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RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 10/10/17 through 10/12/17. Past-noncompliance was identified at: CFR 483.12 at tag F223 and F226 at a scope and severity (J) The tags F223 and F226 constituted Substandard Quality of Care. A Partial extended survey was conducted.	F 000		
F 223 SS=J	FREE FROM ABUSE/INVOLUNTARY SECLUSION CFR(s): 483.12(a)(1) 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(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on medical record review, resident and staff interviews, the facility failed to protect one of one sampled residents from harm. During an altercation, NA#1 hit Resident #1 in the left upper arm with her hand. The findings included: Resident #1 was admitted to the facility 5/10/16.	F 223	Past noncompliance: no plan of correction required.	11/1/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/02/2017

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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Cumulative diagnoses included major depressive disorder, suicidal ideations, anxiety and bipolar affective disorder.

A Quarterly Minimum Data Set (MDS) dated 10/2/17 indicated Resident #1 was cognitively intact. No behaviors were noted on the assessment. Resident #1 required supervision with bed mobility, transfers, ambulation in the room, ambulation in the corridor only occurred one or two times, supervision with locomotion on and off the unit, extensive assistance with toilet , personal hygiene and total dependence with bathing, Balance was impaired but resident #1 was able to stabilize without staff assistance for moving from seated to standing position, walking, turning around and facing the opposite direction while walking, moving on and off the toilet and surface to surface transfers. No impairment with range of motion for upper and/or lower extremities.

An Incident/ Investigation Report from the (name) Police Department dated 10/6/17 at 7:51 AM stated the crime/ incident was simple assault, assault and battery by striking the victim causing physical injury. Weapon used was hand. Victim was Resident #1. Offender was Nursing Assistant (NA) #1. Narrative stated the following: On 10/6/2017 at 7:52 AM, (name) Police Department received a call in reference to an assault at 769 Cheraw Road. Upon his arrival, the police officer spoke to Nurse #1 (witness) who advised that NA #1 and Resident #1 had gotten into an altercation resulting in Resident #1 getting physically struck in the arm. At that time, the officer went inside and spoke with Resident #1 who advised that himself and NA #1 had gotten into several arguments and that the incident had started

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earlier that morning. Resident #1 stated that, after the initial argument, he went to the front hallway of the facility near the entrance. He stated that when NA #1 came back around into the front hallway, she gave him a mean look to which he told her to not look at him in that way. He then stated that she went crazy and began to swing at him and struck him in the top part of his left arm. Both his and the witness stories were consistent with each other in explaining the incident. Upon further investigation, it was determined the name of the nursing assistant was (offender/ suspect) and that she was from an outside agency. She was staying at 769 Cheraw Road and had left prior to the officer ' s arrival. Warrants were advised to both parties involved and obtained on behalf of Resident #1 due to his inability to get into a vehicle to proceed to the magistrate ' s office. The police officer called the magistrate who advised that the officer could swear out the warrants on the behalf of Resident #1 due to the issue. Same were obtained in reference to the assault.

A review of the Emergency Room record dated 10/6/17 stated "Patient states that he feels anxious. Has altercation with CNA (certified nursing assistant) at Richmond Pines. Feels like they are out to get me. She jumped on me twice." Past medical history significant for anxiety, asthma, bipolar disorder, depression. Resident #1 stated he got into an altercation with a CNA and she assaulted him but also stated he did not want to get into it. He provided very little information. He stated he tried to press charges but the law was against him. When asked if he sustained any injuries, he stated "No" and denied any injuries. He stated however it caused him to have anxiety. He reported throughout the day the

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anxiety worsened so he decided to come in for evaluation. Psychiatric/ behavioral: negative for agitation, behavioral problem and suicidal ideas. The patient was nervous/ anxious. He was given Benadryl (antihistamine) and Atarax (antihistamine). At that time, it was safe for him to be discharged to the facility with outpatient follow-up. He denied any trauma or injury from the incident that had occurred 10/6/17.

A review of the 24 hour report dated 10/6/17 at 9:45 AM stated Resident #1 alleged NA #1 yelled and hit him.

A statement from NA #4 dated 10/6/17 (no time) stated she assisted NA #3 in the shower room when Resident #1 was given a shower on 10/6/17 around 6:45 AM. Resident #1 told them that he "was done with her and her snide comments. I ' ll see to it she ' s off my hall. She ' s out of here." Both NA #4 and NA #3 thought he meant he would go to the Administrator as he had done previously.

On 10/10/17 at 9:40 AM, an interview was conducted with NA #4. She stated she was working on the back half of 100 hall (112-116) on 10/6/17. NA #4 said she had walked into room 102 with a breakfast tray when she heard a commotion in the hallway. It had gotten so loud and you could hear curse words flying. NA #4 came to the opening of 100 hall and could see Resident #1 in his wheelchair beside the nursing station and there was a crowd of people surrounding NA #1 trying to pull her back and she was shouting and screaming at the top of her lungs. NA #4 said it was all Nurse #3 could do to try and contain NA #1 and calm her down. NA #4 said she did not witness any physical contact

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between NA #1 and Resident #1.

A statement from Nurse #1 dated 10/6/17 at 8:30 AM stated shortly after clocking in, Resident #1 approached her in his wheelchair. As he began reporting incidents of the earlier morning to Nurse #1 concerning NA #1, NA #1 and several other employees came walking down the hallway. Nurse #1 was facing Resident #1 with her back to the employees. She stated she did not remember whether the resident spoke first to NA #1 or the other way around but NA #1 swung around towards Resident #1 and called him a (profanity) and struck him on his upper arm. The two began yelling at each other. Employees were struggling with NA #1 to prevent her from engaging further with Resident #1. Nurse #1 stayed with the resident who was upset saying "You ' re going to jail." Nurse #1 directed Nurse #2 to call 911 and have the employees remove NA #1 from the building. This interaction began at 7:50 AM. NA #1 was removed from the building by 7:55 AM.

On 10/10/17 at 11:30 AM, an interview was conducted with Nurse #1. She stated she met Resident #1 at the time clock when she clocked in at 7:45 AM. He was facing towards the front door in his chair and Nurse #1 had her back to the front door. He pulled up and just looked at her not saying anything. She asked him if he was ok and he said no. He started to tell Nurse #1 what had happened before she got there. He told her he had hurt his knee because a nursing assistant went to hit him or some threat had been made and he hurt his knee when he stood up. Resident #1 told Nurse #1 that NA #1 had cussed him out and called him a (profanity). The time was between 7:45 and 7:50AM. At that point,

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several staff members including NA #1 were walking towards the nursing station and the next thing Nurse #1 knew, NA #1 screams (profanity), swung with her left hand and hit Resident #1 on his left upper arm. Nurse #1 stated NA #1 ' s fingers were not open but not clenched in a fist. At that point, the staff grabbed her, Nurse #1 jumped in front of Resident #1 and yelled for Nurse #2 to call 911. Resident #1 had moved his chair closer to the nursing station telling NA #1 she was going to jail. NA #1 was still fighting, kicking, swinging and trying to get away from the staff holding her and trying to get to Resident #1 again. That was when Resident #1 stood up from his wheelchair. Nurse #1 told him he needed to sit down and he took ½ step with one foot, then sat back down. Staff pulled NA #1 out of the building. The whole episode lasted about 5 minutes.

A statement from NA #1 dated 10/6/17 (no time) stated she was threatened and cussed out very badly that morning by Resident #1. He cussed her out as she was walking on to the 200 hall to start her work. He sat at the top of 200 hall and was cursing the scheduler out for telling his business to the supervisor in charge at the time and as NA #1 was passing by, Resident #1 started yelling and cursing at NA #1 crazy like and saying that she was supposed to be on a certain hall. He proceeded to stand up like he wanted to hit NA #1 so she left the hall and walked outside to calm down. When she came back in the building to go back to her hall, she stated she was looking straight ahead. Resident #1 said, while he was talking to the nurse "why are you looking at me with the side eye". NA #1 stated she did not say anything. Resident #1 kept talking and cussing NA #1 out. NA #1 stated she

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reached for Resident #1 but did not touch him because she was pulled back and was taken down the hall. She went outside where she tried to calm herself down. The statement said it was the third time he had cussed her out and "stood up on her" like he wanted to hit her. When he stood up, he pushed her and then sat back down.

