide oversight of the administration to ensure implementation of the credible allegation, this will be conducted through weekly conference calls and monthly visits, as well as District Director of Clinical Services review of monthly Quality Assurance and Performance Improvement minutes.

The Quality Assessment and Performance Improvement Committee met on 3/10/2017 to

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review this action plan. DON, ADON or designee will monitor behavior documentation routinely to ensure appropriate follow up and actions/interventions taken. Results of this monitoring to be followed by Quality Assurance and Performance Improvement Committee.

The credible allegation was verified on 3/11/17 at 1:50 PM by interviewing the staff to ensure that they had been educated on reviewing and taking immediate action to protect residents from sexual behaviors, implementing interventions to prevent future behaviors including notifying the Administrator and/or DON, and the assessment of/documentation of newly admitted residents with behaviors. The results of the behavior audit were reviewed and record review was conducted to ensure the care plan was updated for the residents identified as having inappropriate verbal sexual behaviors and inappropriate sexual behaviors. In-service forms were reviewed to ensure Administrator, DON, Assistant Director of Nursing, and Unit Managers were educated in regards to following up on behaviors/adverse events, instructing staff on implementing appropriate interventions.