On 10/10/17 at 12:29 PM, a telephone interview was conducted with NA #1. She stated she was on 200 hall showing someone who to get up and Resident #1 was giving the girls instructions on who to get up. One of the residents on 400 hall fell and she went back to help. NA #1 said he heard Resident #1 say if NA #1 had been on 400 hall, the resident would not have fallen. NA #2 had told NA #1 to go to 200 hall. NA #1 said, as she was coming up the hall, she heard Resident #1 at the top of 200 hall cursing NA #2. NA #1 said she passed NA #2 and went on 200 hall. Resident #1 began cursing and hollering at NA #1. NA #1 said she got upset and Resident #1 stood up like he wanted to hit her. Staff were telling her to calm down and they took her outside. NA #1 said she calmed down and returned into the building. Resident #1 was in the hallway talking to Nurse #1. NA #1 stated she was walking past and paying Resident #1 no attention. Resident #1 said something to her and kept saying stuff to her. NA #1 said that was when she tried to "get at him". NA #1 said Resident #1 said she hit him but she denied that she hit him. NA #1 said NA #2, NA #3 and Nurse #3 grabbed her and took her outside of the building. NA #1 said the police came to the building but, the first time, she had left the building and had gone to the police station. When she went to the police station, they said there had been no charges filed. NA #1 stated

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she went back to the facility to the smoking area across the street so her cousin could get her belongings. The police came back a second time, put her in handcuffs and took her to the police station but no charges were filed. NA #1 stated she had reached her breaking point and again stated she did not make any physical contact with Resident #1.

A statement from NA #2 stated she was sitting in her office at about 7:20 AM when resident #1 came to the door and told her "he wanted NA #1 off his hall and that she wasn ' t supposed to be on that hall anyway." NA #2 told him NA #1 was not supposed to be in his room. He said he didn ' t give a (profanity), he wanted her off the hall. NA #2 went down the hall and switched NA #1 from 400 to 200 hall. As NA #2 was talking to Nurse #2 about what was going on with Resident #1, Resident #1 came up behind NA #2 and asked her why the (profanity) was she telling his business. N A#2 told him that she was telling her business since he had told it to her. Then he started getting upset going on and on. As he was fussing, NA #1 walked up 200 hall and he said something to her and called her a (profanity). NA #1 got upset and told him she was tired of his (profanity). Resident #1 then stood up and told her to "come on". NA #1 went towards him, she was grabbed by staff and taken down the hall. Resident #1 was still cursing and carrying on. NA #2 took NA #1 outside to calm down. When they re-entered the building, NA #1, Nurse #3 and NA #2 walked towards the nursing station. Resident #1 was in the hall between the Director of Nurse ' s office and the Minimum Data Set (MDS) office talking to Nurse #1. Resident #1 said something to NA #1 as she was walking by. NA #1 then said she was so (profanity) tired of resident #1. She

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went to swing but Nurse #3 grabbed her and NA #1 ' s hand barely hit Resident #1 ' s left shoulder.

On 10/10/17 at 10:25 AM, an interview was conducted with NA #2. She said she was in her office around 7:15 AM and Resident #1 came into her office and stated he wanted NA #1 off that (profanity) hall. NA #2 told him NA #1 was allowed to work the hall and just not allowed to come in his room. NA #2 said she was going to wait to talk to the Director of Nursing about the situation and then decided she would handle the situation herself. NA #2 went to NA #1 and told her to switch with the nursing assistant who was on 200 hall. NA #1 went from 400 to 200 hall. NA #2 was talking to Nurse #2 telling her what she was doing as far as switching the staff on the halls because Nurse #2 was the only administrative nurse in the building at the time. Resident #1 came up behind NA #2 and asked her why she was telling his business. She said she told him once he brought it to her, he made it her business and she had to let Nurse #2 know what she was doing. NA #1 was coming up 200 hall and when resident #1 saw her, he said "that (profanity) right there." NA #1 told Resident #1 she was tired of him. NA #2, Nurse #3 and maybe two other people grabbed NA #1. Resident #1 jumped out of his chair, stood up and said to NA #1 "come on". Nurse #3 took NA #1 outside and Resident #1 went on to the dining room to eat breakfast.

NA #2 stated she went outside and stayed with NA #1 to calm her down. She said she told NA #1 that the Director of Nursing was probably going to cancel her and she wasn ' t going to be allowed to be at the facility anymore. NA #2 told NA #1 to get her stuff together. They came back

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in the door and Resident #1 was talking to Nurse #1 about what happened. NA #2 stated she could not remember Resident #1 ' s exact words but he said something and NA #1 went to swing at him. Nurse #3 grabbed NA #1. NA #1 did make contact to Resident #1 ' s left shoulder. NA #1 was hollering and screaming. Resident #1 stood up from his wheelchair. Nurse #3 took NA #1 out the door and she did not come back in the building at all. NA #2 stated as soon as NA #1 ' s hand touched him, Resident #1 said call the police and Nurse #2 called the police.

A statement from Nurse #2 dated 10/6/17 stated a code green was called to 400 hall, As Nurse #2 started in the room where the resident had fallen, Resident #1 came up the hall saying NA #1 let him fall. The door to the resident room was closed immediately. When Nurse #2 came out of the room, Nurse #2 met NA #2 at the 200 hall medication cart and NA #2 was telling Nurse #2 about a the statement that Resident #1 had said when he went to NA #2 ' s office. Resident #1 came up behind NA #2 and started telling her not to be telling nothing about him. NA #2 tried to explain to Nurse #2 what had been said. About that time, NA #1 came up and the explosion happened, cussing from both. Nurse #3 and NA #2 took NA #1 down 200 hall.

On 10/10/17 at 10:49 AM, an interview was conducted with Nurse #2. She stated she had assisted with a resident who had fallen in one of the rooms on 400 hall. When she came out of the room, she went to 200 hall and was at the medication cart. She met NA #2 and NA #2 was telling her about Resident #1 and the conversation regarding NA #1. Resident #1 came up behind NA #2 and was yelling at her not to tell

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his business. NA #2 told him she had to tell Nurse #2 because she was the only administrative staff in the building at the time. NA #2 didn ' t get a chance to tell Nurse #2 what she wanted to tell her because he had come up behind NA #2 and was screaming. Before NA #2 could finish talking, NA #1 came up the hallway. When NA #1 got to the end where 400 and 200 hall meet near the nursing station, NA #1 and Resident #1 both started yelling at each other. By that time, Nurse #3 came up behind NA #1 and grabbed her to keep her away from Resident #1. Nurse #3 took NA #1 down the hallway. Nurse #2 stated she thought they took NA #1 out of the building. Nurse #2 stated she then saw Nurse #1 and Resident #1 talking near the time clock. Then Nurse #2 saw NA #1 come in the side door and Nurse #1 began yelling and screaming and said to call 911. Nurse #2 called 911 to get the police to the facility because Resident #1 and NA #1 were yelling and screaming again. The situation escalated at that time. They took NA#1 out of the building and, to her knowledge, she did not come back in the building. Resident #1 was in his wheelchair near the Director of Nursing office. Nurse #2 stated she saw Resident #1 stand up the first time at the nursing station and that was the only time she remembered him standing up from his wheelchair.

A statement from Nurse #3 dated 10/6/17 stated she was counting the cart with the night nurse and heard arguing on the top of 200 hall. She looked up and saw Resident #1 yelling and cursing at the scheduler (NA #2) stating she should not spread his business around the facility. NA #2 stated she was not spreading his business. She continued to talk to Nurse #2 and Resident #1 got louder and angrier. When NA #1

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F 223	Continued From page 11 walked by, he began cursing her and saying how sorry she was. NA #1 began to argue back with Resident #1 and he proceeded to stand up and threaten NA #1 while pointing at her. At that point Nurse #3 went over and grabbed NA #1 holding her to calm her down. Nurse #3 escorted NA #1 out the door. Upon returning to the building, NA #2, NA #1, NA #3 and Nurse #3 walked into the building not knowing Nurse #1 and Resident #1 were in the hallway. As they walked past, Resident #1 argued with NA #1. Resident #1 stood up and the verbal back and forth started again. Nurse #3 again escorted NA #1 out of the building. On 10/10/17 at 11:05 AM, an interview was conducted with Nurse #3. She stated she was at the nursing station counting narcotics with Nurse #5 around 7:15 AM. One of the aides came and asked them to call a code green because one of the residents was on the floor (400 hall). When she walked down the hall, she saw Resident #1 coming down 400 hall towards the nursing station saying if the aides were on the hall, he wouldn ' t have fallen. It was their fault that he fell. Nurse #3 stated she heard the comment in passing but didn ' t take much stock of it because the nursing staff had been on the hall at the time the resident fell. She went back to the medication cart to finish counting narcotics. As they were counting narcotics, Nurse #3 remembered seeing Resident #1 come across the nursing station to 200 hall where NA #2 was talking to Nurse #2. Nurse #3 heard arguing between NA #2 and Resident #1. Resident #1 got louder and cursing and told NA #2 she did not know what she was doing as he pointed at her. NA #2 began to ignore him and resumed talking to the person she was talking to. Resident #1 continued to curse at NA #2. Nurse	F 223		

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#3 stated she did not see NA #1 walk in resident #1 ' s direction. When Nurse #3 looked back up, she heard Resident #1 call NA #1 a (profanity). By that time, both NA #1 and Resident #1 were yelling and cursing at each other. NA #1 was telling Resident #1 she was not on his hall and she was not bothering him. They started calling each other profane names and NA #1 told Resident #1 she was not messing with his (profanity). Resident #1 stood up and he was pointing at her and they were yelling at each other. When he stood up, NA #1 went towards him.

Nurse #3 stated she went towards NA #1 because NA #1 was shaking other staff off her with her arms saying get off of me. Nurse #3 said she grabbed NA #1 from the front and she was trying to get Nurse #3 away from her. Nurse #3 then bear hugged NA #1 and tried to calm her down because they were related she thought she could calm her down. All this happened at top of 200 hall. Nurse #3 walked NA #1 down 200 hall and around the corner to calm her down. She was visually upset, saying she was getting tired of this, talking junk to us, threatening us and could not take it anymore. Nurse #3 suggested she go outside to calm down. Nurse #3 took her out and then came back in to the building to complete counting narcotics. One of the shower aides came to Nurse #3 and told her that Resident #1 had said he was going to get rid of NA #1 one way or the other. She said she told somebody else but not NA #2. Nurse #3 went outside to tell NA #2 about the conversation and NA #1 seemed calmer at that time. Nurse #3 said she came back inside but did tell NA #1 and NA #2 that Resident #1 was talking to Nurse #1. They were near the nursing station. NA #2, NA#1 and Nurse

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#3 were going to get NA #1 ' s belongings. Nurse #3 stated she did not visualize the next blow up. They were fussing again. This time, Nurse #3 grabbed NA #1 and pulled her out of the doors. Nurse #3 stated she did not see any physical contact on either party.

A statement from NA #3 dated 10/6/17 stated she and Resident #1 were in the shower room and he said he was going to do everything to get NA #1 out of the building. NA #1 didn ' t say anything to him until he called her a (profanity) and (profanity). NA #1 swung at him and NA #3 grabbed NA #1 and Resident #1 stood up.

On 10/10/17 at 12:16 PM, an interview was conducted with NA #3. She stated she was giving Resident #1 a shower around 6:45 AM and he said he was going to get that (profanity) out of this building. By the time he got out of the shower, NA #3 was picking up towels form the shower room and had not seen anybody up front to tell then what Resident #1 had said. NA #3 was in the shower room on 200 hall when she heard a commotion but was unable to see what happened because she had someone in the shower at the time. When NA #3 came out of the shower, breakfast trays were out so she went to get a cup of coffee. NA #3 went to the smoking area and NA #1 and NA #2 were there also. All three came back into the building together. Resident #1 and Nurse #1 were in the hallway. When NA #1, NA #2 and NA #3 passed them in the hall near the Director of Nursing office, Resident #1 called NA #1 a black (profanity) and NA #1 swung at Resident #1. NA #3 said she grabbed NA #1 and somebody took NA #1 from her and took her out of the building. NA #3 stated she didn ' t know if NA #1 made direct contact or not.

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A statement from Nurse #4 stated she was at the nurse ' s station. Resident #1 was talking loudly to NA #2 (scheduler) and Nurse #2. When NA #1 walked by, they started arguing and NA #1 walked toward Resident #1. NA #2 and Nurse #3 walked NA #1 walked KS outside. Around 20 minutes later, Resident #1 was talking to Nurse #1. NA #1 walked around the corner and they started arguing and cursing. Resident #1 stood up and NA #1 walked past him and out the door.

On 10/11/17 at 7:57 AM, an interview was conducted with Nurse #4. She stated she was counting narcotics with Nurse #5 on 10/6/17. They were on the 100 hall side of the nurse ' s station. She heard Resident #1 talking loudly to NA #2 and Nurse #2. Resident #1 was talking loudly and yelling, cursing at NA #2. She stated she was not sure which side NA #1 came from and did not know who said what to each other first. Resident #1 and NA #1 began yelling and cursing back and forth and she was walking towards Resident #1. There were other people who grabbed NA #1 and took her outside. Nurse #4 stated she did not remember if Resident #1 stood up from his wheelchair at that time. Nurse #4 stated they began counting narcotics again and she remembered Nurse "1 was talking to Resident #1 near the Director of Nursing office. NA #1 came around the corner and they started yelling and cursing again. Resident #1 stood up that time. She stated she did not observe any physical contact because she was not in direct view of the altercation.

A statement from Nurse #5 dated 10/6/17 (no time) stated she was counting and heard loud noises, turned toward 200 hall and saw NA #2

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and Nurse #2 talking. Resident #1 was sitting in his chair yelling and cussing and calling NA #2 names loudly. NA #2 responded that she was talking with an administrative nurse and she would be with him in a minute. He continued cursing and yelling. Nurse #5 stated she resumed counting narcotics and heard even more commotion. Resident #1 was standing up yelling threats at NA #1. Then staff removed NA #1 from the hall.

On 10/11/17 at 10:05 AM, attempts were made twice to contact Nurse #5. The phone number was no longer valid.

On 10/10/17 at 8:44 AM, an interview was conducted with Resident #1. He stated it was Friday morning around 7:30-8:00 AM. He had found out that NA#1 was working on his hall for the 3rd or 4th time. Resident #1 stated she could not work on his side when the other aide took a break or was not on the schedule because he and NA#1 could not work together. They had a problem previously and she had been taken off his assignment. Resident #1 said he went to NA#2 and told her he didn ' t want NA#1 on his hall. NA#1 wasn ' t on his assignment but was working the opposite side of the hall so would have been working with him when the other nursing assistant took breaks.

Resident #1 stated he went to his room and grabbed some change to get a drink in the lounge area at the front door. He said he saw NA#2 at the nurse ' s station top of 200 hall talking to Nurse #2. She was talking to her about Resident #1 wanting to get NA #1 off his hall and how much trouble it was causing. Resident #1 asked her to please stop talking about him in front of

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other patients and stuff. NA #2 stated she was talking to management and Resident #1 said he told her that was fine but not to talk about him in front of a bunch of people. NA #2 turned her back to Resident #1 and he got mad. He raised his voice to NA #2. About that time, NA #1 came around the corner and Resident #1 stated he did not know what he said but he was still talking to NA #2. NA #1 got in the conversation and he told her to stay out of it. Resident #1 and NA #1 had words with both of them shouting, name calling and cursing at each other. Resident #1 stated the next thing he knew, she became a windmill swinging her arms and kicking her feet trying to get to him. He said she did not make physical contact but was saying she was going to (profanity) me up. She was about 3 feet away from him at the time. NA#1 was crying and screaming. Staff took her to a room down 200 hall on the left hand side of the hall. Then NA #1 tried to come back out talking junk and Resident #1 was talking junk too. NA #1 tried to hit Resident #1 again. Staff took her down the hall again. He thought she remained in the building.

Resident #1 stated he was talking to Nurse #1 in the hallway near the Director of Nurse ' s office around 9:00 AM (not sure of time) and was telling her what happened. Nurse #1 said she would call the Director of Nursing. NA #1 came around the corner from the dining room with mean look on her face and her fists balled. She kind of cut her eyes at resident #1 and he told her not to cut her eyes at him. NA #1 hit Resident #1 in the head, shoulders, arms, legs and chair. Resident #1 stated Nurse #1 was a witness to the event. He said he didn ' t say anything else to her except she was going to jail. Resident #1 said he only got a long scratch on his left upper arm. He said

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he had no other physical injuries

On 10/10/17 at 3:01 PM, an interview was conducted with the Director of Nursing (DON) and the Administrator. She stated she received a phone call between 7:47 AM and 7:57 AM from Nurse #1 and was informed that a staff member had struck a resident. She told me there was someone on the phone calling 911. The DON said she asked if the staff member had been removed from the building and she was told yes and the resident was ok. The DON stated she called the Administrator immediately after getting off the phone and told her that a staff member had struck a resident and that the staff member had been removed from the building and the resident was ok. The Administrator added that she was called while she was enroute to the facility and was informed the police were at the building. The DON stated the police were at the facility when she arrived. She was told the staff member who had assaulted the resident had borrowed someone ' s car and she had left the premises. The DON stated around 9:00 AM, both she and the Administrator went to Resident #1 and assessed him for injuries. No injuries were noted and Resident #1 did not complain of any pain at the time of the assessment. Resident #1 explained to them that both of them (resident #1, NA #1) got into verbal altercations and "went at each other" meaning verbal arguing and cursing at each other. He did state his left knee would probably start hurting because he stood up at the time of the altercation. The DON asked him if he needed to go to the hospital and he declined. The DON stated she called the physician at 9:22 AM and began the investigation.

The DON continued to state what happened next:

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At 8:50 AM, they received several statements and gave them to Administrator. At 9:00 AM, the Administrator and DON assessed Resident #1. At 9:22 AM, the facility spoke to the Medical Director and conducted an interview with Resident #1 ' s roommate. At 9:35 AM, the facility called the agency that employed NA #1 and informed them of the situation that had occurred between Resident #1 and NA #1.

On 10/11/17 at 8:30 AM, a telephone interview was conducted with the police officer from the (name) Police Department who responded to the call 10/6/17. He stated he and another police officer responded to a 911 call that an assault had occurred at Richmond Pines. He stated, when they arrived, the female aggressor had left the facility. He spoke to Resident #1 and spoke to Nurse #1. Nurse #1 stated the nursing assistant (NA #1) and Resident #1 got into an argument in the hallway and NA #1 had hit Resident #1. The police officer stated Resident #1 had a few surface scratches on his left upper arm. During the interview, Resident #1 was agitated and appeared angry-was not yelling but, by the way he was talking to the officer, he was upset over the situation. The police officer stated NA #1 was arrested when she returned to the facility area later in the morning but no charges were filed. He stated both parties were going to file warrants out against each other. The Magistrate talked to both parties and it was decided on both parties that no charges would be filed.

The corrective action for past non-compliance dated 10/7/17 was as follows:

On 09/17/17, nursing assistants reported to the charge nurse that Resident #1 was using

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profanity towards the accused agency nursing assistant and one other agency nursing assistant. Resident #1 stated the nursing assistants should stay on the hall. Resident #1 has ongoing behavioral issues, is care planned for demonstrating behaviors, and treated by the physician and psychiatric services for behaviors. The two agency nursing assistants did not engage Resident #1 and instead the staff nurse intervened. The staff nurse re-assigned another nursing assistant to Resident #1 for the duration of the shift.

On 10/06/17, the accused agency staff employee was walking in the hall and had a verbal interaction with Resident #1. Resident #1 stood up and made a statement and used profanity towards the accused agency staff. The accused agency staff used profanity in return towards Resident #1. The agency licensed practical nurse removed the accused agency staff immediately from the facility. The agency licensed practical nurse and facility scheduler escorted the accused agency nursing assistant back into the facility to speak with the director of nursing (DON), not knowing the director of nursing was not at the facility. Instead, the quality improvement (QI) nurse was entering the facility where Resident #1 met her on the administrative hall. Immediately upon the agency nursing assistant entering the administrative hall, Resident #1 used profanity towards the agency staff again. The accused agency staff walked by Resident #1, who was sitting in a wheelchair, and swung at Resident #1. The agency staff struck Resident #1 ' s upper left arm with an open hand. The accused agency staff was immediately removed from the facility a second time by the facility staff scheduler and agency staff nurse.

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The QI nurse notified the director of nursing (DON). The DON notified the administrator. The QI nurse was assessing the resident and facility treatment nurse called 911 at 8:00 AM. The city police responded and interviewed Resident #1. The accused agency staff left the facility to self-report to the county magistrate. The accused waited off campus and the city police returned and escorted the accused to the magistrate. On 10/06/17, the DON called and verbally notified via telephone Resident #1 ' s nurse practitioner. Later on 10/06/17, the DON spoke via telephone to Resident #1 ' s physician/facility medical director. No new orders were received from the nurse practitioner or physician. On 10/06/17 in the afternoon, the DON called the psychiatric nurse supervisor and within 30 minutes the psychiatric nurse practitioner was in the facility and assessed Resident #1 related to ongoing behaviors. On 10/06/17 at 9:57 AM, the administrator faxed a 24 hour report for allegation of abuse/suspicion of a crime to the North Carolina Health Care Personnel Registry. On 10/06/17, the DON assessed Resident #1 for physical injury with no signs of injury noted.

As of 10/06/17, the plan to manage the resident behavior in the facility includes 1) the administrator and DON permanently removing the accused agency nursing assistant from the staffing roster, 2) the registered nurse/QI nurse ' s daily support through conversation and encouragement, 3) 1-to-1 staff assignment to assist Resident #1, 4) psychiatric services, 5) Master ' s in Social Work (MSW) social worker meetings to discuss feelings, 6) the DON will work with the physician to provide Resident #1 with tangible interventions for skin and pain relief.

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On 10/06/17 at approximately 7:55 AM, the accused agency staff was removed permanently from the Richmond Pines facility by the facility scheduler and agency licensed practical nurse while the QI nurse was assessing the resident and facility treatment nurse called 911.

On 10/06/17 at approximately 8:16 AM, the DON, QI nurse, and corporate clinical director had identified the root cause of the problem: the agency nursing assistant should not have been allowed back into the facility after the first verbal interaction on 10/06/17. Why did the resident get hit? Because the agency nursing assistant hit the resident. Why did the agency nursing assistant hit the resident? Because the nursing assistant swung at the resident. Why was the agency nursing assistant swinging to hit the resident? Because the assistant was upset. Why was the agency nursing assistant upset? Because of a verbal interaction with the resident. Why was there a verbal interaction with the resident? Because the nursing assistant was being brought in for an interview. Why was the agency nursing assistant being brought in for an interview? Because there was an earlier verbal altercation. Because there was an earlier verbal altercation, the employee should not been allowed back into the facility. The facility staff thought the agency nursing assistant needed to be interviewed and drug tested.

On 10/06/17 at approximately 9:37 AM, the facility administrator and DON notified the staffing agency that the accused agency staff would not be allowed to work at the facility.

On 10/06/17 at 10:45 AM, the social worker initiated abuse interviews for all interviewable

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residents. The interviews were completed at 1:40 PM. The interviews resulted in no concerns expressed by interviewable residents.

On 10/06/17, beginning at approximately 11:00 AM, the treatment nurse and floor nurses assessed all non-interviewable residents who are unable to communicate or who are disoriented. On 10/06/17, the body audits were completed. The 100% body audits of all non-interviewable residents resulted in no identified bodily signs of abuse.

On 10/06/17, the DON completed a review of all nurse progress notes for the time period of 09/22/17 through 10/06/17 for any incidents of abuse/neglect. No incidents of abuse/neglect were identified during the progress note review by the DON.

The processes that lead to the deficiency cited:

To address the processes that lead to the deficiency cited and why it escalated to a physical altercation the facility performed at root cause analysis. The root cause analysis using "5 Whys" determined: 1) the physical abuse would not have happened if the accused agency nursing assistant had not been allowed to re-enter the facility after the initial verbal altercation, 2) if the facility and agency staff would have recognized the initial verbal altercation as a problem with the potential to escalate, and 3) the importance of preventing abuse/neglect. It was determined that the facility needed to train staff on: abuse neglect policies and procedures, prevention of abuse/neglect, identification of abuse/neglect, protecting the resident from abuse/neglect, protecting the staff from burn out, and

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(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

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immediately reporting abuse/neglect.

On 10/06/17, the regional vice president trained the department leaders regarding the policy for abuse/neglect, including reporting requirements.

On 10/06/17, the staff facilitator initiated in-servicing for all staff on abuse/neglect. The training included the definition of abuse/neglect, the types of abuse/neglect, and reporting abuse/neglect immediately. The in-service was completed on 10/10/17 for all staff who have worked. No staff worked until they had received the abuse neglect in-service.

On 10/06/17, the staff facilitator initiated in-servicing for all staff on burn-out. The training included what burn out is. The burn out in-service covered the signs and symptoms of burn out, what to do when feeling frustrated, to let the supervisor know when experiencing/feeling early signs of burn out, and to report to a supervisor when a co-worker shows signs and symptoms of burn out. The in-service was completed on 10/10/17 for all staff who have worked. No staff worked until they had received the burn-out in-service.

On 10/06/17, the DON called a staff meeting with the nurses to knowing where the nursing assistants are at all times, about the abuse/neglect in-service, about the burn out in-service, and about correct staffing assignments. On 10/06/17, the DON called a nursing assistant meeting at the nurse station to review the in-services, offer clarification and support regarding the allegation of abuse/neglect. The DON encouraged the facility staff to communicate with management when they see

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something that is not right. The DON assured the staff the management team that talking about problems is healthy and that the staff can come to the DON. The DON and staff agreed that having more discussions about abuse/neglect and burn out will help prevent future conflict escalation and potential for burn out.

How systems will be monitored to prevent reoccurrence:

The facility social worker will interview all interviewable residents weekly for 8 weeks regarding verbal and physical abuse to ensure any allegations have reported and addressed. All identified areas of concern related to abuse will be reported to the Administrator and/or director of nursing (DON) immediately to investigate.

Charge nurses will complete head-to-toe assessments on residents who are disoriented or unable to speak for themselves to check for signs of abuse/neglect. The head-to-toe assessments will be completed weekly for 8 weeks to ensure no signs or symptoms of abuse/neglect are present. All identified areas of concern related to abuse/neglect will be reported immediately by the nurses to the administrator and/or DON to investigate.

The staff facilitator and/or quality improvement (QI) nurse will continue abuse/neglect in services for all staff monthly for two months and all new employees hired will receive this training before working with residents.

The administrator and/or DON will review all alert and oriented resident interviews weekly for 8 weeks to ensure interviews are completed and

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F 223	Continued From page 25 that any areas of concern related to abuse/neglect are investigated and reported as appropriate. The administrator and/or DON will review all head-to-toe assessments of residents who are disoriented or cannot speak for themselves to ensure that any suspicions of abuse/neglect are investigated as appropriate. The administrator, DON, QI nurse, and minimum data set (MDS) nurse leadership team are monitoring for staff burn out by 1) reviewing audit results, 2) facilitating staff meetings, 3) creating an environment of acceptance of self-reporting, 4) offering support to facility and agency staff through the burn out in-services, 5) easy access postings of the human resources names and phone numbers as an advocate, 6) the payroll manager will monitor payroll hours for excessive overtime and sick call-outs, 7) the staff scheduler will monitor the staffing schedule for overtime and excessive breaks, 8) the administrator and DON will monitor for an increase in disciplinary actions. All findings will be brought to the monthly facility Quality Assurance and Performance Improvement (QAPI) meeting for review by the interdisciplinary team. On 10/06/17, the administrator, DON and facility medical director had an impromptu Quality Improvement (QI) Executive Committee meeting to specifically review the facility four point plan related to abuse/neglect and monitoring tools. The monthly QI Executive Committee will review all audit tool results, results of interviews, and facility progress with each step of the plan, to validate the systems and processes remain in place and are effective. The administrator is	F 223		

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F 223	Continued From page 26 responsible for implementing this plan of correction and QI Executive Committee recommendations. As part of the validation process on 10/11/17 and 10/12/17, the plan of correction was reviewed which included the re-education of agency and facility staff. Interviews with licensed and unlicensed staff (facility and agency staff) revealed they were retrained in the areas of abuse/ neglect policies and procedures, prevention of abuse/ neglect, identification of abuse/ neglect, protecting the resident from abuse/ neglect, protecting the staff from burn out and immediately reporting abuse/ neglect. A review of the monitoring tools revealed the facility completed 100% of resident interviews on 10/6/17, 100% of body audits of residents who were unable to be interviewed on 10/6/17. All staff, including facility and agency staff, received the abuse and burn out in-service on 10/6/17.	F 223		
F 226 SS=J	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3) 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95,	F 226		11/2/17

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F 226	Continued From page 27 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident and staff interviews, it was determined that the facility failed to follow their abuse policy and procedures for abuse prohibition for protecting a resident after a verbal altercation between a resident and a staff member. After the verbal altercation, NA #1 was allowed to come back into the building and a second altercation between Resident #1 and NA #1 resulted in NA #1 making physical contact with Resident #1. The findings included: The facility ' s abuse, neglect or misappropriation of resident property policy last revised 3/10/17 was reviewed. The policy under Prevention read in part "The facility will provide supervision to staff to identify inappropriate behaviors, such as using derogatory language, rough handling, ignoring	F 226	Past noncompliance: no plan of correction required.	

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residents while giving care or directing residents who need toileting assistance to urine or defecate in bed." The policy under Protection read in part "The facility shall take whatever steps are necessary to prevent further acts of abuse, neglect, misappropriation of property, drug diversion, or fraud while the investigation is in progress. Employees accused of being directly involved in allegations of abuse, neglect, exploitation, or misappropriation of property will be suspended immediately from duty pending the outcome of the investigation."

Resident #1 was admitted to the facility 5/10/16. Cumulative diagnoses included major depressive disorder, suicidal ideations, anxiety and bipolar affective disorder.

A Quarterly Minimum Data Set (MDS) dated 10/2/17 indicated Resident #1 was cognitively intact. No behaviors were noted on the assessment. Resident #1 required supervision with bed mobility, transfers, ambulation in the room, ambulation in the corridor only occurred one or two times, supervision with locomotion on and off the unit, extensive assistance with toilet , personal hygiene and total dependence with bathing, Balance was impaired but resident #1 was able to stabilize without staff assistance for moving from seated to standing position, walking, turning around and facing the opposite direction while walking, moving on and off the toilet and surface to surface transfers. No impairment with range of motion for upper and/or lower extremities.

An Incident/ Investigation Report from the (name) Police Department dated 10/6/17 at 7:51 AM stated the crime/ incident was simple assault,

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assault and battery by striking the victim causing physical injury. Weapon used was hand. Victim was Resident #1. Offender was nursing assistant (NA) #1. Narrative stated the following: On 10/6/2017 at 7:52 AM, (name) Police Department received a call in reference to an assault at the nursing home. Upon his arrival, he spoke to Nurse #1 (witness) who advised that NA #1 and Resident #1 had gotten into an altercation resulting in Resident #1 getting physically struck in the arm. At that time, the officer went inside and spoke with Resident #1 who advised that himself and the nursing assistant had gotten into several arguments and that the incident had started earlier that morning. Resident #1 stated that, after the initial argument, he went to the front hallway of the facility near the entrance. He stated that when NA #1 came back around into the front hallway, she gave him a mean look to which he told her to not look at him in that way. He then stated that she went crazy and began to swing at him and struck him in the top part of his left arm. Both his and the witness stories were consistent with each other in explaining the incident. Upon further investigation, it was determined the name of the CNA was (offender/ suspect) and that she was from an outside agency. She was working at the nursing home and had left prior to the officer ' s arrival. Warrants were advised to both parties involved and obtained on behalf of Resident #1 due to his inability to get into a vehicle to proceed to the magistrate ' s office. The police officer called the magistrate who advised that the officer could swear out the warrants on the behalf of Resident #1 due to the issue. Same were obtained in reference to the assault.

A review of the Emergency Room record dated

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10/6/17 stated "Patient states that he feels anxious. Has altercation with CNA (certified nursing assistant) at Richmond Pines. Feels like they are out to get me. She jumped on me twice." Past medical history significant for anxiety, asthma, bipolar disorder, depression. Resident #1 stated he got into an altercation with a CNA and she assaulted him but also stated he did not want to get into it. He provided very little information. He stated he tried to press charges but the law was against him. When asked if he sustained any injuries, he stated "No" and denied any injuries. Skin was noted as negative for rash. There was no documentation of any scratches on Resident #1 ' s body. He denied any trauma or injury from the incident that had occurred 10/6/17.

A review of the 24 hour report dated 10/6/17 at 9:45 AM stated Resident #1 alleged NA #1 yelled and hit him.

A statement dated 10/6/17 (no time noted) from NA #2 stated she was sitting in her office at about 7:20 AM when resident #1 came to the door and told her "he wanted NA #1 off his hall and that she wasn ' t supposed to be on that hall anyway." NA #2 told him NA #1 was not supposed to be in his room. He said he didn ' t give a (profanity), he wanted her off the hall. NA #2 went down the hall and switched NA #1 from 400 to 200 hall. As NA #2 was talking to Nurse #2 about what was going on with Resident #1, Resident #1 came up behind NA #2 and asked her why the (profanity) was she telling his business. N A#2 told him that she was telling her business since he had told it to her. Then he started getting upset going on and on. As he was fussing, NA #1 walked up 200 hall and he said something to her and called her a (profanity). NA #1 got upset and told him she

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was tired of his (profanity). Resident #1 then stood up and told her to "come on". NA #1 went towards him, she was grabbed by staff and taken down the hall. Resident #1 was still cursing and carrying on. NA #2 took NA #1 outside to calm down. When they re-entered the building, NA #1, Nurse #3 and NA #2 walked towards the nursing station. Resident #1 was in the hall between the Director of Nurse ' s office and the Minimum Data Set (MDS) office talking to Nurse #1. Resident #1 said something to NA #1 as she was walking by. NA #1 then said she was so (profanity) tired of resident #1. She went to swing but Nurse #3 grabbed her and NA #1 ' s hand barely hit Resident #1 ' s left shoulder.

On 10/10/17 at 10:25 AM, an interview was conducted with NA #2. She said she was in her office around 7:15 AM and Resident #1 came into her office and stated he wanted NA #1 off that (profanity) hall. NA #2 told him NA #1 was allowed to work the hall and just not allowed to come in his room. NA #2 said she was going to wait to talk to the Director of Nursing about the situation and then decided she would handle the situation herself. NA #2 went to NA #1 and told her to switch with the nursing assistant who was on 200 hall. NA #1 went from 400 to 200 hall. NA #2 was talking to Nurse #2 telling her what she was doing as far as switching the staff on the halls because Nurse #2 was the only administrative nurse in the building at the time. Resident #1 came up behind NA #2 and asked her why she was telling his business. She said she told him once he brought it to her, he made it her business and she had to let Nurse #2 know what she was doing. NA #1 was coming up 200 hall and when resident #1 saw her, he said "that (profanity) right there." NA #1 told Resident #1

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she was tired of him. NA #2, Nurse #3 and maybe two other people grabbed NA #1. Resident #1 jumped out of his chair, stood up and said to NA #1 "come on". Nurse #3 took NA #1 outside and Resident #1 went on to the dining room to eat breakfast.

NA #2 stated she went outside and stayed with NA #1 to calm her down. She said she told NA #1 that the Director of Nursing was probably going to cancel her and she wasn ' t going to be allowed to be at the facility anymore. NA #2 told NA #1 to get her stuff together. They came back in the door and Resident #1 was talking to Nurse #1 about what happened. NA #2 stated she could not remember Resident #1 ' s exact words but he said something and NA #1 went to swing at him. Nurse #3 grabbed NA #1. NA #1 did make contact to Resident #1 ' s left shoulder. NA #1 was hollering and screaming. Resident #1 stood up from his wheelchair. Nurse #3 took NA #1 out the door and she did not come back in the building at all. NA #2 stated as soon as NA #1 ' s hand touched him, Resident #1 said call the police and Nurse #1 called the police.

A statement from Nurse #1 dated 10/6/17 at 8:30 AM stated shortly after clocking in, Resident #1 approached her in his wheelchair. As he began reporting incidents of the earlier morning to Nurse #1 concerning NA #1, NA #1 and several other employees came walking down the hallway. Nurse #1 was facing Resident #1 with her back to the employees. She stated she did not remember whether the resident spoke first to NA #1 or the other way around but NA #1 swung around towards Resident #1 and called him a (profanity) and struck him on his upper arm. The two began yelling at each other. Employees were

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sit down and he took ½ step with one foot, then sat back down. Staff pulled NA #1 out of the building. The whole episode lasted about 5 minutes.

A statement from NA #1 dated 10/6/17 (no time noted) stated she was threatened and cussed out very badly that morning by Resident #1. He cussed her out as she was walking on to the 200 hall to start her work. He sat at the top of 200 hall and was cursing the scheduler out for telling his business to the supervisor in charge at the time and as NA #1 was passing by, Resident #1 started yelling and cursing at NA #1 crazy like and saying that she was supposed to be on a certain hall. He proceeded to stand up like he wanted to hit NA #1 so she left the hall and walked outside to calm down. When she came back in the building to go back to her hall, she stated she was looking straight ahead. Resident #1 said, while he was talking to the nurse "why are you looking at me with the side eye". NA #1 stated she did not say anything. Resident #1 kept talking and cussing NA #1 out. NA #1 stated she reached for Resident #1 but did not touch him because she was pulled back and was taken down the hall. She went outside where she tried to calm herself down. The statement said it was the third time he had cussed her out and "stood up on her" like he wanted to hit her. When he stood up, he pushed her and then sat back down.

On 10/10/17 at 12:29 PM, a telephone interview was conducted with NA #1. She stated she was on 200 hall showing someone who to get up and Resident #1 was giving the girls instructions on who to get up. One of the residents on 400 hall fell and she went back to help. NA #1 said he heard Resident #1 say if NA #1 had been on 400

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hall, the resident would not have fallen. NA #2 had told NA #1 to go to 200 hall. NA #1 said, as she was coming up the hall, she heard Resident #1 at the top of 200 hall cursing NA #2. NA #1 said she passed NA #2 and went on 200 hall. Resident #1 began cursing and hollering at NA #1. NA #1 said she got upset and Resident #1 stood up like he wanted to hit her. Staff were telling her to calm down and they took her outside. NA #1 said she calmed down and returned into the building. Resident #1 was in the hallway talking to Nurse #1. NA #1 stated she was walking past and paying Resident #1 no attention. Resident #1 said something to her and kept saying stuff to her. NA #1 said that was when she tried to "get at him". NA #1 said Resident #1 said she hit him but she denied that she hit him. NA #1 said NA #2, NA #3 and Nurse #3 grabbed her and took her outside of the building. NA #1 said the police came to the building but, the first time, she had left the building and had gone to the police station. When she went to the police station, they said there had been no charges filed. NA #1 stated she went back to the facility to the smoking area across the street so her cousin could get her belongings. The police came back a second time, put her in handcuffs and took her to the police station but no charges were filed. NA #1 stated she had reached her breaking point and again stated she did not make any physical contact with Resident #1.

On 10/10/17 at 8:44 AM, an interview was conducted with Resident #1. He stated it was Friday morning around 7:30-8:00 AM. He had found out that NA#1 was working on his hall for the 3rd or 4th time. Resident #1 stated she could not work on his side when the other aide took a

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break or was not on the schedule because he and NA#1 could not work together. They had a problem previously and she had been taken off his assignment. Resident #1 said he went to NA#2 and told her he didn ' t want NA#1 on his hall. NA#1 wasn ' t on his assignment but was working the opposite side of the hall so would have been working with him when the other nursing assistant took breaks.

Resident #1 stated he went to his room and grabbed some change to get a drink in the lounge area at the front door. He said he saw NA#2 at the nurse ' s station top of 200 hall talking to Nurse #2. She was talking to her about Resident #1 wanting to get NA #1 off his hall and how much trouble it was causing. Resident #1 asked her to please stop talking about him in front of other patients and stuff. NA #2 stated she was talking to management and Resident #1 said he told her that was fine but not to talk about him in front of a bunch of people. NA #2 turned her back to Resident #1 and he got mad. He raised his voice to NA #2. About that time, NA #1 came around the corner and Resident #1 stated he did not know what he said but he was still talking to NA #2. NA #1 got in the conversation and he told her to stay out of it. Resident #1 and NA #1 had words with both of them shouting, name calling and cursing at each other. Resident #1 stated the next thing he knew, she became a windmill swinging her arms and kicking her feet trying to get to him. He said she did not make physical contact but was saying she was going to (profanity) me up. She was about 3 feet away from him at the time. NA#1 was crying and screaming. Staff took her to a room down 200 hall on the left hand side of the hall. Then NA #1 tried to come back out talking junk and Resident

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#1 was talking junk too. NA #1 tried to hit Resident #1 again. Staff took her down the hall again. He thought she remained in the building.

Resident #1 stated he was talking to Nurse #1 in the hallway near the Director of Nurse ' s office around 9:00 AM (not sure of time) and was telling her what happened. Nurse #1 said she would call the Director of Nursing. NA #1 came around the corner from the dining room with mean look on her face and her fists balled. She kind of cut her eyes at resident #1 and he told her not to cut her eyes at him. NA #1 hit Resident #1 in the head, shoulders, arms, legs and chair. Resident #1 stated Nurse #1 was a witness to the event. He said he didn ' t say anything else to her except she was going to jail. Resident #1 said he only got a long scratch on his left upper arm. He said he had no other physical injuries.

A nursing note dated 10/6/17 at 9:01AM indicated Resident #1 was assessed for injury via head to toe assessment with no noted injury.

On 10/10/17 at 11:05 AM, an interview was conducted with Nurse #3. She stated she was at the nursing station counting narcotics with Nurse #5 around 7:15 AM. One of the aides came and asked them to call a code green because one of the residents was on the floor (400 hall). When she walked down the hall, she saw Resident #1 coming down 400 hall towards the nursing station saying if the aides were on the hall, he wouldn ' t have fallen. It was their fault that he fell. Nurse #3 stated she heard the comment in passing but didn ' t take much stock of it because the nursing staff had been on the hall at the time the resident fell. She went back to the medication cart to finish counting narcotics. As they were counting

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F 226	Continued From page 38 narcotics, Nurse #3 remembered seeing Resident #1 come across the nursing station to 200 hall where NA #2 was talking to Nurse #2. Nurse #3 heard arguing between NA #2 and Resident #1. Resident #1 got louder and cursing and told NA #2 she did not know what she was doing as he pointed at her. Resident #1 was fussing at NA #2 because he did not want NA #1 anywhere on his hall in addition to making the statement that NA #1 let a resident fall. Na #2 began to ignore him and resumed talking to the person she was talking to. Resident #1 continued to curse at NA #2. Nurse #3 stated she did not see NA #1 walk in resident #1 ' s direction. When Nurse #3 looked back up, she heard Resident #1 call NA #1 a (profanity). By that time, both Na #1 and Resident #1 were yelling and cursing at each other. NA #1 was telling Resident #1 she was not on his hall and she was not bothering him. They started calling each other profane names and NA #1 told Resident #1 she was not messing with his (profanity). Resident #1 stood up and he was pointing at her and they were yelling at each other. When he stood up, NA #1 went towards him. Nurse #3 stated she went towards NA #1 because NA #1 was shaking other staff off her with her arms saying get off of me. Nurse #3 said she grabbed NA #1 from the front and she was trying to get Nurse #3 away from her. Nurse #3 then bear hugged NA #1 and tried to calm her down because they were related she thought she could calm her down. All this happened at top of 200 hall. Nurse #3 walked NA #1 down 200 hall and around the corner to calm her down. She was visually upset, saying she was getting tired of this, talking junk to us, threatening us and could not take it anymore. Nurse #3 suggested she go	F 226		

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F 226	Continued From page 39 outside to calm down. Nurse #3 took her out and then came back in to the building to complete counting narcotics. One of the shower aides came to Nurse #3 and told her that Resident #1 had said he was going to get rid of NA #1 one way or the other. She said she told somebody else but not NA #2. Nurse #3 went outside to tell NA #2 about the conversation and NA #1 seemed calmer at that time. Nurse #3 said she came back inside but did tell NA #1 and NA #2 that Resident #1 was talking to Nurse #1. They were near the nursing station. NA #2, NA#1 and Nurse #3 were going to get NA #1 ' s belongings. Nurse #3 stated she did not visualize the next blow up. They were fussing again. This time, Nurse #3 grabbed NA #1 and pulled her out of the doors. Nurse #3 stated she did not see any physical contact on either party. On 10/10/17 at 3:01 PM, an interview was conducted with the Director of Nursing (DON) and the Administrator. She stated she received a phone call between 7:47 AM and 7:57 AM from Nurse #1 and was informed that a staff member had struck a resident. She told me there was someone on the phone calling 911. The DON said she asked if the staff member had been removed from the building and she was told yes and the resident was ok. The DON stated she called the Administrator immediately after getting off the phone and told her that a staff member had struck a resident and that the staff member had been removed from the building and the resident was ok. The Administrator added that she was called while she was enroute to the facility and was informed the police were at the building. The DON stated the police were at the facility when she arrived. She was told the staff member who had assaulted the resident had	F 226		

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borrowed someone ' s car and she had left the premises. The DON stated around 9:00 AM, both she and the Administrator went to Resident #1 and assessed him for injuries. No injuries were noted and Resident #1 did not complain of any pain at the time of the assessment. Resident #1 explained to them that both of them (resident #1, NA #1) got into verbal altercations and "went at each other" meaning verbal arguing and cursing at each other. He did state his left knee would probably start hurting because he stood up at the time of the altercation. The DON asked him if he needed to go to the hospital and he declined. The DON stated she called the physician at 9:22 AM and began the investigation.

The DON continued to state what happened next: At 8:50 AM, they received several statements and gave them to Administrator. At 9:00 AM, the Administrator and DON assessed Resident #1. At 9:22 AM, the facility spoke to the Medical Director and conducted an interview with Resident #1 ' s roommate. At 9:35 AM, the facility called the agency that employed NA #1 and informed them of the situation that had occurred between Resident #1 and NA #1.

On 10/11/17 at 8:30 AM, a telephone interview was conducted with the police officer from the (name) Police Department who responded to the call 10/6/17. He stated he and another police officer responded to a 911 call that an assault had occurred at the nursing home. He stated, when they arrived, the female aggressor had left the facility. He spoke to Resident #1 and spoke to Nurse #1. Nurse #1 stated the nursing assistant (NA #1) and Resident #1 got into an argument in the hallway and NA #1 had hit Resident #1. The police officer stated Resident #1 had a few

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surface scratches on his left upper arm. During the interview, Resident #1 was agitated and appeared angry-was not yelling but, by the way he was talking to the officer, he was upset over the situation. The police officer stated NA #1 was arrested when she returned to the facility area later in the morning but no charges were filed. He stated both parties were going to file warrants out against each other. The Magistrate talked to both parties and it was decided on both parties that no charges would be filed.

The corrective action for past non-compliance dated 10/7/17 was as follows:

On 09/17/17, nursing assistants reported to the charge nurse that Resident #1 was using profanity towards the accused agency nursing assistant and one other agency nursing assistant. Resident #1 stated the nursing assistants should stay on the hall. Resident #1 has ongoing behavioral issues, is care planned for demonstrating behaviors, and treated by the physician and psychiatric services for behaviors. The two agency nursing assistants did not engage Resident #1 and instead the staff nurse intervened. The staff nurse re-assigned another nursing assistant to Resident #1 for the duration of the shift.

On 10/06/17, the accused agency staff employee was walking in the hall and had a verbal interaction with Resident #1. Resident #1 stood up and made a statement and used profanity towards the accused agency staff. The accused agency staff used profanity in return towards Resident #1. The agency licensed practical nurse removed the accused agency staff immediately from the facility. The agency licensed

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F 226	Continued From page 42 practical nurse and facility scheduler escorted the accused agency nursing assistant back into the facility to speak with the director of nursing (DON), not knowing the director of nursing was not at the facility. Instead, the quality improvement (QI) nurse was entering the facility where Resident #1 met her on the administrative hall. Immediately upon the agency nursing assistant entering the administrative hall, Resident #1 used profanity towards the agency staff again. The accused agency staff walked by Resident #1, who was sitting in a wheelchair, and swung at Resident #1. The agency staff struck Resident #1 ' s upper left arm with an open hand. The accused agency staff was immediately removed from the facility a second time by the facility staff scheduler and agency staff nurse. The QI nurse notified the director of nursing (DON). The DON notified the administrator. The QI nurse was assessing the resident and facility treatment nurse called 911 at 8:00 AM. The city police responded and interviewed Resident #1. The accused agency staff left the facility to self-report to the county magistrate. The accused waited off campus and the city police returned and escorted the accused to the magistrate. On 10/06/17, the DON called and verbally notified via telephone Resident #1 ' s nurse practitioner. Later on 10/06/17, the DON spoke via telephone to Resident #1 ' s physician/facility medical director. No new orders were received from the nurse practitioner or physician. On 10/06/17 in the afternoon, the DON called the psychiatric nurse supervisor and within 30 minutes the psychiatric nurse practitioner was in the facility and assessed Resident #1 related to ongoing behaviors. On 10/06/17 at 9:57 AM, the administrator faxed a 24 hour report for allegation of abuse/suspicion of a crime to the North	F 226		

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F 226	Continued From page 43 Carolina Health Care Personnel Registry. On 10/06/17, the DON assessed Resident #1 for physical injury with no signs of injury noted. As of 10/06/17, the plan to manage the resident behavior in the facility includes 1) the administrator and DON permanently removing the accused agency nursing assistant from the staffing roster, 2) the registered nurse/QI nurse ' s daily support through conversation and encouragement, 3) 1-to-1 staff assignment to assist Resident #1, 4) psychiatric services, 5) Master ' s in Social Work (MSW) social worker meetings to discuss feelings, 6) the DON will work with the physician to provide Resident #1 with tangible interventions for skin and pain relief. On 10/06/17 at approximately 7:55 AM, the accused agency staff was removed permanently from the Richmond Pines facility by the facility scheduler and agency licensed practical nurse while the QI nurse was assessing the resident and facility treatment nurse called 911. On 10/06/17 at approximately 8:16 AM, the DON, QI nurse, and corporate clinical director had identified the root cause of the problem: the agency nursing assistant should not have been allowed back into the facility after the first verbal interaction on 10/06/17. Why did the resident get hit? Because the agency nursing assistant hit the resident. Why did the agency nursing assistant hit the resident? Because the nursing assistant swung at the resident. Why was the agency nursing assistant swinging to hit the resident? Because the assistant was upset. Why was the agency nursing assistant upset? Because of a verbal interaction with the resident. Why was there a verbal interaction with the resident?	F 226		

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Because the nursing assistant was being brought in for an interview. Why was the agency nursing assistant being brought in for an interview? Because there was an earlier verbal altercation. Because there was an earlier verbal altercation, the employee should not been allowed back into the facility. The facility staff thought the agency nursing assistant needed to be interviewed and drug tested.

On 10/06/17 at approximately 9:37 AM, the facility administrator and DON notified the staffing agency that the accused agency staff would not be allowed to work at the facility.

On 10/06/17 at 10:45 AM, the social worker initiated abuse interviews for all interviewable residents. The interviews were completed at 1:40 PM. The interviews resulted in no concerns expressed by interviewable residents.

On 10/06/17, beginning at approximately 11:00 AM, the treatment nurse and floor nurses assessed all non-interviewable residents who are unable to communicate or who are disoriented. On 10/06/17, the body audits were completed. The 100% body audits of all non-interviewable residents resulted in no identified bodily signs of abuse.

On 10/06/17, the DON completed a review of all nurse progress notes for the time period of 09/22/17 through 10/06/17 for any incidents of abuse/neglect. No incidents of abuse/neglect were identified during the progress note review by the DON.

The processes that lead to the deficiency cited:

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To address the processes that lead to the deficiency cited and why it escalated to a physical altercation the facility performed at root cause analysis. The root cause analysis using "5 Whys" determined: 1) the physical abuse would not have happened if the accused agency nursing assistant had not been allowed to re-enter the facility after the initial verbal altercation, 2) if the facility and agency staff would have recognized the initial verbal altercation as a problem with the potential to escalate, and 3) the importance of preventing abuse/neglect. It was determined that the facility needed to train staff on: abuse neglect policies and procedures, prevention of abuse/neglect, identification of abuse/neglect, protecting the resident from abuse/neglect, protecting the staff from burn out, and immediately reporting abuse/neglect.

On 10/06/17, the regional vice president trained the department leaders regarding the policy for abuse/neglect, including reporting requirements.

On 10/06/17, the staff facilitator initiated in-servicing for all staff on abuse/neglect. The training included the definition of abuse/neglect, the types of abuse/neglect, and reporting abuse/neglect immediately. The in-service was completed on 10/10/17 for all staff who have worked. No staff worked until they had received the abuse neglect in-service.

On 10/06/17, the staff facilitator initiated in-servicing for all staff on burn-out. The training included what burn out is. The burn out in-service covered the signs and symptoms of burn out, what to do when feeling frustrated, to let the supervisor know when experiencing/feeling early signs of burn out, and to report to a

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supervisor when a co-worker shows signs and symptoms of burn out. The in-service was completed on 10/10/17 for all staff who have worked. No staff worked until they had received the burn-out in-service.

On 10/06/17, the DON called a staff meeting with the nurses to knowing where the nursing assistants are at all times, about the abuse/neglect in-service, about the burn out in-service, and about correct staffing assignments. On 10/06/17, the DON called a nursing assistant meeting at the nurse station to review the in-services, offer clarification and support regarding the allegation of abuse/neglect. The DON encouraged the facility staff to communicate with management when they see something that is not right. The DON assured the staff the management team that talking about problems is healthy and that the staff can come to the DON.

The DON and staff agreed that having more discussions about abuse/neglect and burn out will help prevent future conflict escalation and potential for burn out.

How systems will be monitored to prevent reoccurrence:

The facility social worker will interview all interviewable residents weekly for 8 weeks regarding verbal and physical abuse to ensure any allegations have reported and addressed. All identified areas of concern related to abuse will be reported to the Administrator and/or director of nursing (DON) immediately to investigate.

Charge nurses will complete head-to-toe

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F 226	Continued From page 47 assessments on residents who are disoriented or unable to speak for themselves to check for signs of abuse/neglect. The head-to-toe assessments will be completed weekly for 8 weeks to ensure no signs or symptoms of abuse/neglect are present. All identified areas of concern related to abuse/neglect will be reported immediately by the nurses to the administrator and/or DON to investigate. The staff facilitator and/or quality improvement (QI) nurse will continue abuse/neglect in services for all staff monthly for two months and all new employees hired will receive this training before working with residents. The administrator and/or DON will review all alert and oriented resident interviews weekly for 8 weeks to ensure interviews are completed and that any areas of concern related to abuse/neglect are investigated and reported as appropriate. The administrator and/or DON will review all head-to-toe assessments of residents who are disoriented or cannot speak for themselves to ensure that any suspicions of abuse/neglect are investigated as appropriate. The administrator, DON, QI nurse, and minimum data set (MDS) nurse leadership team are monitoring for staff burn out by 1) reviewing audit results, 2) facilitating staff meetings, 3) creating an environment of acceptance of self-reporting, 4) offering support to facility and agency staff through the burn out in-services, 5) easy access postings of the human resources names and phone numbers as an advocate, 6) the payroll manager will monitor payroll hours for excessive overtime and sick call-outs, 7) the staff scheduler will monitor the staffing schedule for overtime and	F 226		

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	345293	A. BUILDING ______ B. WING ______	C 10/12/2017

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F 226	Continued From page 48	F 226		

excessive breaks, 8) the administrator and DON will monitor for an increase in disciplinary actions.

All findings will be brought to the monthly facility Quality Assurance and Performance Improvement (QAPI) meeting for review by the interdisciplinary team.

On 10/06/17, the administrator, DON and facility medical director had an impromptu Quality Improvement (QI) Executive Committee meeting to specifically review the facility four point plan related to abuse/neglect and monitoring tools.

The monthly QI Executive Committee will review all audit tool results, results of interviews, and facility progress with each step of the plan, to validate the systems and processes remain in place and are effective. The administrator is responsible for implementing this plan of correction and QI Executive Committee recommendations.

As part of the validation process on 10/11/17 and 10/12/17, the plan of correction was reviewed including the re-education of staff. Interviews with licensed and unlicensed staff (facility and agency staff) revealed they were retrained in the areas of abuse/ neglect policies and procedures, prevention of abuse/ neglect, identification of abuse/ neglect, protecting the resident from abuse/ neglect, protecting the staff from burn out and immediately reporting abuse/ neglect. A review of the monitoring tools revealed the facility completed 100% of resident interviews on 10/6/17, 100% of body audits of residents who were unable to be interviewed on 10/6/17. All staff, including agency staff, received the abuse and burn out in-service on 10/6/17.

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F 285 SS=D	PASRR REQUIREMENTS FOR MI & MR CFR(s): 483.20(e)(k)(1)-(4) (e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: (1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. (2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. (k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. (1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and	F 285		11/1/17

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F 285	Continued From page 50 (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. (2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the	F 285		

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F 285	Continued From page 51 condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. (3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. (k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to coordinate with the Preadmission Screening and Resident Review (PASRR) Program for reevaluation of their PASRR level II for continued stay at the facility for one of one sampled residents with a level two screening (Resident #1). The findings included: Resident #1 was admitted to the facility 5/10/16. Cumulative diagnoses included major depressive disorder, suicidal ideations, anxiety and bipolar	F 285	Ftag 285 Four Point Plan Criteria Richmond Pines Healthcare 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	

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affective disorder.

A Quarterly Minimum Data Set (MDS) dated 10/2/17 indicated Resident #1 was cognitively intact with a Brief Interview for Mental Status (BIMS) of 15. No behaviors were noted on the assessment

A review of Resident #1 ' s PASRR dated 5/16/17 noted he was PASRR level II code F and the expiration date was 8/14/17. The placement determination indicted nursing facility placement was appropriate for a 90 day period.
The authorization codes and corresponding timeframes/ restrictions for North Carolina PASRR state code F is "30, 60, 90 day limited stay-level 2 reviews only".

On 10/11/17 at 12:37 PM, an interview was conducted with the Social Worker. She stated she had been employed at the facility since July 20, 2017. The Social Worker stated she found out yesterday (10/10/17) that she was responsible for the PASRR level II renewals. She indicated she did not know who was responsible for the renewals prior to her employment. The Social Worker said this was her first social worker job and she had not had any training on PASRR level II. She said it was not covered in her orientation.

On 10/11/17 at 12:37 PM, an interview was conducted with the Administrator who stated she did not know who was responsible for monitoring and renewals of PASRR level II but she would find out.

On 10/12/17 at 11:15AM, an interview was conducted with the Licensed Professional Counselor from the Medicaid Uniform Screening

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written allegation of compliance.

Richmond Pines Healthcare and Rehabilitation Centers 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, Richmond Pines Healthcare 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

The position of Richmond Pines Healthcare and Rehabilitation center regarding the process that lead to this deficiency was staff failed to follow established facility policy and protocol related to Preadmission Screening and Resident Review Program (PASRR) program requirements by failing to coordinate with PASARR for reevaluation of their PASRR level II.

What measures did the facility put in place for the resident affected:
On 10/11/17 the admissions director requested for resident # 1 to have a screening for PASARR renewal from the Medicaid Uniform Screening Program (MUST). On 10/12/17 resident # 1 was screened by a Licensed Professional Counselor from MUST and PASRR evaluation was completed. The findings for Resident #1 evaluation resulted in Level II status.

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F 285	Continued From page 53 Program (MUST). She stated she had seen Resident #1 since his admission to the facility two years ago. She indicated her agency received a request from the facility on 10/11/17 at 10:36AM for the PASRR renewal for continued skilled nursing services. The Licensed Professional Counselor said she received the request at 8:00AM 10/12/17 and it was assigned for her to come out to complete the PASRR review. She stated she would complete the PASRR evaluation and, based on multiple interviews and documentation and observation, that continued skilled nursing would be recommended. On 10/12/17 at 3:52PM, an interview was conducted with the Administrator who stated the social worker was responsible for the PASRR level 2 and she expected the PASRR level II to be current and up to date.	F 285	What measures were put in place for residents having the potential to be affected: On 10/11/17 a 100% audit was completed for all residents with a level II PASRR to ensure there were no expired PASRRS by the facility admissions nurse with no other Level II expired PASRRS. What systems were put in place to prevent the deficient practice from reoccurring: On 10/11/17 the Social Worker was in-serviced by the admission director related to PASRR levels and the need for level II PASRR□s to be reevaluated as indicated. How the facility will monitor systems put in place: On 10/11/17 the social worker began auditing level II PASRR□s using the PASRR audit tool to ensure there were no expired PASRR□s and request for screening has been completed as necessary. This audit will be completed weekly x 12 weeks on going conducted by the admissions nurse. The admission nurse will present all findings at the monthly QI committee meeting for three months. The QI committee will review the monthly for three months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance.	

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F 285	Continued From page 54	F 285	The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	